KING EDWARD'S HOSPITAL FUND FOR LONDON

The HOSPITAL SERVICES *of* WESTERN EUROPE

Report of the

WESTERN EUROPEAN CONFERENCE

November 1962

Held at

THE HOSPITAL ADMINISTRATIVE STAFF COLLEGE

2 Palace Court Bayswater London W2

England

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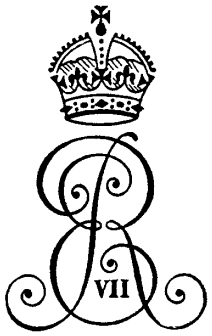
FOR LONDON



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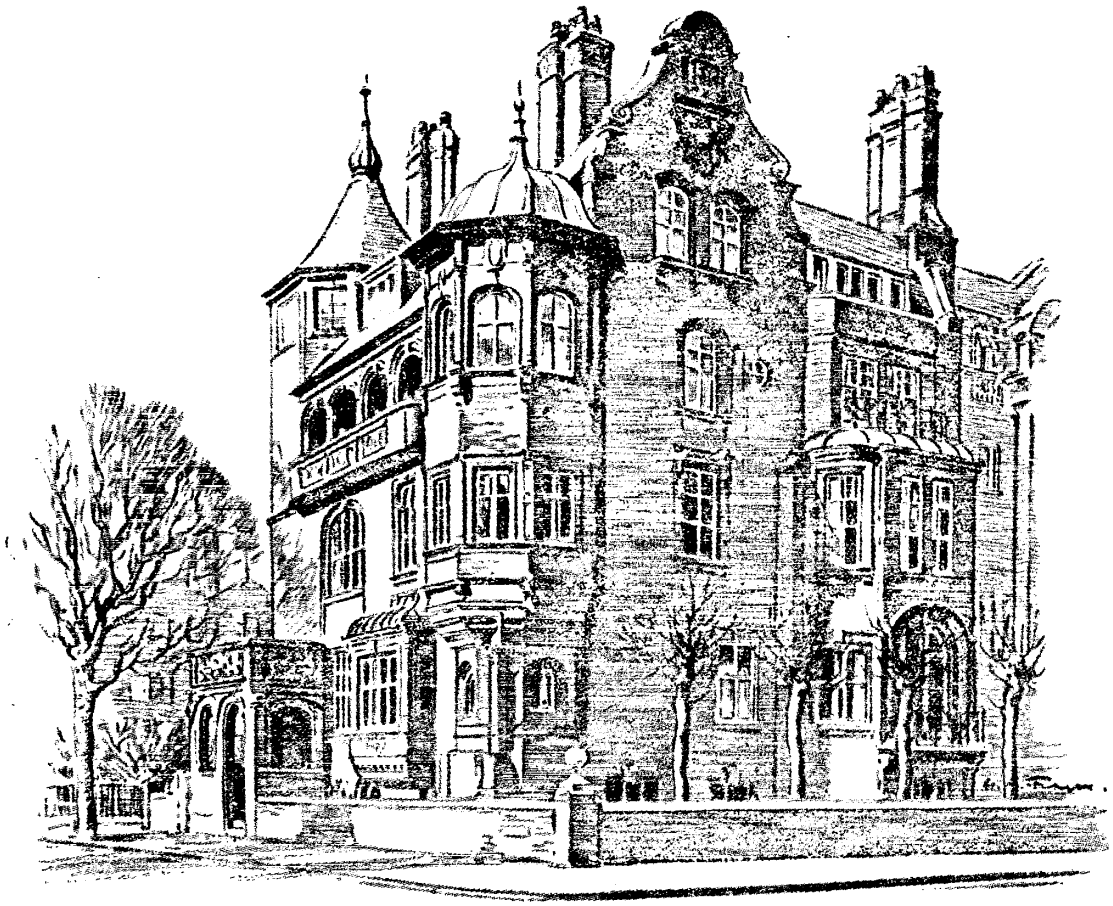

No. 2 Palace Court
(Headquarters of the Staff College)

KING EDWARD'S HOSPITAL FUND FOR LONDON

PATRON:
HER MAJESTY THE QUEEN

PRESIDENT:
HIS ROYAL HIGHNESS THE DUKE OF GLOUCESTER

TREASURER:
LORD ASHBURTON, K.C.V.O.

CHAIRMAN OF THE MANAGEMENT COMMITTEE:
LORD McCORQUODALE, P.C.

SECRETARY:
R. E. PEERS

The Fund was established in 1897 *by His Majesty King Edward VII (when Prince of Wales) for the 'support, benefit or extension' of the hospitals of London, and was incorporated by Act of Parliament in* 1907. *It is not directly affected by the provisions of the National Health Service Act of* 1946.

It was from the first intended that it should:

(*a*) *be a permanent Fund as distinct from a mere agency for the distribution of monies received;*

(*b*) *concern itself with efficiency as well as with the need of hospitals for monetary assistance.*

Moreover it was in the minds of those associated with the foundation of the Fund that it should exercise a co-ordinating influence over hospital affairs in London, and enlist the help of all in the search for solutions to the problems of the metropolitan hospitals.

For fifty years the main functions of the Fund were the distribution of grants and the provision of a system of visitation which did much to help and improve the voluntary hospitals in the Greater London area. In recent years, and more particularly since the coming into operation of the National Health Service Act, the Fund's activities, though still directed to easing the burden thrown upon hospitals, have tended to cover a much wider field.

The last half-century has witnessed a growing recognition throughout the community of the value of training for almost all kinds of work and of good principles and practice in the management of staff. As the Fund's resources were released from the demand of annual maintenance it became clear that they could be invested to good effect in the establishment, amongst other activities, of training centres. Thus the King's Fund now conducts, in addition to the Hospital Administrative Staff College, residential Staff Colleges for Ward Sisters and for Hospital Matrons and a School of Hospital Catering.

HOSPITAL ADMINISTRATIVE STAFF COLLEGE

2 Palace Court, W.2 .. .. *Telephone:* BAYswater 9361

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* Mr. R. A. Mickelwright retired from the office of Principal of the Staff College and was succeeded by Mr. F. R. Reeves on August 1st, 1963.

† Work Study Project.

PREFACE

The Comparative Study of Hospital Services in Western Europe and the papers presented by the participants at the Western European Conference, which are reproduced in this report, indicate the valuable exchange of information which took place during the week's discussions.

The Management Committee of King Edward's Hospital Fund for London were honoured to provide the resources of its Hospital Administrative Staff College for the organization of the conference and wish to record their appreciation of the support of the International Hospital Federation, the contributions of the participants, the special assistance given by Professor T. E. Chester and the authorship of Part I, the Comparative Study by Dr. H. M. C. Macaulay, C.B.E.

The conference proved so successful that those who participated expressed upon its close the strong hope that further discussions might be held. The King's Fund and the International Hospital Federation have accordingly agreed to organize a Second European Conference to be held at the Hospital Administrative Staff College in April 1964.

McCorquodale of Newton
Chairman
Management Committee
King Edward's Hospital Fund for London

October 1963

NOTE BY THE CHAIRMAN OF THE CONFERENCE

R. A. MICKELWRIGHT, O.B.E.
Principal, Hospital Administrative Staff College

The Conference, which lasted five full and intense days, was not long enough to enable all the discussions to be completed and it was necessary, in particular, to shorten substantially the contributions in respect of the United Kingdom.

In order to keep this book to a reasonable size, it has not been possible to include bibliographies, statistical and other factual information so generously furnished by participants. It is regretted, also, that full information about the various training and refresher courses and their content cannot be included.

It was a great privilege to be the Chairman of this Conference and I should like to place on record my appreciation and sincere thanks to the participants for their co-operation during the conference week.

INTRODUCTION

During the past few years there has grown up a rapprochement between the nations of Western Europe of a very encouraging kind. Not only have problems of defence, of trade and of fiscal policy been the subject of concerted action between statesmen but the ordinary citizens of the European countries have become better acquainted with one another. Ease of travel and of communications has enabled the diverse institutions and customs of the various countries to be experienced and usually understood and appreciated by an ever-widening circle of people. In this connection international visits to hospitals and medical conferences are now a commonplace and we Europeans are increasingly taking a friendly interest in the way our neighbours organize their affairs.

In 1962 King Edward's Hospital Fund for London decided to convene a European Conference of very senior administrators of the health services of Western Europe to consider and discuss the hospital services, their organization and scope with special reference to methods of administration. King Edward's Hospital Fund, as a non-governmental body, is in a singularly fortunate position to provide an independent forum for a conference of this nature, enabling discussion to take place with a degree of frankness which might not be possible everywhere. Invitations were issued and during the last week in November 1962 a very imposing international gathering was assembled in London. The participants were invited as individuals and not as delegates and therefore were not necessarily constrained to put forward or support the official policy of their respective governments but were free to express their own views on methods of organization and programmes of hospital development most suited to the needs of their own countries. Those attending the conference worked and lived together for a week at the King's Fund Hospital Administrative Staff College in London and thus in addition to taking part in the formal sessions had plenty of opportunity for informal talks and for establishing personal relationships with one another—one of the most important features of an international gathering.

From each country was presented a paper written by the

representative of that country (sometimes there were more than one) dealing in fairly general terms with the principal features of its hospital service. These papers were printed in advance, circulated to all those attending and at the morning and afternoon sessions were taken as read. So far as practicable the countries were taken in alphabetical order and a session devoted to each. Each speaker was asked to speak to his paper, bringing out any points of special importance and open a discussion on the hospital service of his country. Discussion was animated and occupied the rest of each session: indeed it could have gone on for a much greater length of time, so great was the interest shown.

At the end of the week it seemed to be the unanimous feeling that the conference had been a great success, that it had been stimulating and had provoked new thinking on old problems and that it should be the forerunner of further similar meetings.

The participants were as follows:

Belgium	Dr. S. Halter, Directeur-Général, Ministère de la Santé Publique et de la Famille, Administration de l'hygiene Publique. Professor G. van der Schueren, Director, University Clinics, Catholic University of Louvain. Dr. A. Prims, Director, Federation of Catholic Hospitals.
Denmark	Dr. C. Toftemark, Deputy Director-General, National Health Service of Denmark.
Finland	Professor Dr. N. Pesonen, Director-General, State Medical Board. Dr. O. Vauhkonen, Chairman of Direction, Foundation for Education in Hospital Administration.
France	M. L. Peyssard, Inspecteur Général, Au Ministère de la Santé Publique et de la Population.
Ireland	Mr. C. O. Nuallain, Training Officer, Institute of Public Administration.
Italy	Professor F. Benvenuti, The Catholic University of Milan and The Institute of Public Administration.

Netherlands	Dr. J. B. Stolte, Medical Director, St. Elisabeth-Ziekenhuis.
Norway	Dr. H. Palmer, President, Norwegian Hospital Association.
*Portugal	Dr. C. A. Ferreira, Director-General of Hospitals, Ministério de Sáude e Assisténcia.
Sweden	Dr. A. Engel, Director-General, Royal Medical Board. Mr. G. Albinsson, Landstingets kansli. Mr. G. Högberg, Director, Sundsvalls lasarett.
Switzerland	Dr. (iur.) F. Kohler, Director, Inselspital.
Western Germany	Dr. S. Eichhorn, Manager, German Hospital Institute.
World Health Organization	Dr. L. Kaprio, Public Health Administrator, Regional Office for Europe.
International Hospital Federation	Dr. J. C. J. Burkens, Secretary-General. Mr. D. G. Harington Hawes, Director-General.
United Kingdom	Professor J. H. F. Brotherston, Department of Public Health and Social Medicine, University of Edinburgh. Professor T. E. Chester, Department of Social Administration, University of Manchester. Mr. N. W. Graham, C.B., Under-Secretary, Scottish Home and Health Department. Mr. J. Kinnaird, Department of Public Health and Social Medicine, University of Edinburgh. Dr. D. Macmillan, Director, Nuffield Centre for Hospital and Health Service Studies, University of Leeds. Mr. A. S. Marre, C.B., Under-Secretary, Ministry of Health. Mr. G. McLachlan, Secretary, Nuffield Provincial Hospitals Trust. Mr. R. A. Mickelwright, O.B.E., Principal, King's Fund Hospital Administrative Staff College. Mr. S. R. Speller, O.B.E., Secretary and Director of Education, The Institute of Hospital Administrators. Professor W. S. Walton, G.M., Professor of Public Health, London School of Hygiene and Tropical Medicine.

*Unable to attend.

The chair at the opening session was taken by The Rt. Hon. Lord McCorquodale of Newton P.C., Chairman of the King Edward's Hospital Fund and at the subsequent sessions by Mr. R. A. Mickelwright, O.B.E., Principal of the Staff College.

This Book of the Conference takes the following form: Part I deals briefly with some of the principal features of the hospital systems or services of Western Europe as delineated at the conference. Part II contains a reprint of each of the papers presented.

PART I

A COMPARATIVE STUDY OF THE HOSPITAL SERVICES IN WESTERN EUROPE

A COMPARATIVE STUDY OF HOSPITAL SERVICES IN WESTERN EUROPE

In spite of its high-sounding title this section does not purport to do more than indicate in brief and summary fashion some of the salient points of the hospital services in the countries concerned. The information is derived from papers presented at the recent conference and even more from the discussions which these papers evoked. This has been supplemented here and there by observations of the writer based upon visits to see the hospital services in many of the countries represented. In these circumstances the amount of space devoted to each country is dependent upon the amount of information which happened to be readily forthcoming and is in no way an indication of the relative importance or state of development of the services described. It is unfortunate that the representative from Portugal was unavoidably prevented at the last moment from attending the conference although his paper was circulated. As no discussion of the paper was therefore possible, and as the points raised in discussion supplied the greater part of the information contained in this chapter, reference to the hospital services of Portugal has been omitted although Dr. Ferreira's paper is printed in this book.

The kind of hospital service which any country possesses is largely governed by tradition and custom. These can be of great benefit or on the other hand may prove a handicap in the development of a hospital service. The hospitals which a country has inherited from the past may be accompanied by traditional vested interests in the shape, perhaps, of civic pride which being deeply ingrained may prevent developments which many people would regard as highly desirable. In most parts of the world social changes are taking place at a rapid rate and a hospital needs to adapt itself to these changing conditions. It used to be said that in a case of serious illness the only people who got skilled medical care were the very rich and the very poor. In recent years, however, the public image of the hospital has entirely altered and it has been realized by the great majority of people everywhere that it is only in a hospital that the highest skill and specialized equipment needed in the more

complicated cases is likely to be available. Today therefore there is a greater use being made of the acute general hospital for all classes of the population than there has ever been. This increasing use is being accompanied by rising costs both capital and maintenance due partly to a degree of inflation which has affected all countries to a greater or less degree. The greatest single factor in the running cost of hospitals is the pay-roll which accounts for 50% to 60% of expenditure in Belgium and West Germany, rising to nearly 75% in Sweden. Costs of this order make the use of mechanical aids and of efficiency techniques in hospital a virtual necessity.

Another change which has affected all the countries of Western Europe is the ageing of the population. The expectation of life for men and women is far greater than it used to be and this phenomenon entails the provision of medical care to deal with the conditions to which the aged are susceptible. In every country there seems to be a shortage of accommodation and facilities to deal with the elderly sick. On the other hand medical science has succeeded to a great extent in bringing under control tuberculosis and the acute specific fevers. In consequence a substantial amount of hospital accommodation provided in years gone by for the treatment of these conditions has become redundant and where appropriate is being turned to other use.

Lastly every country of Western Europe was affected to a greater or less degree by the Second World War. In some the effect was no more than a financial stringency which may to some extent have curtailed expansion. In others, however, the effect was catastrophic and many hospitals were partly or completely destroyed.

In the following sections various aspects of Western European hospitals are discussed in the light of remarks made above.

OWNERSHIP, CONTROL AND MANAGEMENT

Technical ownership of a hospital is of less practical importance than the means taken for its control and management. In the United Kingdom practically all hospitals are owned by the state and ultimate responsibility for the service is in the hands

of Ministers who are answerable to Parliament. A very wide measure of decentralization has taken place, however, and much of the Minister's responsibility has been delegated to regional hospital boards (of which there are 21, covering the whole country—15 in England and Wales, 5 in Scotland and one in Northern Ireland) while the day to day running of the hospitals is carried out by local hsopital management committees. In England and Wales teaching hospitals are managed by boards of governors with wide powers, directly answerable to the Minister.

In most of the countries represented at the conference ownership and control of the great majority of the hospitals is public, that is to say they are owned and managed by the state or by local authorities. This however is not the case in the *Netherlands* and *Belgium* in which most of the hospitals are owned and managed by voluntary or charitable organizations such as was the position in Great Britain before the introduction of the National Health Service.

In the *Netherlands*, by tradition as much as possible is left to private enterprise and central control is kept to a minimum. Only about 20% of general hospitals (with about 25% of the beds) are run by the state or local authorities, the remainder are voluntary non-profit-making institutions. Most psychiatric hospitals, however, are run by the provinces. As is mentioned elsewhere there is a tendency to establish hospitals according to creed, and ownership and control in the Netherlands tend to follow denominational lines.

In *Belgium* more than two-thirds of the hospitals (60% of the beds) are owned and managed by private organizations, more than half of which are religious orders, who own and manage 75% of the beds for mental patients. A few hospitals are run by insurance societies and some by privately practising doctors. Of the public hospitals most belong to, and are administered by, the communes, or combinations thereof, through bodies known as public assistance commissions (C.A.P.) of which the local burgomaster is *ex officio* chairman. One university hospital at Ghent belongs to the state as do four establishments for committed mental patients.

In the Scandinavian countries and Finland the pattern of ownership is very similar, nearly all hospitals being publicly owned and managed.

Denmark has one state-owned university hospital at Copenhagen and practically all the other general hospitals are owned and administered by local authorities. Mental hospitals are generally provided by the state.

In *Sweden* the general hospitals are owned and managed by the 25 county councils or councils of the great cities. A very small number of hospitals are run privately or by the social insurance 'funds'. The mental hospitals and three university hospitals still belong to the state.

Norway has one general hospital in Oslo belonging to the state. The state also owns a number of mental hospitals, but steps are now being taken to hand these over to local authorities. The municipalities and the provinces take the initiative in the provision of hospitals and the aim is to have a fairly large (400 beds) general hospital in each of Norway's 20 provinces. The local authority, municipality or province, is the owning authority of the public hospitals. This has always been the traditional pattern in Norway where charitable organizations have never played a large part. There are, however, today a few private hospitals run by religious bodies, but the contribution they make to the country's hospital provision is very small, they are growing fewer in number and are likely to disappear.

In *Finland* voluntary hospitals have never been important and today they account for only about 10% of the hospitals and 6% of the beds. In some cases they receive government aid. Ownership and management of most of the public hospitals are in the hands of local authorities or combinations thereof. The university hospitals, which are large general hospitals in Helsinki and Turku, are owned jointly by the university and the communes concerned. Some ten state-owned hospitals still exist but the intention is that as regionalization progresses these will be superseded. Public hospitals receive 50% of running costs from the state which through the power of the purse has thus a measure of control.

The position *qua* ownership in *Switzerland* is very like that obtaining in the Scandinavian countries. The vast majority of hospitals are owned and run by the cantons and communes or combinations of the latter. There are very few private hospitals but there are some private nursing homes in big cities, either religious foundations or business concerns. The hospitalization of chronic sick and mental defectives in Switzerland is often the work of benevolent institutions, helped by the communes and by the public.

In *France* nearly all public general hospitals are owned by the local authority (commune) and administered in their day-to-day running by a small governing body (*commission administrative*) of which the mayor of the commune is *ex officio* chairman. This is somewhat analogous to the position in Belgium. Decisions of the *commissions administratives* need to be confirmed by the prefect of the *département* who is a state official and who can negative any resolution. To guide him the prefect has the advice of two government officers—a doctor and an accountant-administrator. He is required to give his answer within forty days. This system would seem to make for rather tardy administration. The calculated daily maintenance rate must also be submitted to the prefect for approval. The chief administrator of a general hospital is appointed by the Minister of Health after receiving local recommendations (which he is not bound to accept). The position in France, therefore, is that whilst ownership of a hospital is vested in the commune, the state, largely by the power of veto, is able to exert a very considerable degree of control. Mental hospitals and sanatoria for the tuberculous are owned and run by the *département.* There are a considerable number of private hospitals in France including between ten and twenty large well-managed hospitals run by social security funds. Others are owned by religious orders and some are small private profit-making concerns.

In *West Germany* hospital provision is based on the principle of voluntary self-help. There is no legal obligation in West Germany to provide hospitals and the federal government confines its attention to general supervision of all hospitals and to providing hospitals for disabled ex-servicemen. The provinces (Länder) provide institutions for mental patients and for

cripples. Hospitals are either voluntary (37% of beds), public (56% of beds) or private (mostly belonging to private doctors—7% of beds). The public hospitals are owned and managed by local authorities or combinations thereof.

In *Eire* over two-thirds of the hospital beds are in institutions owned and administered by the health authorities which are the county councils or, in the case of the four principal cities, joint authorities of the city and county councils. Most mental beds are in ownership of counties either singly or in joint partnership. The remaining hospitals, including most of the teaching hospitals and many special hospitals are owned and administered by voluntary religious or corporate bodies. The Minister of Health controls hospitals to a considerable extent through the grant paid by the state to health authorities in respect of authorized expenditure. He also controls staff numbers financially inasmuch as increases in staff and in salary need his prior approval.

In *Italy* the great majority of hospitals are owned and autonomously administered by charitable institutions that are defined as 'local public bodies', depending both for capital works and running costs, upon their endowment funds, legacies, donations from private individuals and the contributions of patients. Only in recent times has the state granted financial contributions and facilities for capital works, in order to enlarge and improve existing hospitals and build new ones. A few, mostly special, hospitals have been set up by national organizations for social insurance. Other exceptions are mental hospitals which are owned and administered by the provinces (counties) and university hospitals which are governed by the universities. All hospitals must conform to the standards of medical, technical and hygienic services laid down in a general act of parliament.

REGIONALIZATION AND REGIONAL PLANNING

Regionalization in its most complete sense is the placing under unified control of the hospital services of a wide area containing a population of anything up to several millions. Given reasonable powers the regional authority is in a position to relate the amount of hospital provision to the needs of the population it has to serve, to have special regard to necessitous

areas, to revise where necessary the functions of existing hospitals and to establish new hospitals in locations chosen with regard to considerations of population and transport and not of local authority boundaries. By regionalization duplication of services between neighbouring hospitals can be eliminated, gaps in the hospital service can be narrowed and such functions as mechanized accountancy and statistics, laundry and bulk purchasing can be exercised more widely and efficiently.

In Western Europe the United Kingdom has gone further than any other country along these lines. The country has been divided into 21 regions (15 in England and Wales, 5 in Scotland and one in Northern Ireland) covering a population of some 50 millions. Regionalization is almost complete but has not quite reached 100% in that there are a few hospitals, mostly religious foundations, which are outside the National Health Service; and the teaching hospitals in England and Wales are not subject to the regional boards (though they are in Scotland). In the provinces there is close collaboration both on planning projects and generally between regional board and teaching hospital. In London, however, with four regional boards, twelve undergraduate and fourteen postgraduate teaching hospitals, all with their separate boards of governors, close collaboration and full co-ordination of services is more difficult to achieve though relations are most friendly.

Sweden with its population of 7½ millions has been divided into seven hospital regions and a system of fairly complete regionalization is just beginning to function. In five of the regions a 'regional' hospital with a complete range of specialties and superspecialties has already been established. Each of the 25 counties into which the country is divided has a 'central' hospital with specialized departments and laboratory services. (Some of the more densely populated counties have two 'central' hospitals.)

Around them are grouped 'normal' hospitals each serving a population of about 40,000 and having for the time being at least three departments—medical, surgical and radiological, to which are added, or will be added, departments of anaesthesiology, obstetrics, gynaecology and paediatrics. It is intended

gradually to eliminate the small undifferentiated cottage hospitals except in very sparsely populated districts.

Finland proposes to adopt a rather similar pattern of regionalization but this has not yet come into operation. Five hospital regions have been designed for a population which in a few years' time will total five millions. The country has been divided into 21 hospital districts each of which will have a large general 'central' hospital. Nine of these already are functioning. They are owned by federations of local authorities forming the hospital district who also own so-called 'regional' hospitals of about 200 beds and roughly corresponding to the Swedish 'normal' hospitals; and also local hospitals of 20 to 40 beds.

In the other countries of Western Europe represented at the conference there is no regionalization in the sense of that described above, but in a number there is a degree of central control.

In *France* this is achieved by what may be termed 'negative direction'. Nearly all public hospitals are owned by the local authority (commune); in addition there are a number of private hospitals. The plans of all new building, including expansion of existing hospitals both public and private need Ministry of Health approval. By sanctioning and favouring the building of hospitals where they are needed and banning them (by withholding financial support or even a building licence) where adequate facilities already exist, the Ministry can effect a measure of co-ordination and prevent waste and overlapping. Through this negative power the Ministry favours building or development of 23 university centred hospitals with a full range of medical services. By the same power it is proposed that each of the 90 *départments* shall have one or two large general hospitals (according to size of population) together with a number of smaller ('ordinary') hospitals and rural hospitals. Though it can make suggestions in a positive sense to a local authority through the prefect, the state has no power of enforcing its wishes, nor apparently can it interfere with existing hospitals which may be providing overlapping services.

In *Denmark* this power of 'negative direction' exists in that all plans for new and expansions of existing hospitals need the

approval of the Minister of the Interior advised by the 'National Health Service' which is the name given to the central administrative authority of the country's public health service. The National Health Service is evolving a hospital master plan for the whole country with a view to ensuring that future hospital development conforms to an overall pattern. To achieve this end it is dependent more upon moral suasion than on compulsion as hospitals are locally owned and administered. It is assisted in its task by a Supreme Hospital Board composed of representatives of central and local authorities one of whose functions is to promote co-ordination and collaboration between hospitals regardless of ownership or county boundaries.

Norway has no hospital law but the Health Directorate may give or withhold sanction for plans of new hospital buildings and it therefore has a power of 'negative direction'. The Health Department in Norway has very considerable influence and although without positive legal powers has succeeded in promoting the establishment of a large number of general and special hospitals since the war. The aim of the national plan is that there should be a central hospital in each of the country's 20 provinces—eight of these are already in existence and three are under construction.

Eire has carried out a hospital survey of the whole country which has indicated fairly precisely where hospitals are needed. Planning is largely the responsibility of the central Department of Health which determines priorities which it is able to enforce through its power of financial control.

In *West Germany* in spite of plurality of ownership, some attempt at regional planning is being made on a voluntary basis through private organizations in the hospital field—the German Hospital Institute and the German Hospitals Association who are usually consulted if a new hospital project is planned and they advise on how to avoid gaps and overlapping. As the *Länder* are usually asked to subsidize the construction costs of new hospitals (which they do to the extent of 30% to 70% of the total building costs) they have a say in the need for, and the siting and size of, new hospitals.

In France, Denmark, Norway, West Germany and Eire

there is no power under present law to introduce a scheme of regionalization as is in operation in Great Britain although some degree of regional planning has been affected in all of them by one means or another. Neither is there power in any of these countries to curtail overlapping of services in existing hospitals.

In several of the Western European countries represented at the conference regionalization either is not desired or for some reason is regarded as impracticable.

Into the first category come *Switzerland* and the *Netherlands*. Switzerland is a federative state composed of 25 independent cantons which are completely autonomous for hospital purposes. Each canton establishes its own planning principles. There is no regional planning for the country as a whole and there seems to be no desire and little need for it at present. This may in part be due to the geography of the country. The result is not unsatisfactory as the smaller hospitals are usually built at the civic centre of a district and the cantonal hospitals in the cantonal capital where communications will be good. Practically all hospitals in Switzerland are publicly owned and there is virtually no tradition of voluntary hospital service in the country. This unity of ownership may well have simplified the position so far as duplication of services is concerned. Co-ordination of the public hospital services is effected to some small extent by frequent meetings of the 25 ministers of health of the cantons.

In the *Netherlands* it is inherent in the Dutch to arrange every aspect of life according to creed and so one finds two or three hospitals in an area providing similar services for Catholics, Protestants and non-denominational groups. This may be wasteful but it is in accordance with the wish of the people. After the Second World War, on account of shortage of labour and building materials, regulations were made requiring the permission of the Minister of Housing before a hospital could be built, extended or renovated. This was a temporary measure but there is a movement to replace the regulation by a licensing law. This has not yet been done but if it materializes it would give the state some control over duplication or triplication in the future but would not affect the present position of existing

hospitals. On the other hand it is interesting to note that the ratio of beds to population is not particularly high in the Netherlands.

In the second category come *Italy* and *Belgium*. In both these countries it is recognized that some rationalization of the hospital service is desirable but in both countries there is plurality of control and up to the present strong political and/or religious differences have prevented any attempt at co-ordination.

In *Belgium* there are two separate communities with different languages—Flemish and French. More than half the beds for acute cases are owned and administered by private bodies, many of them religious foundations, and some have been provided by the six separate insurance organizations. Nearly all the public hospitals are the responsibility of the communes. Added to these diversities are several political parties including the Catholic Party, the Socialist Party and the Liberal Party. As a result there is no authority up to now to regulate or co-ordinate hospital activities.

In *Italy* hospitals under the control of a local public body, are governed by their own individual statutes concerning administration of their funds and appointment of their boards. The state, however, imposes certain requirements as to hygienic and technical standards to which all hospitals must conform. Hospitals are autonomous and finance themselves both as to capital and revenue from their own funds—endowments, legacies, voluntary contributions and payments made by or on behalf of patients. Most are feeling the financial burden of the high cost of modern medicine and many are in serious debt.

The duty of creating the hospital facilities required to meet local needs cannot legally be imposed on an autonomous body. For this reason and for considerations of finance the idea of giving planning and co-ordinating authority to a governmental body has recently been discussed and the government has introduced a bill which would achieve this. A new classification of hospitals on a functional and territorial basis is a major feature of this bill. However, the bill is not yet law. Regional co-ordination and planning of the hospital services is now awaiting

the establishment of the regions, i.e. public independent bodies resembling German *Länder*, to which the Italian constitution gives the task of hospital administration. Unless regions are established in the near future, it will be the task of the central government to provide temporarily for a reform of hospital organization and to constitute a regional or central planning authority.

RATIO OF BEDS TO POPULATION

On general principles one would expect that the need for hospital beds would bear an inverse relationship to the degree of development of a country's preventive and domiciliary services. The number of hospital beds which a country actually possesses, however, is by no means necessarily the same as the need, which may be greater or less than the overall figure owing to the somewhat haphazard way hospitals have been established in most countries. No valid deductions can be drawn as to the progress made in preventive and domiciliary medicine by comparing the number of hospital beds in a developed country with that in another. One can only state that in future development of hospitals the need for beds should be least in those countries which have been most active in promoting preventive and ambulatory services.

In-patient hospital treatment is becoming increasingly costly and in many countries efforts are being made to keep patients out of hospital by making home treatment more practicable and effective and by such measures as arranging for a patient's investigations in laboratory or X-ray department ('diagnostic work-up') to be carried out prior to admission. Admittedly this cannot be done without expense but the cost is likely to be substantially less than that of hospitalization.

It is not practicable to lay down as a standard a uniform ratio of hospital beds to population. There are too many variable factors involved, such as standard of housing, the availability of domestic help in the house, the prevalence of endemic disease, the age structure of the population, custom and tradition, to name but a few. These variables will exist not only between one country and another but between different parts

of the same country. The town-dweller has an entirely different outlook on hospitalization from the countryman.

As might be expected the number of available beds per 1,000 population in the different Western European countries shows wide divergencies, depending doubtless to some extent on some of the factors mentioned above. For instance, in Sweden it is customary for 99% of confinements to take place in hospital whereas in the Netherlands most women have their babies at home and the figure for hospital confinements is only 27%.

The ratio of beds for general and mental cases in the different countries is set out in the following table.

	Beds per 1,000 *population*	
	General (*including maternity*)	*Mental*
Belgium	4·48	3·2
Denmark	6·1	2·24 (including mental deficiency)
Eire	7·83	7·29
Finland	4·35	3·94
France	*c.* 5·0	
Great Britain	4·35	3·3
Italy	4·52	1·89
Netherlands	4·68	3·0 (including mental deficiency)
Norway	8·7	(including mental)
Sweden	6·6	6·4 (including mental deficiency)
Switzerland	6·3	3·4
West Germany	7·2	3·2 (mental and other long-term illnesses)

The figures may not be strictly comparable because in some instances they may refer to different recent years and information as to numbers and proportions is not always available. They do show, however, the wide divergencies which exist. The relatively high numbers in Eire are attributed to the age structure of the population as many young Irish men and women emigrate every year, so there is in that country an excess of old

people who are likely to make greater call on the hospital service than would young adults. The high figures for Western Germany may be due to the fact that most hospitals have no out-patient department, so many patients are admitted to beds for diagnosis only.

The evils of a shortage of hospital beds are self evident in a sense of urgency and hurry in a hospital, premature discharge with subsequent relapse, in long waiting lists and people going untreated, but there are also disadvantages of an economic nature in an excess of hospital beds. For here the tendency is for patients to remain in hospital longer than is really necessary or perhaps even desirable, there being no incentive to early discharge, especially if hospital treatment is not laying any direct financial burden upon the patient. From the figures quoted it would seem that *Belgium* may be in this position in that the average occupation rate over the country as a whole is only 68% and in one province is as low as 53%.

When making hospital provision regard must be had not only to average sickness rates but to peak periods particularly in certain specialties such as paediatrics and infectious diseases. A child or a fever case in need of admission should not be kept waiting and some over provision or possibility of rapid expansion in these specialities is justified to deal with seasonal or other outbreaks of disease.

If the experience of Great Britain gained from the surveys carried out immediately before and since the start of the National Health Service is any criterion, it would seem that there may not be any great overall shortage of hospital beds taking the country as a whole. The need for new building may arise through some of the existing beds being 'bad' beds, that is to say in out-dated premises, or beds in the wrong place. Several speakers drew attention to the mal-distribution of beds intheir countries. In *Belgium* the Flemish Provinces have 5·1 beds per 1,000 for acute cases whilst the Walloon Provinces have only 3·0. In Italy there is a greater shortage of hospital beds in the South (2·03/1,000) than in the North (6·03/1,000).

Modern hospital design and skilful administration can materially reduce the number of beds actually required. The

more a hospital is divided into separate units specifically designed to serve a single purpose and the more beds are inflexibly allocated to individual consultants on the staff, the greater the loss of effective hospital utilization. The nursing units of a hospital which have been designed as far as practicable to a standard all-purpose pattern so that they may be used, for example, for surgical cases on the waiting list in the summer and respiratory infections in the winter can do much to increase bed occupancy; and good administration can reduce the interval time to a minimum.

Recent studies in England have indicated that in that country a bed population ratio of little over three per 1,000 should be adequate for general acute work and it is proposed in the 'Hospital Plan for England and Wales' to reduce the overall number of 3·9 acute beds to 3·3 with a further 1·4 for geriatrics; and to increase maternity beds from 0·45 to 0·58 to meet the increasing demand for hospital confinement.

With the great improvement in the method of treating mental illness, much of it on out-patient lines, it is thought possible, if existing trends continue to reduce the number of beds for these conditions in due course from 3·3 to 1·8 per 1,000 population. This will involve the closure of some of the most unsatisfactory mental institutions, devised years ago for custodial care and replacing some of them by psychiatric beds in general hospitals.

TYPES AND SIZES OF HOSPITALS

The types and sizes of hospitals to be found in any country are governed by many considerations: geography, means of communication, density of population and, most of all, history and tradition. It is only since the Second World War that serious consideration has been given to the underlying philosophy of hospital services in Western Europe and attempts made to determine the proper function of a hospital and to relate the quantity and quality of its resources to the established needs of the community it is to serve. Most existing hospitals were set up many years ago to meet a local need. That need may now have languished but more likely it has grown and land and money may or may not be available to permit the hospital to expand to meet the growing need. If the hospital cannot expand

it may well become inefficient and outlive its usefulness, but efficient or no it has probably become an emblem of civic or sectarian pride, a kind of status symbol, and any attempt to close or modify its use and replace it with a larger modern building elsewhere will probably meet with the most fierce resistance.

The general pattern is fairly uniform throughout Western Europe. Most countries have inherited from the past: (1) a small number of large well-equipped hospitals, possibly associated with the medical faculty of a university and providing practically all specialist and superspecialist services; and having 600 to 1,000 beds or more. (2) a considerable number of district hospitals of perhaps 150 to 600 beds with a good range of special departments, and (3) a large number of small local hospitals, probably undifferentiated and purporting to give general medical and surgical services within a capacity of 20 beds upwards and with no resident medical staff. Variants of this pattern occur in some countries, as will be indicated, but in the development of hospital services the growing tendency is to concentrate on the large district hospital of several hundred beds (the 'intermediate hospital'—World Health Organization) and gradually to eliminate the small local hospital for general purposes. This policy follows the well-founded belief that it is better for a patient to travel further and arrive at a hospital staffed and equipped to meet all his needs rather than to receive an inferior service in his immediate neighbourhood. It is made possible by the ease of transport in most parts of modern Europe. There are some places, however, where the continuance of the small hospital is a necessity if the needs of the local population are at all to be met. In parts of the Northern European countries within the Arctic Circle and on off-shore islands the density of population may not be measured so much by the number of inhabitants per square kilometre as the number of square kilometres per inhabitant. In such areas departmentalized district hospitals are clearly not practicable.

Sweden, where regionalization is practically complete, aims at a large district hospital (central hospital or large intermediate) for every county serving a population of 200,000 to 250,000. These provide general medical and surgical services and a wide

range of special departments. The peripheral county hospital of 100 to 150 beds is a fairly standard pattern and is called a 'normal' hospital (small intermediate) differentiated into three major departments, medicine, surgery and radiology, to which other departments are successively being added. Here it may be noted in passing the emphasis placed upon radiology by the Scandinavian countries. Even in quite a small hospital the X-ray department will be very well developed and will rank as of equal importance to those of medicine and surgery. Each of Sweden's seven regions has, or shortly will have, a large regional hospital containing all special and 'superspecial' departments. The roads in Sweden are so good and cars so plentiful that it is thought that small local hospitals can be eliminated, or up-graded to 'normal' hospitals except in a few very isolated places.

In *Norway* and *Denmark* the position is very similar except that no regional hospitals have been established. A policy in *Norway* is to develop a number of 'B' hospitals, i.e. establishments simply equipped and staffed to which patients from the general hospitals may be transferred for continued care after the acute phase of an illness has passed, e.g. fractures, peptic ulcers, etc. This plan has been tried in Great Britain but merely as an expedient to take pressure off overworked acute hospitals. It has not there proved an unqualified success for two reasons—the proportion of acute cases in the acute hospital is increased and this may mean an increase there of nursing staff and secondly it has been found that the total time of hospitalization of a patient who has been transferred to a 'B' hospital tends to be prolonged so that the cost of treating a case to a conclusion by this method is not lowered and may even be raised.

Finland follows much the same general pattern as Sweden with regional, intermediate and small undifferentiated local hospitals. One central (large intermediate) hospital has over 900 beds but the average size is 350–450.

France has 23 regional centres with a full range of medical services situated in towns which have, or will have, a university with a faculty of medicine. In the 90 *départements* are 80 good large hospitals and 439 good ordinary hospitals (large and small intermediate). In addition there are 351 rural hospitals (30–40 beds) which formerly used to attempt to give a complete

service. These are now restricted to medicine, to geriatrics and to obstetrics, the patients being looked after by their own doctors.

Belgium is a small country with a dense population and therefore, one would have thought, particularly suitable to develop a system of large general hospitals. Possibly for the reasons set out in the sections on regionalization and on ownership this system has not been adopted. Of the 382 public and voluntary hospitals in the country 346 have fewer than 200 beds and 127 fewer than 50. There are 8 hospitals of more than 500 beds.

Switzerland by reason of its constitution and of its geography is a land of small or medium sized hospitals. In five university hospitals the beds may exceed 1,000 but the usual pattern is the 'two-man hospital' of a physician and a surgeon with 100 to 170 beds with a noticeable trend towards the 'three-man hospital' of some 250 beds which aims to give a fairly complete hospital service, together with a number of larger cantonal general hospitals.

In the *United Kingdom* emphasis is on the development of the large district (intermediate) hospital and on the reduction in number of the small local hospitals. Since the National Health Service came into operation a number of small general hospitals have been closed or their use diverted to special purposes such as the care of the elderly chronic sick and this process is likely to be extended during the next ten years. In Great Britain regionalization does not conform to the neat pattern set out in the reports of the World Health Organization. The Minister of Health in 1948 acquired a great number of hospitals, general and special, large and small, efficient and less efficient; and to regional hospital boards was given the task of welding them into a comprehensive hospital service. This was often not made easier by inherited tradition and by the fact that in the years prior to 1948 a number of non-teaching hospitals had developed specialized services some of which had justly acquired a high reputation. Thus although all regions are self-contained in that they can provide all hospital services it is unusual to find all the superspecialities concentrated in a single hospital and that a university hospital. In the London area of the four metropolitan regions there are twelve undergraduate and fourteen

postgraduate hospitals or groups of hospitals most of which provide facilities for one or more of such superspecialties as neuro-surgery, cardiac surgery, plastic surgery and radiotherapy. Moreover departments of these kinds have been established in a few selected non-teaching hospitals. There is no reason why this should not be so as the teaching value of the superspecialties to the undergraduate student is very small.

There is one general problem which affects all countries of Western Europe in greater or less degree. Pulmonary tuberculosis has largely been brought under control with the result that a certain number of sanatoria have become redundant. Many of these were sited in remote country districts to give the sufferers the benefit of pure air and a satisfactory alternative use is often difficult to find. Some of the least satisfactory ones have been, or will be, disposed of, but some of modern construction are beautiful buildings and but for their being away from centres of population would adapt to make satisfactory general hospitals. In Great Britain a number are being used as special hospitals for chest diseases other than tuberculosis—bronchitis is very prevalent in Britain as is bronchial carcinoma. Other countries (e.g. Norway) are using them as institutions for the mentally ill or (e.g. Sweden) for the chronic sick.

THE INTERNAL ADMINISTRATION OF HOSPITALS

The modern general hospital which has developed from small and comparatively simple beginnings has become an extremely complex institution. Its effective management calls for administrative skill of a very high order based upon training and experience. Whether the chief administrative officer of a hospital should be medically qualified or not is still a debated point. Some countries prefer that he should be medical and some take the view that he should be a layman, trained in the science and art of hospital administration and hospital management. Whether the chief administrative officer is medically qualified or not, however, it should always be borne in mind that a hospital is essentially a medical institution and the needs of patients as assessed by medical criteria are paramount. If, therefore, the chief administrator of a hospital is non-medical he will need constantly to be in touch with a medical adviser or

medical committee who can keep him informed of the medical aspects of all administrative measures which may be under consideration.

There are three methods of hospital administration which are in operation in the various countries of Western Europe.

First, the system in which the chief administrator is a doctor. This is the system advocated by the World Health Organization in the First Report of its Expert Committee on the Organization of Medical Care. In this report it was considered that the chief administrator should be medically qualified and engaged whole time in administration without any responsibility for clinical work. This system obtains in many hospitals in Scotland but it is most unusual in other parts of Great Britain, and indeed throughout the countries represented at the Conference. Medical administrators, where they exist, are nearly always also engaged in clinical work. This is the position in Finland, Eire, Sweden, Norway and in many of the hospitals in the Netherlands.

In *Finland* the executive director, a medical man, is appointed from the medical staff of a hospital and holds office for four years. In the state hospitals he has financial responsibility in that he has to control funds handled by the business manager (steward) and approve the hospital budget. In the communal hospitals he has administrative but not financial duties. The university central hospitals at Helsinki and Turku have an administrative director.

In *Eire* the local authority hospitals are largely managed from the central administrative offices of the health authority. The detailed work of administration is largely delegated to a resident medical superintendent or to the county physician or surgeon or matron. In the voluntary hospitals in Eire non-medical administrators, though regarded as junior in rank to the medical administrators, have a higher status than in the local authority hospitals, and in recent years have been given increasingly greater authority.

In *Sweden* the daily administrative work rests with the medical director while economic responsibility is placed upon the hospital secretary. County councils in Sweden have recently

been given power to put full guidance of the hospital in the hands of a non-medical hospital manager. Ten hospitals have adopted this course. In these hospitals one of the doctors on the staff is appointed chief medical officer to guide the administrator on medical matters.

Norwegian hospitals usually have as managing director one of the head doctors of the hospital who remains an active clinician and has had usually no business or administrative training. The system is said to work as most non-medical duties are delegated to the steward, the bursar and administrative nurses.

In the *Netherlands* the practice is variable. Most hospitals have a medical superintendent in charge assisted by a business manager of slightly lower rank but the part played by non-medical men in hospital management is growing.

In the second system of hospital administration the head of the hospital is a layman, who is in fact the hospital manager. This is the position in most general hospitals in England and Wales where the hospital secretary is guided on medical matters either by a member of the medical staff elected for this purpose or by the chairman of the medical staff committee.

General hospitals in *Belgium* have a non-medical director but the Ministry of Health require that a doctor, preferably one chosen by his peers, should be appointed to advise and assist the management. He has responsibility for technical procedures, safety measures for staff and patients and the rules of professional conduct. This regulation applies both to public and private hospitals.

In *Denmark* the position is very like that in the United Kingdom, where there is a manager advised by the medical committee on medical matters of major importance and general interest.

In *Italy* a medical director is appointed as a medical co-ordinator, in other words to deal with matters of purely medical administration, but there is a managing director who is regarded as the senior and who attends the meetings of the board of government. Legal regulations govern the appointment of medical director but not that of managing director.

In *France* the *directeur* appears to be paramount. He supervises the general running of the hospital and is assisted in the larger hospitals by an *econome* who is a kind of steward. In most French hospitals there is no matron and the *directeur* assisted by the nursing superintendent directs and controls the nursing care of the patients. There is usually a medical consultative committee, the meetings of which the *directeur* attends as a minute taker and this functions as a means of bringing the views of the medical staff to the commission administrative. Consultants are officially under the general authority of the *directeur* except in purely medical affairs and he deals with any 'incidents' with the assistance of the medical consultative committee and if necessary the health inspector of the department (a doctor). *Directeurs* are appointed by the Ministry of Health.

In *Switzerland* single-type hospitals, e.g., tuberculosis or mental, either have a medical superintendent assisted by a non-medical administrator, or a medical superintendent and a non-medical administrator of equal rank. In general hospitals there is an administrator with the chairman of the medical committee as his adviser on medical matters who also attends meetings of the board as spokesman for his colleagues.

The third method of hospital administration is through a triumvirate consisting of medical director, the director of administration and the matron, who are jointly responsible to the governing body of the hospital for its efficient running. In case of disagreement between the three, the matter concerned is brought to the governing body for their solution. This is the system which is being operated in *Western Germany* where one of the leading department physicians acts at the same time as medical director of the hospital with the task of general supervision in medical and hygienic matters. The director of administration is in charge of the business side of the hospital.

A somewhat similar system is being tried in some hospitals in the *Netherlands* under the name of a 'Directorium', the heads of the medical, nursing and administrative services being jointly responsible to the governing body. Though not bearing so dignified a name, a similar system obtains in effect in some hospitals of the United Kingdom.

In all the countries mentioned nursing administration is in the hands of the matron except in the case of France where matrons, as understood elsewhere, are practically non-existent.

It was formerly the custom for a matron, in addition to her nursing administrative duties to undertake responsibility for various housekeeping services—linen, catering, detailed supervision of the nurses' staff quarters, etc. This practice has been, or is being, abandoned in all Western European countries, except in the smallest hospitals; as it is now recognized that the control of these services calls for a degree of technical knowledge beyond that contained in a nurse's training.

MEDICAL STAFFING

As might be expected there are considerable divergencies in the systems of medically staffing hospitals in the countries of Western Europe. Differences exist in the methods of making senior appointments, in the terms and conditions of service, in the access to hospital beds of doctors not on a hospital's staff and in the relation to one another of specialists within any one department of a hospital.

In this last-mentioned respect the most constant pattern is a kind of hierarchical system whereby each department has a single medical head who determines the policy of his department and is responsible for all the medical services that department provides. The department, in fact, may be regarded as a pyramid with the director occupying the apical position. This is the situation for example in Italy, Belgium, Finland, West Germany, Denmark and Norway. Denmark and Norway, however, are considering truncating the pyramid so that in a large department there might be several specialists of equal standing without any single chain of command. This would have the effect of creating more senior medical posts and so improving prospects of promotion. Such a parallel system is found to operate in France, in Great Britain and in the Netherlands.

In *France* in the larger departmentalized hospitals including the university hospitals the medical staff is on a full-time salaried basis but a consultant is permitted a few private beds and twice a week may hold private consultation clinics in the hospital.

The salary which is fixed by the Ministry of Health is the same for all specialties and in the case of university hospitals is paid half by the university and half by the hospital. Each consultant is master within his own specialty which generally comprises two to four wards of about 30 beds each and he is not answerable to any medical supervisor. The small rural hospitals are staffed by general practitioners. In many hospital centres there have been set up 'public open clinics' outside the main hospital building where any doctor, surgeon or midwife of the town may bring and treat his or her own patients as in a rural hospital.

The *United Kingdom* also has adopted a parallel system of consultant medical staffing without any chain of command, each consultant acting independently. Appointments of consultants and trainee consultants (registrars and senior registrars) are made by the regional hospital board on the advice of an advisory appointment committee containing (in the case of consultant appointments) a member each from the university and from the appropriate Royal College as well as two representatives (one medical and one lay) from the management committee of the hospital to which the appointment is to be made. Appointments, which have to be advertised, may be made on a whole-time or part-time basis and the salary is based upon the number of half-days for which the contract is made. Over and above his salary a consultant is paid a fee for visits (up to a maximum) he makes to a patient's house at the request of a general practitioner. A consultant appointed on a part-time basis can, and usually does, engage in private consulting practice. Appointments to the staff of a teaching hospital in England and Wales are made by the board of governors on the advice of an advisory appointment committee containing representatives of the university, the appropriate Royal College and the regional hospital board. Small local hospitals are usually staffed by local general practitioners with periodical visits from consultants.

In *Italy* the medical staff is salaried on a full-time basis, i.e. for so many hours a day but they are allowed to undertake such private work as time permits. The general practitioner has no place in the hospital service.

In *Eire* the appointment of senior medical staff to public

hospitals is made by a centrally appointed selection board. In voluntary hospitals the appointment is made by the board of governors of the hospital on the advice of their own medical staff committee. Many small cottage hospitals in Eire are staffed by general practitioners.

In *Finland* hospital doctors are salaried on the basis of a 37-hour week and are allowed private practice at the hospital in the evenings. Many of the rural communes have a small hospital with a few beds which are looked after by the health officer who combines the duties of medical officer of health and general practitioner.

In *Belgium* on the other hand the line of demarcation between preventive and curative medicine is particularly sharp. The Ministry of Health through special commissions have established criteria of qualifications to justify specialist rank and have compiled lists of recognized specialists. Voluntary hospitals may be 'open' (i.e. a patient therein may be treated by any doctor of good repute), 'closed' (patients treated only by members of the appointed hospital medical staff) or mixed.

In the *Netherlands* about one-third of the hospitals are completely 'open' but most are 'closed' with a few 'open' beds. The medical staff are specialists or trainees but many hospitals admit family doctors but usually only to undertake normal delivery of their own patients and then often under some supervision of the specialist obstetrician. Specialists are appointed by the board of the hospital. There is a very clear-cut line between general practitioner and specialist. It is considered unethical for a specialist to accept for treatment a patient unless referred to him by a general practitioner. This is the position also in Great Britain but not in all other European countries.

In *West Germany* apart from small private hospitals staffed by general practitioners and other part-time members, every department of a general hospital is directed by a senior consultant who is paid a salary but who derives most of his income from private practice. To become a specialist, four years' training is needed under the supervision and control of a departmental head. At the end of this time most trainees leave to set up in private specialist practice or themselves to become

heads of departments elsewhere. There is therefore a considerable shortage of medical staff in West German hospitals.

In *Denmark* more than half the nation's doctors are in hospital service. They are on a whole-time basis and very few earn any fees outside their salary. There is a shortage of doctors, especially in rural areas.

In *Norway* nearly half the nation's doctors work in hospitals on a whole-time salary but heads of departments have a right to a limited amount of private practice. No doctors from outside the staff work in hospitals but periodical clinical meetings for general practitioners are held at the larger hospitals to bring them into personal touch with the hospital staff. Appointments are largely made centrally: applicants are given a ranking by the Health Directorate and the hospital board can then choose between the first three on the list.

Sweden has a somewhat similar system for making hospital appointments. Heads of departments are appointed by the National Board of Health. Assistant doctors are placed in ranking order by a local commission appointed by the National Board of Health and the county may then appoint any out of the first four on the list. Hospital doctors are appointed on a full-time salaried basis but make a great part of their income from fees paid by out-patients. There is a shortage of doctors especially in the north and here higher salaries and other inducements are offered in an attempt to overcome this shortage. In rural areas the district medical officer, a salaried appointment, is responsible both for hygiene and for the domiciliary and ambulatory care of patients.

With the growing complexity of medicine and the tendency almost everywhere to concentrate upon the larger and elimination of the smaller hospital the part played by the general practitioner in hospital work is becoming inevitably less. In some ways this is a pity as it is most undesirable that a country's medical services should be unduly sectionalized. The general practitioner needs to be kept in touch with hospital life and to know personally as many as possible of the consultants to whom he refers patients. There are many ways in which this can be done without necessarily giving him charge of beds—ward

rounds, clinical meetings at the hospital, use of the hospital's medical library for reference, part-time work on a rota as assistant (paid) in the casualty department.

Ways of effecting co-ordination between hospital and family doctor might form one of the subjects for discussion at a future conference.

SOCIAL INSURANCE

Some form of state-sponsored or state-operated social insurance is in force in all the Western European countries represented at the conference. Some of the schemes are very comprehensive, giving protection against such contingencies as unemployment, loss of income due to sickness and disablement as well as the expenses of illness itself. In this section, however, attention is confined to insurance against the cost of hospital treatment and so far as practicable indicates the different lines of approach which have been followed in the various countries in their efforts to secure protection for those who are sick and to safeguard the finances of the country's hospitals.

In the Scandinavian countries, Sweden, Norway and Denmark social insurance is compulsory and applies to the entire population.

In *Sweden* the individual's contribution is based upon his income and covers his children under 16. This entitles him and his family to free in-patient hospital treatment in a public ward —if he desires private or semi-private accommodation he must pay the difference between third-class and first or second-class rates. For out-patient treatment he pays a fee to the consultant and subsequently recovers a proportion (usually three-fourths) from the insurance agency. National sickness insurance pays only a small part of a patient's hospital treatment. Most of the cost is met by county rates plus a small subsidy from the state.

In *Norway* by tradition hospital treatment is free. The contribution made to the hospital by the sick-insurance system no longer covers the actual expenditure and the difference is made up by ordinary taxation by the province. The sick insurance system pays the same contribution in respect of a patient who chooses to go into one of the few remaining voluntary hospitals, but the difference here must be paid by the patient.

In *Denmark* hospitals are open to all in need of treatment and practically without cost to the patient. Above a certain income a small charge is made. Private patients are practically non-existent. As in the other Scandinavian countries the contribution from social insurance funds does not meet the hospital running costs in Denmark, indeed the proportion of cost derived from social insurance is very small, about 10%, the deficit being met from general and local taxation.

In a number of countries social insurance is compulsory for all employees irrespective of their salaries or wages. This is the position in France, Italy, West Germany and the United Kingdom.

In *France* compulsory insurance applies not only to employed persons but to students, war invalids, widows, orphans and self-employed farmers. Contributions which are based on salary and are mostly the financial responsibility of the employers, cover also dependants so that the great majority of the population is insured. A patient admitted to hospital is expected to pay the hospital charges but is entitled to reimbursement from social security to the extent of 80% in respect of a public hospital but less if treatment was in a private hospital. In all but the smallest hospitals representatives of social security bodies sit on the *commissions administratives.*

In *Italy* all employees and some categories of independent workers are compulsorily insured against sickness in one of a number of insurance organizations. No charge is made to the patient for hospital treatment but the insurance organization may, and not infrequently does, decline to agree to a hospital's maintenance rate, with the result that the hospital is the loser and many are heavily in debt. There is no law regulating these relationships and the state does nothing to make good the deficit. The insurance organizations in Italy are seeking means to give themselves a measure of control in hospital administration in order to reduce hospital expenditure. There are very few private patients in Italy.

In *West Germany* health insurance covers 80% of the population. In addition to all employed persons (and their dependants) compulsory insurance is extended to self-employed persons

whose income does not exceed a certain figure, widows, widowers and orphans. About 10% of the population does not have to pay for hospital treatment (armed forces, etc.); the remaining 10% are self-paying and usually protect themselves by private insurance. Insurance covers hospital treatment, agreed charges being paid to hospitals directly by the insurance society.

The United Kingdom has a comprehensive scheme of social insurance covering a number of contingencies and applying to all employed persons whatever their salary or wages. Although social security funds make a limited contribution to the National Health Service, free hospital treatment is not restricted to insured persons, but is available to all insured and non-insured alike and even to foreigners taken ill in Great Britain. Most of the cost of the hospital service is met by general taxation.

In certain countries compulsory health insurance is restricted to employees earning less than a certain wage or affords protection only against certain risks, e.g., accidents at work.

In the *Netherlands* it is a traditional characteristic of the people that as much as possible should be left to private enterprise. Employed persons of comparatively small means are the only people to whom compulsory health insurance applies. This is affected through the 'sick funds'—non-profit-making private insurance companies. Self-employed of similar income can insure voluntarily through the 'sick funds' as can people over 65 at a reduced rate if their income is not above about half that of the employed group. About 73% of the population of the Netherlands are insured voluntarily or compulsorily in the 'sick funds'. Of the remainder at least three quarters have taken out sickness insurance policies with commercial companies. Insurance in the 'sick funds' covers the cost of treatment in a general hospital, but, what to some seems anomalous, not in a mental hospital where a patient is required to pay in accordance with his means.

Belgium has a scheme of compulsory social insurance for certain employees and their families which protects a little over half the population. Contributions are paid to the insurance

funds by employers, employees and the state: the deficit on the scheme being made up by the state. Insurance does not cover the entire cost of hospital treatment; part of the hospital charge has to be met by the patient. Health insurance therefore is only partial unless the patient is treated in a hospital or policlinic set up by a mutual insurance organization.

In *Finland* compulsory insurance applies only to accidents to employees. A compulsory insurance scheme will be introduced in 1964 designed to apply only to medical services *outside* hospital—general practitioners' fees, drugs, X-rays, pathological examinations and transportation, part of the cost of all of which would be covered by social insurance; the idea being to encourage people to be treated at home and take some of the pressure off hospitals.

In *Switzerland* the accent is all on voluntary insurance and 80% of the population is insured against sickness. There is only compulsory insurance against accidents to employees and against tuberculosis. As in many other countries the contribution made by the insurance organization is far from sufficient to meet the cost of hospital treatment, the deficit being made up by the canton or the commune out of ordinary taxation.

FINANCING OF HOSPITALS

During the past two or three decades the cost of hospital treatment has risen to such heights that the day of the voluntary hospital, supported by the gifts and legacies of the charitable, is over in most Western European countries. To an ever increasing extent hospitals of this type have been compelled to accept financial help from the national exchequer or from the local authority if they are to continue to remain open. Until it becomes inevitable, acceptance of this help has usually been opposed in the knowledge that subvention would ultimately be likely to lead to control.

The above statements are not universally true, for the voluntary principle still largely holds in Italy, the Netherlands, Belgium and to some extent in West Germany.

In *Italy* neither the state nor the local authority plays a part in the financing of hospitals for revenue expenditure save in the

case of the indigent. New hospital building has to be financed by private funds and by legacies. These may, however, be supplemented by state grants. Revenue is derived from patients' payments, from insurance societies on behalf of patients and from interest on endowment funds. Responsibility for the hospital treatment of the uninsured indigent patient is by law placed upon the commune of the district in which he is ordinarily resident—a situation similar to that which existed in Great Britain under the old poor law and was not finally brought to an end until the introduction of the National Health Service.

In the *Netherlands* four-fifths of the hospitals (about 75% of the beds) are run by religious or other non-profit-making corporate associations. New buildings for these are financed from legacies and voluntary gifts but mostly from money borrowed from public or insurance companies at normal interest rates. For revenue, hospitals are dependent upon payment from patients for in-patient or out-patient services (mostly covered by insurance), supplemented only rarely by subsidy from the government or local authority. In some hospitals the daily maintenance rate includes doctors' fees. In others the doctors' fees are separately paid, privately or by the social insurance societies.

In Belgium where over two-thirds of the hospitals (60% of the beds) are run on voluntary lines, non-profit-making voluntary hospitals can receive a state subsidy of 15% in respect of constructional work, the balance being found from private sources. Their revenue is derived from charges to patients, including fairly high charges for private rooms, payments from insurance societies and interest from endowments.

In respect of public hospitals the *Commission Assistance Publique* can receive 60% of the cost (sometimes more) for approved new building projects. The running costs of publicly owned hospitals are obtained from the patients themselves, and from compulsory or voluntary insurance payments. The deficit is made up by the C.A.P. from the local communal budget. A special scheme foresees a state subsidy for the making good of communal deficits.

In *West Germany* constructional costs are met in part by the *Länder*. The amount varies from *Land* to *Land* and may be any-

thing up to 70%. The other financial sources for capital works are the hospital's own endowments and private contributions. Day to day running costs are met almost entirely by the insurance societies. Hospitals are grouped according to the kind of service they provide, a daily maintenance rate is fixed for each group and the insurance societies enter into a contract with each group of hospitals on this basis and pay the agreed maintenance rate directly to the hospitals concerned. Insurance does not completely cover the full cost as the agreed maintenance rate is based on the previous year's costs—and prices are rising. It also takes no account of interest on loans or depreciation. The deficit is met by public or private contributions or by drawing upon a hospital's real assets. Apart from private accommodation of first or second class—which accounts for 6% to 8% of all patients—daily rates are price-controlled by legislation.

In the remaining countries the financing of hospitals both for capital and revenue is largely or entirely a function either of central government or of the local authority. Countries where the central government is the main source of money are the United Kingdom, Eire and Finland.

In the *United Kingdom* the Exchequer provides practically the whole of the money needed both for constructional work and running costs. It is true that some hospitals within the National Health Service still have endowment funds—occasionally quite substantial—and some of this money may be used to finance a new building project which is outside the Minister's programme. Prior ministerial approval has to be obtained, however, as the government will later be responsible for the running costs of the new building. On the revenue side though there is a limited contribution derived from social security funds most of the running cost of the nation's hospitals is met by funds provided by the Exchequer from direct or indirect general taxation. The only income is from charges made to out-patients towards the cost of drugs, spectacles, dentures and surgical appliances; and the fees charged to the relatively few in-patients who desire private or semi-private accommodation. Endowment funds may also be used for some items of current expenditure, including the provision of extra amenities.

Eire derives a substantial part of its resources for hospital construction and maintenance from national sweepstakes on horse-racing. The profits from these are put into a government-controlled Hospital Trust Fund. This is used to provide grants towards capital expenditure. These may be supplemented by subventions from the health authorities (councils of the counties and certain great towns) so long as the proposed new building fits into the national scheme. Revenue for the publicly owned hospitals (over two-thirds of the total) is provided as to one half by local rates and one half from national taxation. Health authorities may send to voluntary hospitals, and pay for, patients they wish treated on their behalf or they may accept financial responsibility for patients already so admitted. This is one source of income of voluntary hospitals. Others are payments by patients, interest on endowment funds and grants from the Hospital Trust Fund towards deficits in the running costs.

In *Finland* capital costs of the central (intermediate—W.H.O.) hospitals are shared by the state and the local authorities. For running costs, 50% comes from the state and the balance from patients and from the communes. Patients' fees are controlled by the government, are very low (treatment of tuberculosis is free) and are uniform throughout the country. There is therefore a heavy subsidy. The charge for in-patient treatment is extremely low—hence the introduction of the proposed compulsory insurance law covering extra-hospital facilities, with a view to encouraging domiciliary treatment. In the few state hospitals capital and revenue are provided by the state.

Countries where the local authority is the principal source for the financing of hospitals are Norway, Sweden, Denmark, France and Switzerland.

In *Norway* the few voluntary hospitals receive no financial help from the state or local authority either for capital or revenue costs. The local authority hospitals derive their income for running costs from the insurance funds which pay up to a certain sum per diem, varying according to the category of hospital. The deficit, which may amount to 50% is met by local taxation by the province or municipality. The Rikshospitalet in Oslo is state-financed.

Sweden at present finances its three state general (university) hospitals and its mental hospitals directly from the central government. The other public hospitals are financed both as to building costs and running costs by local taxation levied by the councils of the counties and large towns which have unlimited powers of taxation. This is supplemented by a small subvention from the state, contributions from social insurance and patients' fees for private accommodation and for out-patient treatment. Public health and sick care, including hospitals, absorbs 80% to 85% of the gross expenditure of counties. County councils have to pay practically the entire cost of patients from their counties admitted to the state general hospitals. In future, however, it is likely that all state hospitals will be administered by county councils with a heavy subsidy from the state.

In *Denmark* it is the duty of counties and certain towns to provide buildings and equipment of hospitals. As to revenue, about 65% of the running costs is borne by the government the amount being calculated upon a somewhat complicated formula which relates one-third to population, one-third to bed-days and one-third to total cost. Twenty-five per cent is paid by local authorities from local taxation and the balance (5% to 10%) comes from compulsory social insurance funds.

In *France* a hospital is independent, financially and legally, from every other authority. Each patient receives a bill for in-patient or out-patient services and this does not include the doctor's fee which is separately charged. There is in effect a means test for both insured (if indigent) and non-insured patients. If the charge per day, as estimated at the beginning of the financial year does not in fact meet the actual daily maintenance cost, and there is a deficit at the end of the year, this deficit is carried over and incorporated in the calculation of the charge per day of the next succeeding year. Of the total running costs of a hospital about 45% is paid by social security funds, 45% by the state and 10% by patients.

In *Switzerland*, communal and inter-communal hospitals are financed as to constructional costs by the communes, usually assisted by a subsidy from the canton. The canton pays the total building cost of cantonal hospitals with a subvention from the federal government in respect of establishments for tuber-

culosis and for rehabilitation. Revenue for running expenses is obtained from fees from patients (usually covered by insurance), and the deficit, which may be substantial, is derived from local taxation levied by the communes and cantons.

As will be seen the above notes do no more than indicate in brief and general terms the sources of money which pay for the hospital services both as to capital and revenue in the various countries. They do not attempt to go into such matters as the methods of preparing estimates, auditing or financial control of hospitals which are outside the scope of a short survey of this kind. One further note, however, should be added; this concerns departmental costing. This was introduced some six years ago in a small number of selected large hospitals in *Great Britain* and has since been extended to an annually increasing number, so that now a substantial number of hospitals throughout the country are operating this system. *Sweden* and the *Netherlands* have also introduced departmental costing in a number of hospitals. This system, when it has been established for a few years, does enable reasonably fair comparisons to be made, department by department, between one hospital and another. When the cost of a unit of service in a particular hospital shows a substantial deviation above or below the average figure for a corresponding unit of service elsewhere, it indicates where inquiry should be made to ascertain whether the variation is justified by special circumstances or whether there is perhaps some administrative defect which calls for rectification.

SPECIAL SERVICES

In this section reference is made to certain special features which a hospital service provides and which were touched upon by various speakers at the conference. In a symposium of this kind, when discussion of any country's medical resources is limited to what can be compressed into a morning or afternoon session, it is clearly impossible to deal with every aspect of the subject. The fact that in this and other sections of this chapter mention is not made of certain countries is not to be interpreted as meaning that those countries are lacking in the matters under consideration. It is simply that information on this or that

specific point was not brought out at the conference and was not otherwise readily available.

(*a*) *Out-patient Departments* (*Policlinics*). For the purposes of this section the term 'out-patient department' will be restricted to those services attached to a general or special hospital which deal with ambulatory sick or injured persons. They may be 'open' in that any member of the public may present himself for treatment or 'closed' in that patients other than accidents and emergencies are seen only on the referral of a doctor. The open system which formerly was common has now almost disappeared in most countries of Western Europe.

The classes of patient with which a closed out-patient department of a hospital may appropriately deal are:

(1) Accidents and emergencies.
(2) Patients referred to hospital by a family doctor for a specialist's opinion or for a special diagnostic investigation or for some special form of treatment outside the province of a general practitioner.
(3) Patients referred by a member of the hospital staff for diagnostic work-up before admission, for follow-up after discharge, or for some specialized treatment (e.g. physiotherapy) in another department.

With the increasing number and severity of accidents, particularly road accidents, opinion in many countries is veering towards the establishment of special accident and emergency centres in a limited number of hospitals. These would be manned throughout the twenty-four hours by a specialized staff of surgeons and nurses and would have always available facilities for resuscitation. A start is being made in this direction in Great Britain, the intention being that ultimately all major accidents and emergencies should be taken directly to these hospitals and not to the nearest hospital (whatever its size and resources) as is usually the case at present.

In the *United Kingdom* all large general hospitals and a number of the smaller ones have closed consultative out-patient departments dealing with the classes of patient mentioned above, as do also the special hospitals—children's, orthopaedic, neurological, ophthalmic, etc.

In *Sweden* all general hospitals have out patient departments —each special department having its own out-patient section. Each patient attending pays the doctor a fee who in his turn pays over a portion to the hospital for the facilities provided. Sweden is increasingly developing the use of out-patient departments and of preventive and domiciliary measures to make more intensive use of beds.

In *Norway* all acute hospitals have out-patient departments for accidents and emergencies and the same premises are used for the follow-up of discharged surgical patients. Few hospitals have policlinics for internal medicine or obstetrics and gynaecology. All are 'closed'.

Finland has very good out-patient departments in its newer central hospitals.

In the *Netherlands* the out-patient department is a very important part of a hospital's organization and most of the specialist diagnostic work-up is done there.

In *Denmark*, although the open out-patient department is not favoured, consultative out-patient work has a rather limited but increasing application. Diagnostic facilities in radiology and pathology are being made more available to general practitioners.

In *Belgium* out-patient departments have been established at most public or voluntary hospitals and some separate policlinics have been set up and run by mutual insurance schemes and at these treatment is free to insured persons. More than 100 policlinics exist apart from hospital premises, established as private ventures by specialists who practise there a kind of group medicine.

In *West Germany* out-patient departments have not been established in most hospitals which are therefore burdened by many patients admitted for diagnosis only.

In *France* the out-patient departments of general hospitals are becoming more active each year.

The pattern throughout Western Europe is thus very variable but the general and growing tendency is for countries to develop their out-patient services with a view to treating more patients

as ambulatory cases, thus reducing pressure on beds with resultant economy and avoidance of the disruption of family life which admission to hospital entails.

(*b*) *Care of the chronic sick—Geriatrics.* The great majority of patients suffering from chronic disease and who occupy beds in our hospitals are old people. It is, of course, true that a certain number of young adults and children may need prolonged or even permanent hospitalization for such conditions as tuberculosis, poliomyelitis, certain bone and joint disorders, injuries to the spinal cord, etc., but these constitute a fairly small group in comparison with the elderly chronic sick and are not the subject of this section. The ageing of the population which everywhere is being experienced is bringing its own problems. Due to the progress of medical science and to the improved standard of living to be found in most Western European countries, there are great numbers of old people living today who in years gone by would have been cut off early in life by some then incurable illness.

It is not all old sick people who present a great problem. The old person is subject to most of the acute illnesses which affect the younger—a visit to an acute medical ward of almost any general hospital will confirm this, for it will be found that the majority of patients are old. But these mostly respond to treatment, albeit perhaps more slowly than the younger ones, and in due course can be discharged. The problem of hospital accommodation arises in respect of old people who are suffering illness as a result of irreversible changes mostly degenerative in character and arising out of the ageing process itself. These include the osteo-arthritics, the victims of cerebro-vascular catastrophes, the late stages of organic disease of the central nervous system and cases of inoperable malignant disease. The fate of old people of this type admitted to hospital and handled on modern geriatric lines has been studied in Great Britain. It has been found that by the end of three months after admission roughly one-third will have died, one-third will have been sufficiently improved to be discharged to their homes and one-third will need prolonged or permanent institutional accommodation. If these patients are allowed to remain in the acute hospital the place will slowly but surely silt up with

chronic cases to the exclusion of the acutely sick for whom the hospital was primarily designed.

The large chronic hospital is not the answer to this problem; staffing is difficult and it is unlikely that diagnostic facilities will be available to enable an accurate assessment to be made and as a result a patient may be condemned unnecessarily to a bedfast existence for the rest of his life. Every chronically sick old person should be admitted in the first place to a general hospital for diagnosis, assessment and early treatment. If very long-stay or permanent institutional care is found to be needed he should be transferred to a long-stay annexe, a simply equipped, not too large and homely building near to his home and remain under the care of the same physician who looked after him in the general hospital whither he can be readmitted if acute symptoms supervene. Modern methods of training and of physiotherapy can do much to ameliorate the lot of many of these unfortunates even to the point of discharge to their homes. Some of the immobile can be taught to walk again and some of the incontinent made clean.

However devoted a family may be, the continuous care of a sick or disabled old person can be a tremendous burden. The admission of such a patient to hospital or long-stay home for a short spell to give the family temporary relief and the chance of a rest and holiday can be a great help; as can also be the establishment of day hospitals to which suitable chronic elderly sick can be brought and given some occupational therapy, returning home to sleep at the end of the day.

Methods such as those mentioned above are being increasingly applied in the *United Kingdom* in different parts of the country. The problem is also being tackled on these or similar lines in *Sweden, Denmark* and the *Netherlands. France* is using parts of its many small rural hospitals as long-stay annexes.

In most countries there is a shortage of accommodation for the chronic sick. This is true of the *United Kingdom. Switzerland* has a waiting list for these patients owing to shortage of beds. In that country chronic sick are incorporated in the general hospitals and the idea of separate establishments for them is being abandoned.

Norway, on account of shortage of homes and hospitals for geriatric patients, has many long-term cases blocking beds in acute general hospitals when they would be more suitably housed in simpler accommodation.

In *Belgium* there are wards for chronic sick in a number of general hospitals and there are geriatric wards annexed to homes for healthy aged people, but it is stated that too many aged sick lie in bed without adequate medical supervision or skilled nursing. About 80% of all chronic sick beds are in public hospitals and more special hospitals for geriatrics are in course of construction to meet the present shortage of beds.

The problem of adequately caring for the elderly chronic sick is one which affects all Western European countries to greater or less degree, and with everywhere an ageing population, is one which is bound to become more serious. Methods of setting up a geriatric service to meet the varying needs of different countries might form a subject for discussion at a future meeting.

(*c*) *Rehabilitation and physical medicine.* It is only since the Second World War that the current concept of rehabilitation has gained acceptance. Formerly it was considered that the job of a hospital ended when cure or a maximum degree of amelioration of a disability had been achieved. Today it is being increasingly agreed that the responsibility of a hospital should extend to secure, so far as is humanly possible, that a discharged patient is brought back to a state of working and living efficiency. It is hardly an exaggeration to state that the idea of rehabilitation should be in the mind of all who care for a patient from the time of his admission to hospital. In a number of instances the possibility of a patient's return to his former occupation does not exist or is so fraught with peril to his mental or physical condition as to be strongly contra-indicated. In such cases an alternative occupation must be sought and this may entail re-training if a new skill has to be acquired. This will require the co-operation of employers of labour and may need the help of government departments.

In many hospitals there is a tendency to turn from passive to active physiotherapy; to make a patient do more for himself and to depend more on remedial gymnastics than on the time-

honoured practices of massage, remedial baths (other than for weight-bearing) warmth and electricity. Early ambulation is the most obvious form of this trend and the object is not only by exercise to make a damaged limb or organ stronger but to make a patient more self-reliant and by increasing his confidence enable him to take his place again in the workaday world. The psychological effect of physiotherapy is most important: passive methods, though undoubtedly having their uses especially in relieving pain, if used to excess can make a patient dependent and indeed almost an addict.

Apart from work done at general hospitals many countries have set up *ad hoc* rehabilitation centres. These may be general and deal with most types of residual disability or special, as for the limbless or for paraplegics. They are usually residential but in densely populated areas, where transport is not a problem they may be day centres—the patients spending the day there, being given a midday meal and returning home in the evening.

The *Netherlands* has converted some of its now redundant tuberculosis hospitals into rehabilitation centres. In *Switzerland* the federal government subsidizes both for capital and revenue establishments for rehabilitation and the Swiss Accidents Insurance runs a school for retraining the limbless.

Sweden has rehabilitation departments within the framework of its central hospitals. *Norway* is developing rehabilitation departments and has one already working. *Denmark* has recently established several special rehabilitation centres. In the *United Kingdom* there is a centre for retraining paraplegics which draws its patients from all over the country and many of the hospital regions have set up *ad hoc* rehabilitation centres, day or residential.

The subject of rehabilitation and the organization of a rehabilitation service might be a suitable topic for discussion at a future conference.

MENTAL HEALTH

It is only in comparatively recent years that the subject of mental health has been placed upon a reasonably scientific foundation and that it has been realized that most mental illness

is susceptible to modern methods of therapy. The idea of a mental hospital as a purely custodial institution has died very hard as has the feeling of shame which a mental illness could bring to a patient's family. The world indeed has not yet completely accepted the fact that mental ill-health, just like physical ill-health should be treated by its appropriate remedy with, in most cases, the strong probability of cure. Such is the effect of centuries of wrong-thinking of which our many large, old and frequently unsuitable mental hospitals are the monument.

Opinions are divided on the future of mental hospitals. Some think they should be improved and retained in their entirety for the treatment of the mentally sick. Others would go so far as to suggest they should be abolished altogether, in that the vast majority of psychiatric patients by suitable prevention and early therapeutic means in general hospitals are capable of being restored to the community where they naturally belong.

The World Health Organization in its various reports on the matter takes a middle course and advocates the setting up of psychiatric services, both for in-patients and out-patients at general hospitals and that these should closely co-operate with mental hospitals.

None of the countries represented at the conference has a well-developed mental health service, although progress towards this end is proceeding in several and some very promising experimental work in the early treatment of the mentally sick within the community is being carried out, especially in the *Netherlands* and in *Great Britain.* Links between general and mental hospitals are increasingly being made—in some countries such links have been in existence for many years with psychiatrists from mental hospitals holding clinics for out-patients in general hospitals.

Many countries have adopted the measures advocated by the World Health Organization in that they have established psychiatric out-patient clinics (mention was made of this at the conference in respect of *Belgium, Eire, Great Britain, Finland, Norway, Sweden*), and have provided in some of their general hospitals beds for mental illness (*Belgium, Denmark, Great Britain,* the *Netherlands, Norway, Sweden* and to a limited extent

Switzerland). Other countries in Western Europe may well have done likewise but the specific point was not brought out at the conference. Even where these measures have been adopted a number of *ad hoc* mental hospitals will be needed, at any rate for some years to come. A well-administered mental hospital with an adequate staff of skilled and active-minded psychiatrists can today treat to a successful conclusion the very great majority of patients admitted who can then be returned to the community. At the end of a year the number of new patients who have become chronic and need long-term or even permanent institutional care should be small. In most countries the problem is one of the great number of chronic patients now in hospital, admitted years ago before the possibilities of active treatment had been fully realized and modern methods of psychiatric therapy had not been devised. These patients are now victims of prolonged institutionalization and having for so long been deprived of contact with the community are mostly incapable of being rehabilitated. Even among this large group, however, some are still susceptible to appropriate treatment and where the resources of a hospital permit (especially in terms of staff) a proportion is capable of improvement to the point of discharge. Work of this kind is going on in certain hospitals with a view to diminishing the backlog of chronic patients.

The keynote for the future is to prevent psychiatric patients from becoming chronic.

TRAINING FOR HOSPITAL ADMINISTRATION

The essential work of a hospital is carried out by the medical and nursing staff with their auxiliaries and it is part of an administrator's job to create conditions in which that work can be performed with the maximum efficiency, with comfort for the patients and ease to the staff. Compared with the position of twenty or thirty years ago the hospital of today has become so departmentalized and diversified that it is now a highly complex organization. Although specialized training for hospital administration was started in the United States of America some thirty years ago it is only in comparatively recent years that the need has been realized in Western Europe.

It seems hardly necessary to continue the controversy of

medical or non-medical administration. 'Medical administration' ought to mean that part of administration which can best be undertaken by a medically qualified man, general administration can be undertaken by one who is either medically qualified or not as already demonstrated in many countries. Some see advantages in the former and others in the latter. What has become clear is that fewer serious mistakes are made and better results obtained if administrators are adequately trained in administration. Training can teach the technicalities, procedures and methods; more importantly, it can develop the qualities of mind, spirit and leadership, which it is hoped, may be in those whose selection as potential top-class adminstrators has been carried out with proper care and skill. A sense of dedication should not be confined to the clinicians and nurses; it should be shared by all who work in hospital and not least by the administrator.

In the past the position of medical superintendent of a hospital has been filled by the appointment of a medical man with little or no experience of administration other than perhaps what he may have acquired by trial and error in the management of his own department. It is true of course that during his medical education a doctor will have learned much of certain aspects of hospital life; other aspects, however, will be to him a closed book. If a medical man is called upon to undertake the administration of a modern hospital, even with the help of a capable business manager, it is most desirable that he should have had adequate training in the basic philosophies of administration as well as an adequate amount of instruction in the technical details of a hospital's organization, its methods and procedures. By reason of his background and experience the course of instruction a doctor should undergo will need some modification from that considered suitable for a non-medical man. It might also be shorter.

The non-medical administrator (director, house governor, secretary-superintendent or whatever name he is called) has usually in the past been appointed by promotion from more junior administrative posts in the hospital service or he may have been a man with administrative experience in some other walk in life. This method of appointing is still the practice in

many countries but the desire now being so widely expressed in almost all Western Europe for the provision of training in hospital administration is perhaps sufficient evidence that the old ways do not fit the new conditions and complexities.

The precise content of hospital administration is difficult to define. It ranges from administrative and organizational aspects at national, regional or local levels to the individual large, medium or small hospital. Moreover the social changes, the advances of medical science, economic and other factors have carried the problems far beyond the realm of simple staff management, accountancy, supplies and maintenance that formed the content a few years ago.

Short 'refresher' courses or conferences for practising administrators and correspondence courses or part-time theoretical courses have been provided in varying degree in some countries. But outside the United States and Canada the idea of pre-entry training for university graduates or others of good education who wish to make a career in hospital administration is a relatively new one and one which has so far been adopted by very few countries. The establishment of full-time courses of one or two years' duration is uneconomic and therefore hardly practicable in a small country with a population of, say ten million or less where there are few vacancies each year in senior administrative posts in hospitals. As basic principles of hospital administration are universal, even though traditions, circumstances and language differ between countries, it is almost inevitable that there must be collaboration in this field between countries if the problems and difficulties of the new era are to be satisfactorily met.

In *France* all administrative posts in the public service are filled by competitive examination. For posts of hospital administrator candidates must be under 30 and either (a) be university graduates; (b) be civil servants holding the baccalaureat and having worked for three years in hospitals or in the Ministry of Public Health; or (c) have held a minor post in hospital for six years. Candidates are given a written examination with papers in administrative law, economic policy, hospital law and social legislation. Those who pass the papers have a series of oral examinations and an interview to assess

character. The successful candidates, known now as 'administrative trainees' are given a year's course of theoretical instruction and practical work in hospitals. This is organized by the National College of Public Health, established at Rennes in Brittany. There is a final examination and the presentation of a thesis after which appointments to posts in hospital are made by the Minister.

In *Italy* no schools of training have been established due to lack of uniformity in the hospital organization and the autonomy of various charitable institutions, but annual courses and study meetings have been arranged.

In *Norway* and in *Switzerland* non-medical hospital administrators for the most part learn by doing, in other words they graduate from the lower to the higher positions in hospitals with no systematized training. In both countries the annual number of vacancies is small and Switzerland is further handicapped by having three national languages. The Swiss Hospitals Association organizes annual refresher courses and the institutes of economics of Zurich and St. Gallen organize regular short sessions for hospital administrators. The *Netherlands*, though appreciating the need for specialized training, have not so far established any pre-entry courses. A post-entry in-service course of one academic year is now in its third year. It is attended by medical and non-medical hospital administrators and a few matrons. It is sponsored by the Universities of Nijmegen, Tilburg and Utrecht. There are also some shorter courses for people already in the hospital service. Non-medical hospital administrators are often appointed from graduates in economics or from industry.

Belgium has established courses at university level in hospital management at the Universities of Louvain and Brussels with a view to training competent staff for top-level appointments. The classes are very small and consist mostly of people already in the hospital service. The course at Louvain is of two years' duration and is for university graduates leading to a master's degree in hospital sciences. That at Brussels which has been set up under the aegis of the World Health Organization, is for one year and leads to a special licence degree.

A number of countries have organized short courses for in-service training and these may be intensive and whole-time or part-time spread over a period.

Finland has short courses in hospital administration for juniors. Candidates for the position of administrative director in the university hospitals must hold an academic degree; and for the post of business manager at least a diploma from a commercial college. For these qualifications they take the ordinary course at university or institute.

Eire has no pre-entry training but the Institute of Hospital Administrators conducts a two-years' course leading to a diploma in hospital administration; and also short courses—both for people already in the hospital or related health services.

In *Denmark* which has vacancies for no more than five or six high level hospital administrators each year, the Association of Danish Hospital Administrators runs two in-service advanced training courses a year and a number of short (one week) refresher courses.

West Germany has an in-service course organized at the University of Cologne and extending over two years during which participants come four times for about one month each time for lectures and seminars on the basic principles of hospital management.

In *Sweden* hospital secretaries usually work up from junior positions and have a three to four months' course at a school of social work and public administration.

Both Sweden and West Germany are considering pre-entry education for intending hospital administrators—a four-years' course at the University of Uppsala and a three-years' course at the University of Cologne, respectively.

In the *United Kingdom* there are two training courses each of two and a half years' duration; the national scheme was inaugurated in 1956 and the regional scheme in 1962 by the Ministry of Health. The annual intake bears a relation to the anticipated number of administrative vacancies in the hospital service.

There is a very careful and a common selection of candidates for both schemes by a national selection committee appointed by the Minister of Health and stress is laid on character and personality as estimated at interview. Eligible candidates are (a) graduates of a British university; (b) those in possession of a professional qualification acceptable to the selection committee; (c) those who have held a post in an administrative department in the health service for not less than three years and have passed the intermediate examination for an acceptable qualification. The majority of candidates are newly qualified university graduates.

The national trainees are the responsibility of the University of Manchester which receives half the annual intake and the King's Fund Hospital Administrative Staff College which takes the other half. The regional trainees are the responsibility of the regional staff advisory committees and their training officers, who arrange the practical training. The theoretical part of the course is provided by the Universities of Leeds and Manchester and by the Hospital Administrative Staff College; each taking one-third of the trainees. There are some variations between the two training courses, the principal one being that the regional scheme provides for more practical and less theoretical training than does the national scheme.

In addition to these long courses there are a number of short courses of from one week to several months' duration for in-service training. Some of these are also conducted by the Hospital Administrative Staff College and by the University of Leeds, whilst the staff advisory committees of the regional hospital boards undertake the organized training of junior administrative and clerical staff in the hospital service.

The Institute of Hospital Administrators—a voluntary body —conducts an examination with external examiners in hospital administration leading to a diploma.

Two further university training courses need mention. The University of Edinburgh conducts a diploma course in medical services administration, sponsored in its initiation by the World Health Organization. It provides an academic year of advanced study to persons of experience in health services in the United

Kingdom or overseas and who possess a medical or other university degree or are of other approved educational status. Many of the students come from abroad. The University of London runs a three-months' course in medical administration for doctors, which after a period of experiment it is hoped to expand into a two-years' course leading to a university diploma. It is intended for doctors who aspire to become senior administrative medical officers of regional hospital boards, medical superintendents in Scotland or to hold administrative positions in public health.

As will be seen from the above account the countries of Western Europe have not as yet proceeded very far in the systematized training of medical or non-medical administrators but considerable progress has been made in teaching the principles of nursing administration to those who wish to achieve senior positions in the nursing service. For those who aim at the position of hospital matron in *Denmark*, *Norway*, *Finland* or *West Germany* satisfactory attendance at a one year's course in hospital and nursing administration is almost a *sine qua non*, whilst in *Belgium*, *Eire*, the *United Kingdom*, *Sweden* and *Switzerland* organized education in these subjects has for long been established.

Detailed discussion of schemes of training of hospital administrators and in particular the practicability of various forms of international co-operation could very advantageously form the subject of a future conference.

PART II
PAPERS PRESENTED AT THE CONFERENCE

BELGIUM

by

DR. S. HALTER

Directeur-Général, Ministère de la Santé Publique et de la Famille, Administration de l'hygiene Publique

HEALTH AND HOSPITAL SERVICES IN BELGIUM

I. General Information

Belgium has an area of 30,507 square km. It is divided into nine provinces.

Its population at 31st December 1959 was 9,128,824 inhabitants, or a density of 299 inhabitants per square km.

Population of the Provinces:

Antwerp	1,416,441
Brabant	1,950,779
West Flanders	1,058,746
East Flanders	1,268,034
Hainaut	1,271,888
Liege	1,010,611
Limbourg	563,645
Luxembourg	218,166
Namur	370,514

Belgium has five great centres of population:

Antwerp	546,500
Brussels	1,003,937
Charleroi	211,201
Gand	217,456
Liege	443,094

Belgium has 2,669 communes, of which

54	have more than 20,000 inhabitants
292	have more than 5,000 inhabitants
1,789	have more than 500 inhabitants
534	have fewer than 500 inhabitants

Vital statistics

	1960
Percentage of births	17·60%
Percentage of deaths	11·34%
Natural increase	6·26%
Population increase (between 1947 and 1959)	6%
Migratory movement (1959). . . .	0·76%

Health indices

		1960
Expectation of life . .		70 years (men, 67 years 7 months) (women, 72 years 10 months)
Average age . . .		36 years 2 months
	(1880)	28 years 6 months
Infant mortality (under one year)		2·5%
	(1900)	17%
Neonatal mortality (under one month) . . .		2%
	(1900)	5·15%
Percentage of people aged over 65 years in the population	1880	6·4%
	1947	10·7%
	1960	12%

Morbidity rates:

No particulars, as no research has been conducted in this field.

Chronic diseases:

Patients in clinics, hospitals, homes	1959	16,150

Chronic patients in or out of hospital represent 40% of the population.

Infectious diseases:

	1945 cases	1950	1959
Typhoid fever .	715	318	92
Diphtheria . .	6,106	541	1,011
Polio . . .	852	86	142
Syphilis . . .	3,498	1,188	328
Tuberculosis:			
Number of new cases	15,989	6,132	4,440
Total diagnosed and under supervision 1949 . . .	86,422	77,506	72,664

Mortality

Infections . .	28% in 1900	2·5% in 1960
Cancer . . .	9% in 1930	21% in 1960
Lung cancer . .	680 cases 1955	880 cases 1958
Leukaemia . .	840 cases 1954	1562 cases 1958
Accidents . .	4·5% in 1900	7% in 1958

Road accidents 175,000 in 1960:
64,000 slight injuries
13,800 severe injuries
1,500 fatalities

Accidents at work over 400,000 in 1958 with over 500 deaths.

Occupational diseases 1% of exposed persons in 1953
1·5% in 1958

Mental diseases 23,000 committed in 1953
25,500 committed in 1959

Belgium is a constitutional monarchy founded in 1830. The Belgian Constitution dated 7th February 1831 recognizes three national powers:

i. The LEGISLATIVE POWER exercised by the *Chamber of Deputies*, with 212 members elected direct; the *Senate*, composed of three sections, one elected direct, one elected by the provincial councils, and a third co-opted by the

other two sections; and the King, who sanctions the laws passed by the two Chambers.

ii. The EXECUTIVE POWER constituted by the King and his Ministers (at present numbering 20) assisted by government departments.

iii. The JUDICIARY POWER exercised in the name of the King by the courts and tribunals which are independent of the other two Powers, but are under the administrative charge of the Minister of Justice.

The Constitution further recognizes a subdivision of the country into nine Provinces (Brabant, Antwerp, West Flanders, East Flanders, Limbourg, Liege, Luxembourg, Namur and Hainaut).

The Provinces are administered by a Provincial Council elected direct for four years, and a permanent Deputation appointed by the Provincial Council. The Governor, who is appointed by the King, presides over the permanent Deputation and attends the meetings of the Provincial Council. He has authority over the Communes, which represent the basic administrative unit of the country.

Finally, the Constitution recognizes the autonomy of the *Communes* which in fact hold all powers on the local plane. The boundaries of the Communes are fixed by law.

Belgium has more than 2,600 communes, of which the smallest has only 26 inhabitants.

Each commune is administered by a *Communal Council* elected for six years, which appoints from among its own members a *college of deputy-mayors* to attend to current administration under the chairmanship of the Burgomaster, who is appointed by the King either from among the communal counsellors or even from outside.

The Burgomaster actually holds all the administrative and police powers and carries all responsibility on the communal plane.

Thus the power of initiative in matters of sanitation, and public hygiene and health is mainly in the hands of the local authority.

It is only because of the inability of these authorities to deal with their problems without technical or financial assistance that the intervention of the Central Executive has developed, and that the authority of the Minister of Health has asserted itself in certain spheres. This historic evolution manifested itself very clearly through the events of the past century.

The communal powers in the matter of assistance to the poor and to the indigent sick are exercised through the Public Assistance Commission which was created in each commune by the Law dated 10th March 1925. This Commission is composed of persons appointed by the Communal Council. The Burgomaster is its chairman, *ex officio*, though a chairman, in addition, is chosen from among the members.

iv. GENERAL CONSIDERATIONS

From the historical point of view it must be remembered that Belgium proclaimed its independence in 1830 and that until then it had been buffeted in different directions and formed part of different political constellations.

It had successively belonged to Bourgogne, Spain, France, Austria and Holland.

However, from the eleventh century, its cities had claimed and secured important privileges and had perpetuated themselves as entities despite changing dominations.

From the point of view of hospitals and social medicine, we have to consider four periods:

The period preceding the Revolution of 1789, evolving from the preceding eras;
The Middle Ages;
The Renaissance;
The French eighteenth century.

A characteristic of the pre-Revolution period was the existence of many institutions, hostels, hospitals, orphanages, leprosy homes, maintained by religious orders and the towns. However, all of them were staffed by a majority of nuns and, sometimes, by lay persons, chiefly ladies of good family. This work was essentially charitable and voluntary.

The second period runs from 1789 to about 1850.

The hospitals had been nationalized by the Revolution, but from 1800 the religious orders resumed serving them, though without regaining possession of them.

The charitable nature of the organizations was recognized by law and constituted a communal charge. However, hospitals retained their charitable character and depended on the goodwill of the local officials.

The third period extends from 1850 to 1945.

It is characterized by the erection of many public hospitals between 1850 and 1900, then by the creation of many private institutions and clinics, at first on the initiative of physicians and surgeons, then, particularly from 1900, by religious orders. Finally, from 1920, a number of hospitals have been established by mutual benefit movements.

The year 1925 saw the reform of Public Assistance. In each of the 2,600 communes the welfare offices and hospital commissions, formerly independent of each other, were combined.

The fourth period began in 1945 by the inauguration of compulsory social insurance. (Law dated 28th December 1944.) Since then, the social medicine movement has accelerated. Poverty, which had constituted the criterion for the operation of Public Assistance, has considerably diminished, decreasing from 80% to 10% among the patients of the public hospitals. Since 1945 a very large number of new hospitals have been built, particularly in the private sector.

However, it should be noted that the last two periods since 1850 were characterized by a distinct difference as regards the hospital movement between the northern part of the country, the Flemish region which has a Catholic majority and an agricultural character, where there are many hospitals and clinics; and the southern, French speaking Walloon region which is more accessible to social movements, has a Socialist majority, has been highly industrialized during the past century, and has less hospital provision.

This difference persists today and has, if anything, increased.

The Flemish provinces have 22,116 beds for acute cases in a population of 4,306,866, or 5·1%.

The Walloon provinces have 10,647 beds for a population of 2,871,179, or 3%.

The Province of Brabant, which includes the capital and has a mixed structure, has 8,362 beds for a population of 1,950,779, or 4·29%.

The Belgian Constitution and laws give sole responsibility for medical care to the communal authorities. In the case of the individual indigent this responsibility is fulfilled through the agency of Public Assistance, but private initiative plays a very important role in medical care on a voluntary or charitable basis.

Social Security, which covers only 5,200,000 persons out of the 9,129,000 inhabitants, is alone in having delegated to the Ministry of Health the responsibility for the provision of sufficient medical care.

So far, then, Belgium has no authority whose task would be to regulate or co-ordinate initiatives in this sphere. The State has only auxiliary powers and confines itself to the granting of subsidies for new building. These powers have not been sufficient to even out the distribution of institutions.

II. Responsibility for and Organization of Medical Services

The authority for health organization in Belgium lies, in fact, and in law, with the communes. Here also private initiative plays a large part on a voluntary basis.

However, it is necessary to distinguish the various aspects of this provision and to consider general health problems and medical practice.

The general health problems, which in fact include responsibility for public health and protection of the population against the drawbacks of the environment and neighbourhood, are at present in effect shared between the local authorities, which were originally solely responsible, and the provincial and central authorities.

Public sanitation, street cleaning, the removal of solid and fluid garbage, the guardianship of the peace, the water supply, domestic sanitation and town planning, are still very definitely in the hands of the local authorities.

The battle against transmissible diseases is already being conducted with more intervention from the central authorities, particularly the Ministry of Health, to which the provincial health inspectors are directly subordinate. The task of these inspectors in each province is to assist the communal authorities in all matters that lie within their competence. They therefore appear as the natural advisers of the Burgomasters, with whom they collaborate in the struggle against infectious diseases. In this specific sphere they can even act instead of a defaulting or negligent burgomaster by taking the necessary prophylactic measures.

The powers of the communal authorities also extend to the supervision of foodstuffs, which some towns and large communes exercise themselves, while others leave it to the government food inspectors.

On the other hand, in the sphere of the *medical services* the intervention of the public authorities is of recent origin, apart from the responsibility of the communal authorities and the public assistance commission on the financial plane in connection with poor people.

In Belgium the *art of healing*, which includes medical practice, pharmaceutics, dentistry, midwifery and certain paramedical activities, is governed by an old law. (12th March 1818.)

This law regulates the medical and paramedical professions through local medical commissions and particularly provincial medical commissions, which were completely reorganized in 1949.

The exercise of the healing art is further subject to registration on the panels of the Order of Physicians and the Order of Pharmacists, and to the discipline imposed by these Orders, which are of recent creation (Physicians, 1938, Pharmacists, 1949).

Belgian law on medical practice, and that relating to the conferment of academic degrees, does not recognize medical

specialization. In principle, each physician is therefore universally competent in all aspects of medicine. Until now, medical specialization has developed on an empirical basis, without legal sanction. But since the introduction of Social Security the need for official recognition has made itself felt. Since 1957 the Ministry of Health has created special commissions with the task of recognizing medical specialization. These commissions have established criteria of qualification and have compiled lists of recognized specialists.

A tendency is now evolving in official quarters towards the introduction into the law on university education provision for medical specialization.

Medical science is headed by the two Academies of Medicine (French and Flemish), which are the supreme consultative medical authorities.

While the practice of medicine is wholly and exclusively the preserve of the doctors, there are on the social and financial plane a great many arrangements and institutions designed to facilitate medical practice in the various curative and preventive spheres.

It should be noted, first of all, that theoretical separation between curative and preventive medicine is particularly sharp in Belgium. This separation was rendered necessary by the pressure of the medical profession. However, we must distinguish between preventive medicine proper, public sanitation and medical prophylaxis through the early detection of certain diseases.

Further, certain diseases whose social or economic repercussions are important are grouped in a context of social medicine whose artificial character is apparent.

These facts are important for an understanding of the structure of the institutions and their hierarchization.

We shall distinguish between the structure of the institutions of curative medicine, preventive medicine, social medicine and certain activities involving segregation of a purely social nature (the aged, orphans).

This begins in the surgery of the *general practitioner* who receives the patients there or calls on them.

It continues with the *medical specialist* who attends to patients at his surgery or calls at their homes.

During the past few years *polyclinics* have developed (combined general or specialist medical surgeries under joint administration). Originally, these polyclinics were almost exclusively created on the initiative of the friendly societies or annexed to private or public clinics. At present, a large number (more than 100) exist separately from hospital premises and practise a form of group medicine. In the eyes of the promoters these innovations are justified by the quality of the medical service as well as advantages on the administrative and financial plane.

Medicine is further practised in public or private hospitals which greatly differ as regards capacity, specialization of services, equipment and staffing.

The hospitals and clinics are of a general character, and are equipped for surgery, general medicine, paediatrics (less frequently) or obstetrics. Some of them provide other medical services.

Finally, there are special *hospitals or clinics* (ear, nose and throat, ophthalmology, rheumatology, orthopaedics, traumatology, dermatology, etc.).

In addition to these curative institutions, which deal with acute complaints, there are specialized *therapeutic sectors* which in Belgium are ranked in the category of *social medicine*. They include establishments to combat tuberculosis, cancer, establishments for mental patients, for abnormal children and some specialized centres for the treatment of cerebral paralysis, disseminated sclerosis, etc.

A tendency to create geriatric hospitals and hospitals for chronic patients in general has become apparent, but has not yet developed further. Some hospitals have installed rehabilitation sections, notably some of the traumatological hospitals.

In the sphere of *early diagnosis of disease*, a chain of *health centres* has developed, public and private, where various kinds of research is conducted on special groups. Antenatal consultation centres are frequently separate or are attached to maternity hospitals. Consultations for infants are assisted or sponsored by the National Institute for Childhood. School medical inspection is obligatory in the primary schools. Adolescents at work are protected by legal provision under the General Regulations for the Protection of Labour. Arrangements exist for the care of workers and for the control of occupational diseases; medical inspection for those engaging in sports; vocational guidance; consultation on mental hygiene; and many other activities, which are exercised in divers ways according to the centres and the concepts underlying their management.

The work of the health centres, although essentially concentrated on early diagnosis of disease, particularly tuberculosis and diabetes, frequently develops in the direction of prophylaxis proper, notably by means of vaccination, health education and health propaganda.

In the past, the diagnosis of and the campaign against tuberculosis were conducted by the *Anti-tuberculosis Dispensaries;* these still exist, but have lost much of their *raison d'être.* The prevention of tuberculosis is promoted by the existence of *preventive centres* and by a large chain of *institutions for debilitated children* established or sponsored by the National Institute for Childhood.

This succinct and incomplete picture will now enable us to consider the character of the various public and private organs and their responsibilities.

II. *1.* A. NATIONAL CENTRAL ADMINISTRATION

The responsibility for welfare and health is essentially in the hands of:

(*a*) The Ministry of Health and Family (Public health, institutes of social medicine, mental diseases, tuberculosis, and public assistance).

(*b*) The Ministry of Social Welfare as regards the combating of disease within the framework of social insurance (National

Insurance Fund against Sickness and Disablement (F.N.A.M.I.)).

(*c*) The Ministry of Labour as regards the medical protection of the workers.

The MINISTRY OF HEALTH AND FAMILY is responsible for:

Public health at the central and provincial levels (prophylaxis of communicable diseases—protection of the population).

Supervision of the quality of foodstuffs and meat.

Supervision of pharmacies and medicaments.

Supervision and installation of the water supply.

Combating air and water pollution.

It is further responsible for approving medical specialists and hospitals and clinics.

It is responsible for combating tuberculosis, which is the task of the Belgian National Institute for Combating Tuberculosis, a semi-private organization supervised and financed by the Ministry.

There are 120 anti-tuberculosis dispensaries, 16 preventive centres with 2,200 beds, 27 sanatoria with 4,600 beds, three reception centres with 135 beds, and six preservation centres with 114 beds.

Prevention of infantile diseases is the task of a semi-government institute which is administratively and, in particular, financially, under the Ministry of Health.

The National Institute of Childhood, created in 1919, whose work chiefly covers the antenatal period and the first months of life (373 antenatal consultations and 1,172 consultations in infancy), combats infantile debility in nine homes with 1,600 beds, 90 approved homes with 10,000 beds and 166 sections for debilitated children with 18,700 beds.

The war against mental disease is carried on by the Ministry of Health in four government establishments and 46 private establishments, altogether with a total of 25,000 beds.

Apart from the four establishments for mental disease, the Ministry of Health and Family has no medical establishments.

The Ministry of Social Welfare owns and runs two centres for treating miners suffering from silicosis.

The Ministry of Labour's only function in this context is through its regulations and its medical inspection service.

II. *1.* B. ON THE PROVINCIAL LEVEL

There are only a few establishments, although the law relating to the provinces imposes on them a residual responsibility.

It should be noted that three provinces (Namur, Limbourg, Hainaut) have created and are running a provincial maternity clinic with an obstetric centre. Further, one province (Hainaut) runs a centre for the re-education of crippled people. One province (Namur), has created a network of health centres. Two provinces (Liege and East Flanders), run anti-tuberculosis sanatoria.

While the Provinces have taken the initiative in social medicine only in exceptional cases, they have in general favoured, administratively and even financially, the creation of medical establishments.

II. *1.* C. It is essentially on the LOCAL LEVEL (communes and Public Assistance Commission) that the activities of the public authorities have developed.

Thus 24 communes or towns have established health centres.

All the communes have to provide for school inspection. Finally, 100 hospitals are owned by the Public Assistance Commissions. Mental health consultation centres are often due to communal initiative.

II. *2.* PART PLAYED BY PRIVATE BODIES

Historically, since the remotest times, the religious orders have undertaken the task of providing medical care to the sick and under-privileged.

After a gap of a century, caused by the Revolution of 1789, these orders resumed the initiative at the end of the nineteenth century.

At present they constitute the largest section engaged in

providing medical care, for they own 144 clinics for acute cases, with 15,204 beds, or 38% of all the hospitals for acute cases.

They own and manage 75% of the beds available for mental patients, and their activities extend to all sectors.

In addition to this organization, which is at present largely centralized in the Federation de Caritas Catholica, there are also other private groups:

The Mutual Aid Associations, which are the executive organs of Social Security, own and run 19 clinics with 1,695 beds, or 5% of the provision for acute disease.

Groups of doctors, non-profit making associations, limited companies, factories or groups of factories, private physicians, etc., are various private bodies which, with 110 hospitals and 7,425 beds, cover 29% of the establishments.

On the whole, as regards hospitals for acute cases, 72% of the establishments and 59% of the number of beds are owned by private bodies. The majority of anti-tuberculosis establishments are owned by private institutions, while 80% of the beds for mental patients are owned by private bodies, mostly religious orders.

Finally, as we have seen, the polyclinics are generally private institutions.

The very type and the different forms of private organization render inquiries as regards staffing particularly difficult.

On the whole, it can be said that there is a constant shortage of paramedical staff, particularly nurses.

Most of the institutions owned by religious orders employ a mixed staff, both lay and religious.

A fair number of hospitals owned either by public authorities or by some form of private organization have at their disposal both religious and lay staff.

II. *3.* DEVELOPMENT OF HEALTH INSURANCE

Until 1944 there were in Belgium three forms of payment for medical care:

Poor patients were wholly or partly paid for by the Public Assistance Commissions.

Friendly society members (then voluntary) were treated free of charge at the polyclinics and clinics owned by their assurance society. Elsewhere, only part of the cost was paid by the society.

Other citizens had to pay for their own medical treatment.

At present the situation has considerably improved, because the number of indigent patients has greatly decreased owing to compulsory health insurance and a large number of people get free insurance and also refund of the cost of medical treatment.

Compulsory Social Security derives its revenue from contributions by the workers and employers, as well as from the State, for the purpose of forming its general reserves. The State further covers any deficit arising from its operations.

A part of the cost is charged to F.N.A.M.I. (health insurance) which, however, does not cover all the charges of the illness, but pays a lump sum for both general practitioner and specialist treatment as well as hospital treatment. In the case of hospital treatment there are two systems of payment, one involving a lump sum; the other, more advantageous, by contract.

The F.N.A.M.I. also covers pharmaceutical expenses, which are governed by a special tariff which varies according to the products concerned. It similarly pays the greater part of the cost of tuberculosis treatment, dental treatment, prosthesis, etc.

A considerable allocation is made for re-education.

Of the 9,200,000 inhabitants, approximately 5,200,000, or 55%, enjoy the benefits of health insurance. Of the 45% or four million inhabitants who are not covered, 8% are officials, 2% paupers, 10% landworkers, 20% business men and artisans and 5% members of the liberal professions or executives.

It is estimated that in Belgium the 55% having social insurance contribute 62% to health expenditure, against only 38% contributed by the 45% who are uninsured.

Despite the lump-sum and partial character of the refund for medical and other treatment, health insurance shows a large

deficit each year. This is partly ascribed by some people to the plural system of this organization, which consists of six central bodies differing as regards political (Socialist, Christian, Liberal, neutral) or professional affiliations.

Each of these bodies, on its part, has a highly decentralized structure, which in practice comes down to communal units (2,600 communes) with necessarily cumbersome administrative machinery.

In 1960, the receipts of the F.N.A.M.I. amounted to 10,680,000,000 frs. and the expenditure to 11,656,000,000 frs., or a deficit of 976 millions. In this total, the health services account for 6,345,000,000 frs., the balance representing disability allowances and administrative expenses.

In addition to health insurance, there is insurance against accidents at work, against the risk of occupational diseases and, finally, compulsory insurance against road accidents.

The Belgian State pays the cost of hospitalization and treatment of the great majority of mental patients. The budget of the Ministry of Health and Family in fact includes a special fund for assistance to confined, sequestrated patients, impecunious tuberculosis patients, cancer patients and patients suffering from certain other diseases, as cardiopathies, poliomyelitis, cerebral paralysis, etc.

This provision is of the order of 700,000,000 frs. per annum.

The National Organization for Child Welfare, which provides both preventive and curative treatment for children, has an annual budget of the order of 450 million francs, entirely covered by the Ministry of Health and Family.

II. *4.* MEDICAL AND PARAMEDICAL STAFFING

(*a*) *Physicians*

As at 1st January 1960 there were in Belgium 11,380 doctors, or 12·5 per 10,000 inhabitants.

It should be noted that in 1952 the figure was 8,685 or 10 per 10,000 inhabitants.

Of the 11,380 we must deduct 2,000 doctors who are not in practice, while the number of specialists may be estimated at 3,082.

(*b*) *Pharmacists*

As at 1st January 1960 there were 5,266 pharmacists, or 5·6 per 10,000 inhabitants, but the number of dispensaries is about 4,350. In 1952, the figures were 4,234 and 3,500 respectively.

(*c*) *Dentists*

There are 226 stomatologists, 269 doctors qualified in dental science, 1,041 licentiates, 570 qualified dentists ('capacitaires'), or a total of 2,106.

(*d*) *Midwives*

The profession of midwife has long been made comparable by law with that of physician or pharmacist.

Since 1952, the training of midwives has been modified and since then midwives have also been nurses. However, their status has remained in force.

As at 1st January 1960 there were 3,815 midwives as against 3,674 in 1952.

(*e*) *Other paramedical personnel*

It is difficult to determine the exact number of these personnel, because there is no compulsory registration of them. However, it is estimated that there must be 13,000 female nurses, only half of whom work at hospitals, 6,757 male nurses, 1,065 male nurses for mental patients, 2,263 'capacitaires', 437 'kinesistes' and 3,818 children's nurses.

II. 5. HEALTH EXPENDITURE

It is difficult to give precise figures concerning the cost of the health services in Belgium; but by approximation and extrapolation on the basis of social security expenditure, the total expenditure may be estimated at 18,000 million frs.

The F.N.A.M.I. pays 3,055 millions for medical and dental treatment. Private individuals, whether insured or not, pay about 5,782 millions; which makes a total of 8,837 millions without medicaments and hospitalization.

The pharmaceutic expenditure of F.N.A.M.I. amounts to 1,719 millions. It may thus be estimated that the total expenditure, together with that of private individuals, amounts to 3,000 million frs.

Hospital treatment of patients in the different sectors may be estimated to account for about 6,000 million francs. (There are 10 million working days at the hospitals and clinics, to which must be added the mental patients, etc.).

Thus the total of these charges approximates 18,000 millions, which represents 12% of the national budget, and probably 5% of the national income (this income is very variously estimated in Belgium and there is no official figure).

III. Hospital Services

III. *1.* A. The 382 hospitals and clinics had on 1st July 1960 a total of 40,925 beds, or 4·48 beds per 1,000 inhabitants.

They are divided into 109 public hospitals with 16,601 beds and 273 private hospitals and clinics with 24,324 beds.

Capacity

Of the 109 public hospitals
27 have fewer than 50 beds
32 fewer than 100 and more than 50
20 fewer than 200 and more than 100
27 fewer than 300 and more than 200
7 fewer than 500 and more than 300
6 have more than 500 beds.

The average capacity is 150 beds.
Of the 273 private hospitals
100 have fewer than 50 beds
88 fewer than 100
61 fewer than 200
17 fewer than 300
5 fewer than 500
2 have more than 500 beds.
The average capacity of these establishments is 90 beds.

OWNERSHIP

Of the 109 public hospitals 98 belong to the C.A.P., the others belong either to the communes or to intercommunal bodies or the provinces. One academic hospital is owned by the State.

Of the 273 private hospitals 19 are owned by friendly societies, 144 by religious orders and 110 by other owners.

The hospitals are very unequally distributed throughout the country (see map).

While the proportion for the country is 4·48 beds per 1,000 inhabitants, the Province of

Antwerp	has	5·30 beds per 1,000 inhabitants
Brabant		4·29
West Flanders		5·62
East Flanders		4·75
Hainaut		4·10
Liege		4·02
Limbourg		4·67
Luxembourg		1·92
Namur		2·03

The hospitals for acute cases are further divided into:

University hospitals:

One at Gand (State), two at Brussels (C.A.P.), two at Louvain (one C.A.P., the other the University), one at Liege (C.A.P.).

General hospitals:

with all services, generally publicly owned, in the large towns.

Regional hospitals.

Local hospitals.

Specialist hospitals.

ESTABLISHMENTS FOR MENTAL PATIENTS

(*a*) Closed, for committed patients

Four State establishments at Geel, Rekem, Tournai, Mons. 46 others. Total beds 25,000.

(*b*) Open, for voluntary patients

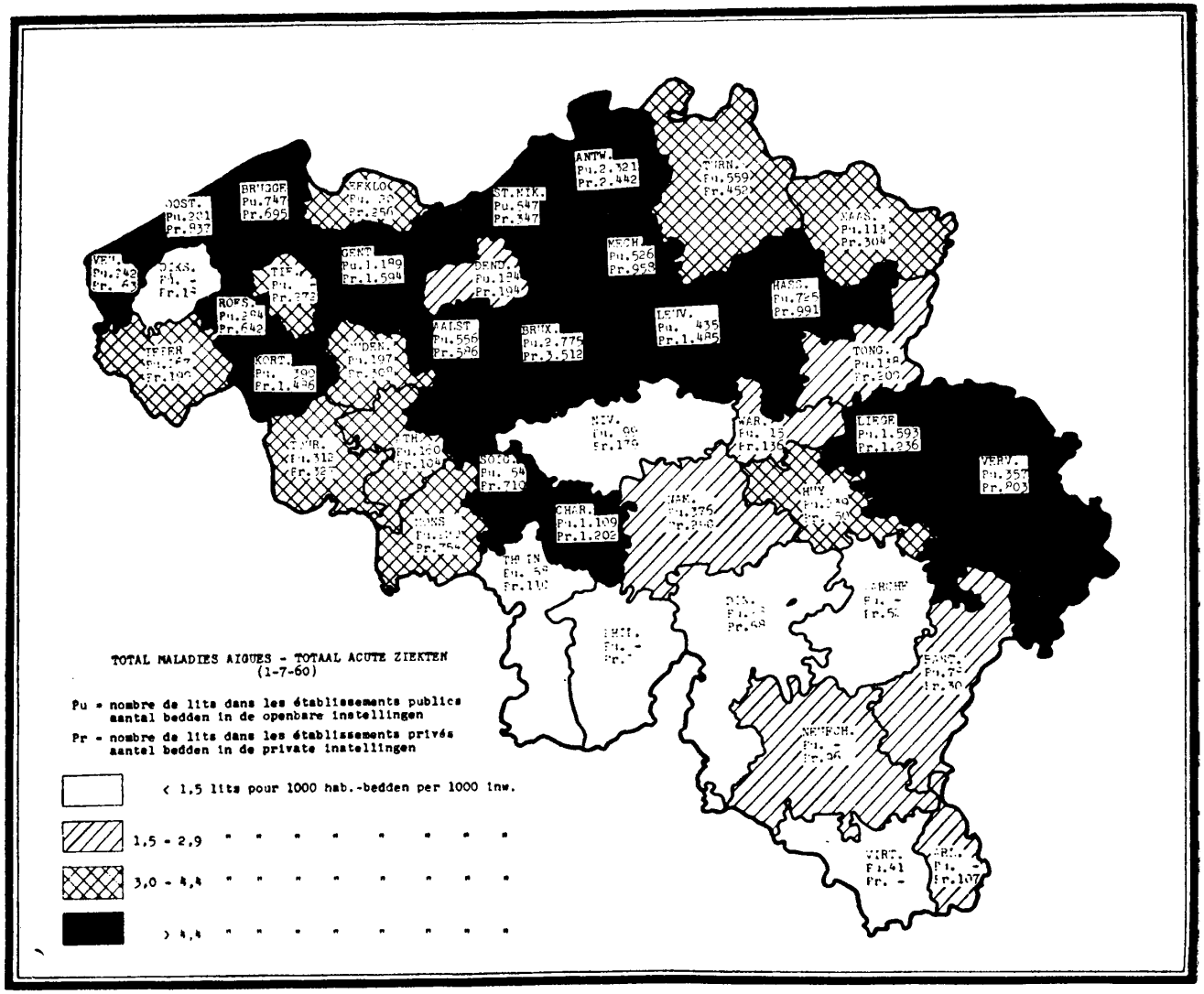
15 establishments or wards with 950 beds.

(*c*) Abnormal or backward children

80 establishments with 11,200 beds.

(*d*) Mental health clinics without hospitalization: 17.

(*e*) Psychiatric wards in general hospitals: In course of creation.


ANTW.
Pu.2.321
Pr.2.442
BRUGGE
Pu.747
Pr.695
ST.NIK.
Pu.647
Pr.347
MECH.
Pu.526
Pr.958
LEUV.
Pu. 435
Pr.1.486
BRUX.
Pu.2.775
Pr.3.512
LIEGE
Pu.1.593
Pr.1.236
CHER.
Pu.1.109
Pr.1.202
TOTAL MALADIES AIGUES - TOTAAL ACUTE ZIEKTEN
(1-7-60)
Pu = nombre de lits dans les établissements publics
aantal bedden in de openbare instellingen
Pr = nombre de lits dans les établissements privés
aantal bedden in de private instellingen
< 1,5 lits pour 1000 hab.-bedden per 1000 inw.
1,5 - 2,9
3,0 - 4,4
> 4,4

ESTABLISHMENTS FOR COMBATING TUBERCULOSIS

(*a*) Clinics (grouped, owned generally by the Belgian Anti-Tuberculosis League): 120.

(*b*) Sanatoria (grouped and owned by the Belgian Anti-Tuberculosis Association): 27, with 4,405 beds.

(*c*) Preventive centres (owned by the Association or the League for the Protection of Children): 16, with 2,200 beds.

(*d*) Clearing centres (pre- and post-sanatorium) owned by the C.A.P.: three with 135 beds.

(*e*) Child protection centres: six with 114 beds.

GERIATRIC OR CHRONIC HOSPITALS

A number of hospitals or clinics have wards for chronic patients, while others have a proportion of chronic patients as well as ordinary cases. Finally, geriatric wards are annexed to homes for healthy aged people.

A number of hospitals for chronic or geriatric patients are in the course of construction.

At present there are 34 sections for chronic patients with 2,026 beds; five of these establishments accept only chronic patients.

The above figure is made up of 1,715 beds in public and 311 in private hospitals.

HOSPITALS FOR CONVALESCENCE AND RE-EDUCATION

Eight hospitals each have a convalescent section totalling 303 beds. Two of them specialize in convalescence and receive the patients of the general hospitals.

In addition, seven sections for re-education total 192 beds.

III. *1.* B. Each of the UNIVERSITY HOSPITALS has a statute of its own. There are six of these.

GAND

The University Hospital is owned by the Ministry of Works and is run by the State University on behalf of the Ministry

of Education on which it is administratively and financially dependent.

It comprises important polyclinics and has nearly 500 beds, 130 for paediatrics and 370 for other specialties.

Formerly, the University used a C.A.P. hospital as its teaching hospital. Now the situation has changed and the University runs its own hospital, the building of which is nearing completion. Operational deficits are covered by the Ministry of Education.

BRUSSELS

The Free University and the C.A.P. have an agreement which makes available to the Faculty of Medicine the two large St. Peter's and Brugmann's Hospitals, as well as the cancer centre of the Bordet Institute.

These establishments are run by the C.A.P. which meets the costs and the deficits. The University is in sole charge of the medical work. The overall problems of management are dealt with by a mixed committee of the C.A.P. and the University. The premises comprise approximately 1,300 beds.

LOUVAIN

The Catholic University has a similar contract to that of Brussels for the C.A.P.s St. Peter's Hospital. In addition, it owns the St. Raphael Clinics, which the University runs on its own account and whose financial soundness it ensures. St. Peter's Hospital at present has 400 beds and the University Hospital 749.

LIEGE

The State University has an agreement with the C.A.P. with regard to the Favière Hospital which has 721 beds. The management is in the hands of a mixed commission, but deficits are paid by the C.A.P.

Since 1951, a Royal Decree relating to the grant of subsidies to C.A.P.s (Public Assistance Commissions), which run university hospitals prescribes the formation in each case of a

management and consultative committee composed of representatives of both parties. The efficiency of these committees has varied in the individual case.

III. *1.* C. UTILIZATION OF HOSPITALS

The percentage of beds is 4·48% per 1,000 inhabitants for acute cases.

In 1959 there were 4,059,585 in-patient days at the public hospitals and 5,908,946 in the private hospitals, or a total of 10,004,531 days.

The *average hospitalization per patient* for the country amounts to 15 days in the public hospitals and to 12 days in the private hospitals, with an overall average of 13 days.

The *occupation of a bed* extends to 249 days in both public and private hospitals, representing an extent of occupation of 68% for all the establishments, with fluctuations per province between 53% and 72%.

Confinements take place in 80% of cases in maternity hospitals, this rate being exceeded in some provinces.

The situation as regards maternity beds is paradoxical, because considering that a woman's stay lasts an average of 10 days and that a maternity hospital bed provides from 25 to 30 confinements per annum, one would conclude that in Belgium the number of beds per 1,000 inhabitants ought to fluctuate around 0·6 if all confinements took place at maternity hospitals, which is not the case. Actually, some provinces whose birthrate is not definitely above the average have up to 0·82 bed per 1,000 and, on the regional level, 0·97 and even 1·02 beds.

III. *2.* A. INTERNAL ORGANIZATION OF HOSPITALS

There are hardly any laws governing the charters of hospitals and their administrative organization.

The public hospitals are in general run by the Public Assistance Commissions which include a number of members without previous qualification.

C.A.P. very often decides on its own initiative on all measures

to be taken, so that in fact the secretary of the Commission exercises executive rights.

However, in a number of hospitals—and this tendency is rapidly developing—one director, mostly an administrative one and very rarely a doctor, is charged with daily management. He is assisted by a variable number of executive officials.

The medical techniques are exclusively in the hands of the doctors, who jealously guard their prerogatives.

The nursing staff is in most cases subordinate to the director himself and sometimes to a head nurse (matron).

In the hospitals belonging to religious orders the leadership is often in the hands of the mother superior of the order.

The recruitment of staff is competitive, but the appointing C.A.P. has relatively wide powers within the staff cadre which it is able to determine for itself, subject to the approval of the appropriate provincial authorities and the Ministry of Health.

For some years past, the Universities of Brussels and Louvain have had special courses in hospital management and organization, with a view to training competent staff for the top-level direction of hospitals.

In the past, only a few schools of management have provided a basis—often inadequate—for these functions.

The qualifying conditions fixed by the Ministry of Health and Family provide that a doctor, preferably chosen by his peers, should be appointed to assist and advise the management, and should be responsible for the technical procedures, safety measures for staff and patients, the application of the rules of professional conduct and the legal and by-law provisions.

This provision also applies to private hospitals and clinics.

Further, the rules also provide that each specialty should be headed by a competent doctor, who should be responsible for the satisfactory conduct of his department.

Finally, as regards public hospitals, a Royal Decree dated 27th February 1961 relating to the organization of hospital accountancy, provides that hospitals belonging to public assistance boards are administered separately and have an

independent accountancy with permanent inventory. Responsibility of daily management is assumed by a special committee on behalf of the assistance board.

The special committee is chaired by the chairman of the board and is composed of 4, 6 or 8 members, together with the head doctor, the heads of the nurses, of the technical part and of the management.

This committee attends to daily management but its powers are limited, and all its decisions must be approved by the C.A.P.

III. 2. B. CATEGORIES OF STAFF

As regards staff, the situation in Belgian hospitals varies a great deal.

In general, the University Hospitals have an ample staff, both medical and paramedical. The other establishments, and particularly the private ones, barely manage to satisfy the qualifying norms, which provide that there must be in permanent employment at least one certificated nurse per 30 patients (one per 20 in maternity hospitals) and that she must be assisted by a sufficient number of auxiliary staff to ensure all necessary attention.

The greatest difficulty is experienced in recruiting nurses, though the schools were officially reorganized in 1957 and 1960.

At present the schools train a certain number of people. In 1959 the figures were: 1,011 nurses, 197 social medicine nurses, 41 nurses for mental patients, 83 midwives, 604 male nurses and 105 male nurses for mental patients.

III. 2. C. MEDICAL TRAINING

A medical degree is granted after seven years of University study (three as undergraduate, four for the doctorate, with obligatory hospital practice).

Specialist diplomas can be obtained, in accordance with certain criteria, by additional study or probation. At present the Universities train anaesthetists in two years and paediatrists

in two years. Specialization in other spheres requires more time: surgery five years of probation, gynaecology five years, etc.

The status of doctors at the hospitals is generally governed by internal regulations which in the case of public hospitals require the approval of the superior authority.

At present the private hospitals affiliated to Caritas Catholica make a contract with their doctors the standard of which has been uniformly fixed for all the institutions.

As a condition of accreditation by the Ministry of Health, each specialist department must be headed by a responsible medical specialist.

Though this provision is not yet entirely general, it is actively gaining ground.

Some private clinics and some small public hospitals are accessible to a large number of doctors. Though entry appears to be unrestricted, in all cases the doctors must be previously approved at least by the owner of the establishment or by the management.

The Public Assistance Law further provides that each C.A.P. must appoint in its hospital a certain number of doctors whose task is to treat indigent patients.

At present, this section of patients has become very small and the doctors mostly treat social insurance and paying patients.

III. *2.* D. The remuneration of hospital doctors is effected in very different ways.

Some hospitals—whose numbers are increasing—have full-time doctors. The doctors devote all their time to their hospital practice. They are either paid an annual salary, and the fees from the patients are collected by the hospital, or a smaller salary with a percentage of receipts, or, finally, by a system under which fees are collected by a medical secretariat and the doctor is paid a percentage of the fees or even a sort of lump sum hire.

However, it is the mixed system that is favoured at hospitals and doctors prefer the last method.

In these cases, the fractions given up by the doctor often amount to 10% in the case of an interne, 20% for the surgeon, from 50% to 60% for the laboratory or radiography. These last sometimes give up 75% of their fees, for of course the hospital has to invest capital in the equipment and pay the cost of operation.

There are no statistics to show how many doctors and specialists work at the hospitals and clinics. But it may be estimated that a fair proportion of the 3,082 specialists work there.

Each year approximately 500 new graduates leave the four universities. In 1960 the figure was 494.

Up to 1960, a number of these doctors went to the Congo. Since then, as a result of events, several hundreds of them have returned to Belgium.

There are only a very few foreign probationer doctors at the Belgian hospitals.

III. *2.* E. The Belgian hospitals, both public and private, admit the patients sent to them by the medical attendant.

Most of the hospital doctors communicate in writing with their general practitioner colleagues concerning the cases.

Some hospitals, notably the University hospitals, have created a home treatment service so that beds can be vacated more quickly, which is a valuable aid to the doctors.

These services provide after-care for many cases and have proved highly interesting financially.

III. *3.* COST OF FINANCING THE MEDICAL SERVICES

A. HOSPITAL EXPENDITURE

Since Social Security has introduced the system of contracts with hospitals and clinics, it has become possible to make certain comparisons and to consider the elements of the cost of a hospital day.

In general, the largest fraction concerns the cost of staff, which represents 50% or more of the cost of the day.

Next come:

Food
Overheads
Pharmaceutical costs
Administrative costs
Amortizations.

Some time hence, as a result of the application of the accounting plan for public hospitals provided in the Royal Decree dated 27th February 1961, it will further be possible to know exactly the constituent parts of the cost of maintenance at these establishments. However, it would be premature to enter into this now, and we must wait two years, that is, until 1964, before we can draw any valid conclusions.

At present, the prices paid by F.N.A.M.I. to the hospitals with which it has contracts vary according to the existing services, but are nevertheless fixed in lump sums between 145 and 190 frs. which represent the two extremes of cost, one for simple hospitalization and one for maternity cases. Surgery being computed at 175 frs. On the other hand, the daily cost fixed officially for indigent patients is considerably higher, amounting to 350 frs. and more in some hospitals.

It should be noted that this is an outright price, although the hospital can invoice to the F.N.A.M.I. in addition thereto for a number of medical and pharmaceutical services.

Many attempts have been made to control real hospital expenditure and stem the constant rise of costs.

While it is indisputable that the progress of medicine and nursing impose an increasing financial effort, it is nevertheless most important to ensure that no superfluous or avoidable expense has been incurred.

In this connection, the official accounting plan that has been introduced must necessarily be allied with an efficient auditing service with real powers of intervention. For in the past the accounting tests that have been made in Belgium have had a platonic character and have in fact constituted an additional expense without return.

As stated above, hospital resources are fed in various ways according to the patient's capacity, who may be:

Indigent and treated at the expense of the C.A.P.
He is admitted on a requisition from the C.A.P. which undertakes to pay.

Indigent, but with social insurance, and treated at the expense of the F.N.A.M.I. and the C.A.P. As regards the uncovered portion, admission is effected with the agreement of the friendly society and possibly the C.A.P.

A patient with social insurance, treated at the expense of the F.N.A.M.I.
If this patient is treated in a Mutual Aid hospital or in certain public hospitals, he will not have to pay any charges. On the other hand, if he is treated at some private clinics or at certain other public hospitals, an additional payment may be claimed from him which must be paid by himself. Admission is effected with the agreement of the social insurance societies.

A paying patient.
This category, which is becoming smaller, is composed of patients who have to pay personally. Admission, except in case of urgency, is accompanied by the deposit of a security covering a stay in hospital of from 15 days to one month.

Victims of an accident.
Victims of accidents at work enjoy the benefits of compulsory insurance paid by the employer, and all expenses are repaid in accordance with very wide rules.
On the other hand, the victims of road accidents are in general in the same position as paying patients, because responsibility has yet to be ascertained.

Many tourist organizations (touring club, automobile club, etc.) guarantee their members in relation to clinics where they have to be admitted. This enables these persons to avoid tiresome discussions or indeed difficulties concerning admission to hospital.

Moreover, the Law dated 8th April 1958 makes the C.A.P.

of the locality of the accident responsible financially for first aid and urgent hospitalization, as well as for ambulance transport. It is the responsibility of the C.A.P. to make contracts with the neighbouring hospitals to provide for such cases. Then it has to endeavour to recover the sums advanced by it in this manner either from the patient or from his guarantors.

The foregoing essentially concerns acute illnesses.

As regards mental patients, if they are committed, the expense is assumed by the Ministry of Health and Family in the majority of cases. This is covered by the Special Assistance Fund.

In the case of certain special diseases, such as poliomyelitis, there exist certain private bodies who are concerned, and certain forms of insurance.

All hospitals enjoy the benefits of civil personality and can therefore receive donations and legacies. However, patronage and generosity on the part of testators are becoming less and less frequent.

In summary, it can be said that the funds are provided either by the patient himself or by the C.A.P. or by the F.N.A.M.I. or by some other form of insurance, or yet by the Special Fund or, finally, by certain charitable institutions.

III. *3.* C. FINANCING OF MEDICAL RESEARCH

Until 1958, medical research was conducted almost exclusively at the Universities whose budget more or less covered requirements.

Many clinicians set apart from the resources of their service the sums required for research.

At the C.A.P's university hospitals the Commissions showed a certain benevolence as regards research and agreed to have the cost included in the hospital's charges.

Finally, some philanthropists have contributed, sometimes generously, to the development of this work.

The National Fund for Scientific Research, which has been in

existence since before 1930, contributed only to a modest extent, because it kept its means largely for fundamental research.

Since 1958 a Scientific Medical Research Fund has been created which has credits for promoting all forms of research and in particular clinical research. These credits might be larger, but they have incontestably given an impetus to research, which can now be conducted even outside the University centres.

FINANCING OF THE PUBLIC HOSPITALS

This financing is governed by a Royal Decree dated 2nd July 1949.

The C.A.P.s can receive 60% of their total expenditure and in some cases this rate may be increased (up to 90% or even 100%). At present this financing is effected by means of a loan, the redemption and interest on which are covered by the Ministry.

A complex and protracted approval procedure has to be followed and this is reflected in delays in the building of public hospitals.

FINANCING OF PRIVATE HOSPITALS

This is governed by the Royal Decree dated 25th July 1953.

The private body must be non-profit-making; they can obtain a 20% subsidy on the sums borrowed by them. These loans must not exceed 75% of the total expenditure. At best it is 15% of the total expenditure.

The procedure is fairly simple and payment is made in two portions: one after the completion of the main structure, and one after the conclusion of the work.

In both cases the plans must be submitted to the Medical Establishments Section of the Ministry of Health and Family for approval.

This examination is only superficial in the case of private establishments, the object being to ensure that the work and

plans conform with the approved standards and also with modern technical knowledge.

In the case of public hospitals the examination is more thorough and comprises the preparation of a draft plan, its approval by the Minister, then the preparation of final plans with details of the proposed means, of the sectional plans, and of the materials to be used.

III. *4.* PLANNING AND CONSTRUCTION OF NEW BUILDINGS

This refers to hospitals and clinics for acute and chronic complaints.

Construction of anti-tuberculosis establishments has been stopped and only modernization is proposed. The building of psychiatric hospitals is under consideration but the problem has not been resolved.

(*a*) The responsibility for hospital building is essentially in the hands of the local authorities, the C.A.P.s and the private institutions. The provinces can do this, but so far they have done so in only three cases (Provincial maternity hospitals).

The State (Ministry of Health and Family), has the role of giving encouragement, but ought to have the responsibility of even distribution, which it could have steered by granting or refusing subsidies. But it has to be stated that this has not been the case. So far, there is no co-ordination and cases of overlapping are numerous. (Examples of simultaneous building of a public hospital and private hospitals in the same locality, while large regions of the country are under-equipped. Also examples of a multiplicity of maternity clinics in certain regions.)

(*b*) The public or private authorities who take the initiative in building a hospital have to collect the necessary funds and prove their capacity to finance their share when they apply for subsidies.

The C.A.P.s may contract loans or use their own assets, which are generally derived from donations or legacies.

Private establishments may borrow money, but may also

collect it in various forms. They must possess at least 25% of the expenditure in order to obtain the subsidies. These are granted by the Ministry of Health which enters them in its supplementary budget (investments).

Finally, public tenders are compulsory for public hospitals, and the credits are granted when the Ministry has approved the documents of the tender.

The execution of the work is supervised by the engineers attached to the Ministry of Health and Family (Building Section). The Ministry demands of the contractors a planned building programme which it is unfortunately often difficult to observe.

In either case (public or private) the intervention of the departments of the Ministry of Health and Family constitutes a highly centralized technical intervention whose consultative character is in general highly appreciated because the competence of the officials has considerably developed through the vast experience acquired by them. (During the past 15 years more than 150 public and private hospitals have been built or modernized.)

(*c*) In general, the building of private hospitals is less expensive than that of public hospitals. This is due, in particular, to the flexibility and ease of transacting business in the private sector by contrast with the rigid and cumbersome procedure in the case of public hospitals. Further, the public hospitals often tend to equip themselves better and to use more expensive apparatus or material.

The cost per bed in private hospitals varies from 300,000 to 500,000 frs. A traumatological centre with re-education has cost 900,000 frs. per bed.

The price per bed in public hospitals varies between 400,000 and 900,000 frs. and in some large hospitals now in course of construction the price will exceed 1,000,000 per bed. There is a tendency on the part of the Ministry of Health and Family to fix a ceiling price which must not be exceeded. This is already in existence for private hospitals which can receive no subsidy if the price per bed exceeds 450,000 frs.

(*d*) Hitherto hospitals have been built on the basis of modern conceptions of the functional unit. That is why all the hospitals comprise blocks of wards on several floors. Each floor represents one or more units of from 22 to 30 beds. The technical departments, consulting rooms, radiology and operating theatres are in another part of the building.

The standards of approval lay down the need for rooms with one bed, two beds, four beds and six beds, with larger numbers only in exceptional cases.

The hospital units comprise a variable number of technical premises for the staff and for the patient's comfort. There is a definite tendency to build units with several dressing rooms and, in particular, single bedrooms each with an adjoining dressing room.

Experience confirms that 30 beds per unit should not be exceeded and that the optimal size of a hospital is between 150 and 450 beds.

Similarly, experience shows that it is desirable to create units with 8 to 16 beds for the active treatment of very acute cases (accident, surgical, etc.) requiring intensive care. All hospital units are served by intercom. systems. The lighting and heating of the rooms has been very thoroughly studied, as well as the problems of acoustics and the utilization of materials.

Great efforts have been made in the realization of technical installations, operating theatres, radio-diagnostic services, and various therapeutic services.

Cuisine and laundry have been inquired into with attempts at standardization.

Similarly, research and experiments are in progress with a view to building hospitals with an unencumbered area or surface so that the rooms can be easily reorganized.

Extremely flexible hospitals have been erected at Renaix, Verviers and Antwerp with special materials and unusual, original apparatus for the many drainage systems required in a hospital.

(*e*) One of the greatest difficulties of the Ministry of Health

and Family in the performance of its mission is due to the absence of information concerning actual morbidity rates and population developments.

Hitherto, planning has been based on the objective of 4·5 beds per 1,000 inhabitants. This aim has now been exceeded in many localities.

For this reason, a private study group in social medicine has been instructed by the Ministry of Health and Family to carry out an extensive inquiry with a view to arriving at a basis of rational planning of current and future needs; this research includes an inquiry into the normal morbidity rate of the population and the demographic and economic development of the country.

It is not yet possible to supply information on these points.

IV. General Conclusions

It can be asserted that the Belgian population currently enjoys medical services of good quality, but it has to be stated that the doctors are generally overworked and lack the time effectively to keep abreast of medical progress.

The hospitals are generally able to receive the patients who are sent to them, and in Belgium the kind of waiting lists that exist in other countries are unknown. It is in fact probable that some regions are over-supplied, with the result that the patients' stay in hospital is prolonged.

Social Security has greatly favoured reliance on the medical services and has entailed considerable additional expense in the sphere of health care.

The spheres where there is a need for progress are those relating to chronic disease, geriatrics and paediatrics.

The last named branch of medicine has undergone considerable development in the last 10 years (hospital admissions have doubled) but the number of paediatrists has not followed the same rhythm and it is highly desirable that this specialty should develop. It is further desirable that the number of doctors should increase, so that the individual doctors should have the time to improve their knowledge.

At present negotiations are proceeding between the medical corps and Social Security with a view to better collaboration. The current problems include:

1. Adaptation to other uses of the anti-tuberculosis provisions.
2. Development of new conceptions in psychiatric therapies.
3. Creation of a structure for the rational treatment of chronic patients and for geriatrics.
4. Medical research in spheres where specialization is still only empirical.
5. Better knowledge of morbidity conditions in the population, so as to be able to make better provision for the future.
6. Improvement of knowledge concerning the financial, administrative and medical management of hospitals, so as to avoid an adverse reaction on the part of the quarters responsible for financing *vis-à-vis* the rapid and continuous increase of costs.
7. Co-ordination of the various private and public initiatives to avoid the overlapping which exists at present and might multiply in the future.

BELGIUM

by

PROFESSOR G. VAN DER SCHUEREN,
Director of the University Clinics, Catholic University of Louvain

The Belgian hospitals are, according to their administration, either public or private. They were spread over the country up to now without real planning. They all complain of being in financial troubles. Their administration is entrusted to self-trained men or women but recently real efforts have been made to prepare hospital administrators at different levels. The nursing staff is devoted and on the average of high quality but often below the needed number. Individual medicine in the hospitals is of good quality but in some of them there is a lack of real team work.

THE HOSPITAL SERVICE: ITS ORGANIZATION AND SCOPE

The acute public hospitals are organized by the local communities, only one is owned by the government. By law they are intended to be the hospitals of the poor, but they get round this law, as a horse of Troy, to become hospitals for everybody with gradual increasing social standards, though they are still called 'hospital' which unfortunately sounds a little pejorative in the ears of the Belgian public.

The acute private hospitals have a few more than 24,000 beds against 16,600 for the public sector. The overall number of approximately 41,000 beds gives 4·38 beds for 1,000 inhabitants. A majority of the private beds belong to the catholic religious orders. A smaller number is dependent on social insurance organizations and another small group belongs to several other societies. They are called 'clinics', which suggests more privacy for the patient, which is not always true. These private hospitals are of the 'open' type allowing every doctor to treat his patients, or of the 'closed' type with an appointed staff. There is also a third, 'mixed' type where the appointed staff is supplemented by free doctors. In the open type there may be a definite lack of team work. The nucleus of these private clinics lies often in buildings at first intended for other

purposes. Reconstruction and adding new wings might be badly affected because of the original design. Since World War II however a fair number of private clinics have been built in accordance with modern standards.

Private clinics suffer often from lack of capacity and were at first rather oriented towards a branch of specialized medicine: surgery, obstetrics, paediatrics. There has been a change in this orientation for the last years and many of these smaller hospitals have increased their accommodation making the activity possible of a diverse team of specialists.

The patient is free in the choice of his institution but usually follows the suggestions of his private physician in the matter. The poor patient, who relies on welfare aid, is definitely guided to the public hospital in his locality. Some social insurance organizations may also limit the choice of institution for their members.

Location of the public and private hospitals over the country is the result rather of chance. Every community usually has its public hospital and one or more private institutions. There is no real rivalry between public and private hospitals but sometimes it exists between private hospitals themselves. Anyway there is a lack of collaboration, although it is felt that some sort of hierarchy in equipment and specialization should be accepted.

One can only encourage the existing goodwill of some promoters of the public and private hospitals to set up, in common understanding, a general planning of hospital beds for the future. A planning-bureau has also been decided on by representatives of both parties, '*CEDERSAN*'.

Financial difficulties exist both in the public and in the private sector though of a different kind. Nearly 75% of the Belgian population is compulsorily insured. The day-cost however for hospitalization, fixed by the Ministry of Social Welfare, remained on the same too low level for years. The supplement which can be charged to the patient by the hospital administration is limited by the Ministry of Public Health. No co-ordination exists between this overall day-cost and the

accreditation standards, which results in a regular increase in daily expenditure on personnel, buildings and equipment.

The public hospitals directed by the local committee of Public Welfare—called Commission of Public Assistance—turn for their deficit towards the budget of the town or city hall. The town administration, in case of the bigger communities, pass a greater part of this deficit to the Ministry of Interior Affairs. These steps loosen the ties of local financial responsibility.

The private hospitals partly make up their shortage by a higher charge for single bedrooms, which are usually in a smaller proportion, by investing all the salaries of their religious nurses and sometimes by arrangements about doctors' fees.

Notwithstanding this financial stress the public seems to be convinced that a hospital remains a profit-making concern. An appeal to the public by a private hospital either to aid the annual budget or for a new building, as is commonly done in the U.S.A., would have neither welcome nor response. The fault lies with the administration of both the public and private hospitals who do not make any effort to stimulate the community's interest or pride in their achievements.

ADMINISTRATIVE STAFFING

The administration of the public hospitals depends on the Board of Public Assistance Commission whose members are recruited on a political basis and may change after every election. These changes may influence fundamental decisions. The meetings of this Board are held usually outside the hospital while the local representative administrator is not allowed to take real decisions. The decisions of the Board are very slow and impaired by control on different higher levels: city, province and government. So the university hospital of the Louvain University, decided to be rebuilt by the local board in 1946, is only finished for one-third of its capacity in 1962. A new law passed in 1960 was a first effort to bring an improvement in the situation.

In the religious private hospitals, administration is concentrated in a single person who is appointed rather for her

general capabilities which do not necessarily coincide with a serious training in hospital management. As a representative of the owner she appoints the medical staff, which in itself may constitute a difficulty. Suggestions have been made that religious congregations should limit their activity to nursing and pass their rights as owners, or at least for the daily management, to a committee of lay-men.

Among the hospital administrators of both public and private hospitals, practically none is up to present university graduate standard and practically no medical doctors interest themselves in the field on a scientific basis but exert the influence which they get through their professional accomplishments.

TRAINING OF HOSPITAL ADMINISTRATORS

The appointment of the administrators, as it has been pointed out, cannot really be called an example. A first effort was started with a post-graduate school for trained nurses in 1939 in connection with the University of Louvain and in 1946 with the University of Brussels. They turned out respectively 275 and 173 graduates.

Another initiative was the in-service post-graduate training for head nurses (graduates) and last the regular cycles of in-service training for hospital matrons assumed by the Catholic Hospital Federation.

At university level a section for hospital administration was started in the University of Louvain in 1961 and in the University of Brussels in 1962. In Louvain this section is open to University graduates and provides a cycle of two years' teaching, leading to a master's degree in hospital sciences on a post-graduate level.

DENMARK

by

DR. CHRISTIAN TOFTEMARK

Deputy Director General, National Health Service of Denmark

I. The Hospital Service, its Organization and Scope

A Royal Decree of 1806 imposed upon the counties the duty of establishing the necessary number of hospitals, which were to serve both rural areas and towns. The hospitals were intended for such patients as could not be given the necessary nursing in their homes. They had to pay for the treatment if they were able to, otherwise the cost was defrayed by the poor relief fund and by the county. The cost of building and running the hospitals was in all other respects to be shared equally by counties and towns.

Prior to this there had, of course, existed some small and scattered institutions—mostly on a charity basis.

In 1740 the King had founded a teaching hospital in connection with the Copenhagen university.

The Hospital Act of 1806 forms the basis of the development and position of our present-day hospital system. The Danish hospital system is still as it was when it was founded, i.e., public and mainly municipal, so that the local authorities own and manage practically all medical-surgical hospitals.

Up to the beginning of this century, the development of the hospitals could be handled by the local authorities with the aid of local medical officers because the problems, apart from that of limiting the spread of infectious diseases, consisted mainly in meeting the requirements of surgery. There was one exception to this: the Copenhagen hospitals were early in opening specialty departments, including the Copenhagen university hospital.

Around 1925 the number of hospital beds had been increased to 3·4 per 1,000 inhabitants, exclusive of beds for epidemic, insane, and tuberculosis patients.

With one exception (Copenhagen), mental hospitals have for many years been run by the State and directed by the central administration. Recent years have seen a trend to establish a closer collaboration between the general and mental hospital systems.

Around 1930 our hospital system was ripe for reorganization and expansion, not in order to increase the number of hospitals but to extend some of those already existing with a view to providing space for specialty departments. It was suggested that each of our 23 counties (populations between 100,000 and 150,000) should develop an existing hospital into a central hospital, which would start with at least three departments—surgical, medical, and radiological—which subsequently would be supplemented by specialty departments to such extent as would be found desirable and financially warrantable.

This programme had been practically accomplished before 1950, having been somewhat delayed by the war.

In 1946 a Hospital Act, which is still in force, was passed. Section 1 of this Act lays down the old rule that it is a duty of the counties and the towns (where convenient, in collaboration) to build and run hospitals according to needs.

All plans for new hospitals, expansions as well as discontinuation of departments, have to be approved by the Ministry of the Interior, which is advised by the National Health Service.

The Act holds out the possibility that certain highly specialized departments that do not fit in with a restricted local administration may be built and run by the State.

The Act, moreover, provides for such State subsidies as are to be paid to the local authorities.

Finally, the Act lays down rules for the establishment of a Supreme Hospital Board made up of political and administrative representatives of central and local authorities. It is the duty of the Board to assist the National Health Service in obtaining a smoothly running, effective and economic hospital service, especially concerning co-ordination and collaboration between hospitals, regardless of ownership and geographical location.

It may be appropriate to mention that the special Danish institution, the National Health Service, which only to a certain extent functions as a ministry or department of health, was founded in an Act of 1932, from which we quote:

'1. The central administration of the country's public health system shall be called The National Health Service.

2. (1) The National Health Service shall be the chief superviser of public health and nursing, including dental surgery, midwifery and pharmacies, and chief adviser to the public in all matters requiring a knowledge of medicine or drugs. In this capacity the National Health Service shall be consulted by the various departments of the central administration on all matters whose decision is considered by the ministry concerned to require such knowledge—including budgetary questions of this kind. The National Health Service shall likewise on request by the said authorities give opinions on matters of such nature.

(2) The National Health Service shall have . . . overall supervision of all public curative institutions and nursing institutions. The opinion of the National Health Service shall be required as to plans for the building or for extensive alterations to the said institutions.

The National Health Service must be consulted as to qualifications before any appointments are made to posts as physicians at hospitals and elsewhere.

The head of the National Health Service, the Director General, must be a physician, but must not have a professional practice.'

During the last decade many of the existing hospitals have been modernized and expanded, especially with new treatment facilities, such as operating theatres, X-ray departments, laboratories, etc.

Five complete major new hospitals have been built.

The present position may be seen in the map (page 115).

The official statistics for 1959 show that in 144 hospitals with

25,649 beds 539,471 patients were treated by 2,283 doctors with the aid of 9,026 nurses and at a cost of approx. 480 million Danish kroner (£25m.).

Today the National Health Service is working on the outlining of a general plan aiming at ensuring that the future hospital building and development programme as a whole will proceed in accordance with well considered and consistent principles, so that it will be possible to establish priorities and ensure that each separate development is undertaken in the light of the overall pattern to be produced. Improvements in the hospital service have already done a great deal to enable more patients to be treated in a given number of beds. With the acceleration of physical improvements, greater concentration of treatment in district general hospitals, and greater efficiency generally, the average number of patients treated per bed may be expected to increase still further.

The intention is to achieve an even distribution of effective hospital beds throughout the country at a rate of five per 1,000 inhabitants—approximately 25% of these beds in specialized departments—including the teaching hospitals.

Most hospital beds will in future, we hope, be concentrated in hospitals of about 400 beds, though naturally some of the regional hospitals, where more specialties are provided, will be larger, while some of the existing smaller ones will prove adequate within the general system for many years to come.

It must be remembered that the hospital system is very old, is locally owned and run and, therefore, not very susceptible to major alterations—which can only be achieved by very intensive propaganda on the part of the National Health Service.

II. Administrative Staffing Structure in the Hospital Service

Modern legislation on the hospital service in Denmark makes it the responsibility of the local authorities to establish and run a requisite number of hospitals in places where the State has not provided the necessary facilities. Apart from mental hospitals, the State runs hospitals to only a very limited extent,

and the hospital service in Denmark, therefore, rests mainly on the local authorities.

Such local authorities as own hospitals will generally appoint a hospital board, which will be responsible to the local council for the management of the hospital. For this purpose the board will be assisted by an administrator (inspector, director, or executive), who will be responsible for the day-to-day administrative leadership.

The administrator looks after the hospital's economic and central administration. He is in charge of the finance department, maintenance of buildings, furniture and equipment, purchasing, personnel administration, and so on. Some of these matters are submitted to the board for its decision, through the administrator, who as a rule acts also as secretary to the hospital board. The records of the admission and discharge of patients as well as all accounts relating to their period of hospitalization are handled by the administrator.

In addition to the above-mentioned duties, the administrator supervises the technical departments: the kitchen, the day-to-day management of which is in charge of a kitchen matron; the laundry, the head of which is a laundry matron or laundry manager; and the boiler and machine department under the management of a chief engineer, who is responsible for the supply of heat and steam to the hospital, and also, in collaboration with various mechanics and artisans, for the inspection and upkeep of the technical installations.

The established rule nowadays is for the administrator to be a non-medical man. The medical chiefs are co-ordinate, each one deciding on all questions concerning the treatment and nursing of patients within his own department. At the larger hospitals the medical chiefs generally constitute a medical committee. On medical matters of major importance the hospital board or the administrator, as the case may be, obtains a statement from the medical committee, and on less important matters a statement from the medical chief concerned.

The administration and supervision of the nursing staff is carried out by a principal (matron) in close collaboration with the administrator and the medical chiefs.

ADMINISTRATIVE SET-UP OF THE NURSING SERVICE

Grades: Matron
Assistant Matron
Departmental Sisters (large hospitals only)
Ward Sisters
Staff Nurses
Student Nurses
Assistant Nurses

RESPONSIBILITY OF THE MATRON

The administration and supervision of the nursing care and the nursing personnel, including assistant nurses and student nurses, are the responsibility of a matron in close collaboration with the hospital administrator and the medical chiefs. In most hospitals she will be assisted by an assistant matron. In addition she is in charge of the training of the staff, and will organize the practical work of the student nurses if the hospital is co-ordinated with a nursing school.

RESPONSIBILITY OF DEPARTMENTAL SISTERS AND WARD SISTERS

Departmental and ward management, planning and supervision of the work of the nursing personnel. They are responsible for the care of the patients and for carrying out the prescribed treatment.

Training of student nurses.

III. Appointment and Training of Hospital Administrators

A. APPOINTMENT

The above-mentioned Hospital Act provides that schemes for the erection, extension, major rebuilding and major repairs, as well as the closing of municipal or county hospitals, shall be approved by the Minister of the Interior. The Medical Officers and Practitioners Act provides that no post as medical chief at a municipal hospital can be filled until a statement has been obtained from the National Health Service regarding the qualifications of the candidates for the post in question.

On the other hand, local authorities are free to appoint any hospital administrator they may choose, for their hospitals, provided however that the salary of the post is approved by the Minister of the Interior—a condition applying to all comparable official posts.

In former times the post of responsible administrator was held by a senior medical chief in addition to his medical duties. However, since the position as senior medical chief is nowadays a whole-time job, and since the administrative duties in consequence of the increasingly intensive operation of the hospitals demand insight in a wide-ranging field of knowledge, the management has by virtue of the evolution been transferred to an independent administrative leadership co-ordinate with the medical leadership. It should be said that this development has taken place by agreement with the senior medical chiefs who, thanks to this relief, can devote their efforts entirely to their specialties.

An advertised vacant post of administrator at a major hospital will as a rule be applied for both by university graduates and laymen. The university graduate, however, is unlikely to be preferred unless his graduation as Bachelor of Laws, M.A. (econ.), M.Sc.(econ.), or the like is supplemented by a thorough, practical hospital training. The successful candidate will in most cases be a man who after a commercial training and a subordinate administrative position in a hospital has held a post as deputy chief. In doing so he will have acquired a many-sided training in the different branches of the administration and will have the requisite fund of theoretical knowledge by participation in various courses, studies at a commercial high school or possibly at a university.

A growing number of hospital administrators are graduates of universities or schools of commercial science, but as mentioned before, they are typical in that they have practical training in hospital management, often acquired concurrently with their studies.

That so much importance is attached to practical training when hospital administrators are appointed is due to the fact that a hospital is an institution with many different and special

functions, with departments whose fields of work are overlapping or touching each other, and with highly differentiated groups of staff, each with its special characteristics. Consequently, the co-ordinating tasks, for instance, to be carried out by an administrator will be so much easier for him if he has grown up in the atmosphere typical of hospitals. Finally, the administrator is required to possess such a comprehensive technical know-how that it will hardly be possible for him to acquire the necessary knowledge at any other place but within a hospital.

B. TRAINING

The Danish hospital administrators, who have formed a professional organization, realized at an early stage that in addition to an all-round, practical training, a comprehensive, theoretical knowledge is required.

As early as 1925 a special theoretical training was suggested, but as it was and still is beyond the possibility of the hospital administrators' association to establish such training by its own means, the association has now and again tried to make the financial authorities and the Copenhagen School of Commercial Science interested in its plans, though no implementation of the latter has been achieved so far.

Consequently, since 1934 the association has organized a series of courses. These courses have been called *advanced-training courses* and *continuation courses*, respectively, and have been arranged in the form of lectures and visits to institutions.

Up to two *advanced-training courses* have been held a year, and a committee set up by the association of hospital governors (the hospital administrators' association) is at present trying to intensify this education, which is designed for officers having the status of managing clerk or some higher rating. In future this education will be given mainly in the form of group work, and the aim is to arrange special courses dealing with subjects pertaining to the management of institutions. Such subjects will comprise: organization, rationalization, automation of office work, conduct of meetings, staff policy, agreement conditions, budgets, accounts, statistics, building activities, purchasing, etc.

The *continuation courses* have been held in the form of lectures, and, in contradistinction to the advanced-training courses, are also intended to be continued in this manner. Whilst the object of the advanced-training courses has been to impart to the participants an all-round knowledge of the different branches of hospital administration, the principal aim of the continuation courses has been to keep already functioning hospital administrators posted on developments in general.

Among subjects taken up for study during recent years may be mentioned:

1. Principles relating to present-day hospital building.
2. Computation of fees for hospital architects and engineers.
3. Hospital-technical installations.
4. Instruments and apparatus.
5. Arrangement of anaesthetic and recovery departments.
6. Psychiatric departments in county hospitals.
7. Hospital hygiene.
8. Odontological services in our hospitals.
9. Labour-saving experience gained at U.S. hospitals.
10. Future care of the mentally deficient.
11. The Rehabilitation Act.
12. The Ombudsman (the Comptroller of Public Affairs appointed by the Folketing) and the municipal administration.
13. Emergency measures and civil defence duties encumbent upon hospitals in peacetime.
14. Automation of the administration and electronic calculating machines.
15. Safety measures in connection with the use of inflammable and explosive organic solutions in hospitals.

In addition, frequent visits to institutions.

The committee on courses set up by the association of hospital governors fully realize that the best arrangement would be if, in addition to a practical training, prospective hospital administrators could be given a specialized hospital training at an institute of higher education, but it will probably be necessary to face the fact that this solution is impracticable, since in Denmark five to seven candidates only will be needed per year.

However, a hospital will have every reason to be satisfied with an administrator who, concurrently with his practical training, has been energetic enough to attend the courses arranged by the association of hospital governors and, in addition to this, to graduate as an M.Sc. (econ.). Such a person will possess a detailed knowledge of hospital administration and also the all-round knowledge of the general principles of administration provided by the specialist study. If at the same time he possesses the proper human qualities, he will have extremely good prospects of becoming an efficient hospital administrator.

C. TRAINING OF OTHER GROUPS OF STAFF CONCERNED WITH HOSPITAL ADMINISTRATION

Appointment and training of administrative nursing personnel. All hospital nurses are invariably state-authorized nurses.

The matron is chosen from the group of experienced nurses with a post-graduate training from the Nursing Institute at the University of Aarhus. The training, which extends over one academic year, takes the form of lectures, seminars, etc.

The curriculum comprises: Nursing subjects, social sciences, psychology, ward management, administration of nursing service and nursing education, teaching methods, etc.

This course is also attended by an increasing number of ward sisters and departmental sisters.

A one-month refresher course has been introduced for senior matrons, comprising subjects such as: special administrative problems, personnel management, etc.

Kitchen Matrons. As previously mentioned, a kitchen matron is in charge of the day-to-day management of a hospital kitchen. The kitchen matron receives a special hospital training, partly practical, partly theoretical. The practical training, which takes place in the various sections of the kitchen, at present lasts for a term of three years, to which is added a six-month stay at a matron school, common for the whole country, at which the theoretical lessons in dietetics, etc., take place. On completion of her practical and theoretical training, the student will be appointed assistant kitchen matron, and may later apply for a

position as kitchen matron. It should be mentioned that education for kitchen management is in the mould at the moment, and there is every indication that the education of students will in future comprise:

(1) a five-month stay at a preparatory school (domestic science school);

(2) a two-year practical training in a hospital kitchen; and

(3) a six-month stay at the matron school.

Laundry Matrons or Laundry Managers. As previously mentioned, a laundry matron or laundry manager is in charge of the day-to-day management of a hospital laundry. This person will also see to it that the linen is mended and kept in good repair. The laundry matron (the laundry manager) has generally received a special hospital training. This training lasts for a term of three years, and consists partly of a practical training given in a laundry, a linen depot, and a dressmaker's workroom, partly of a theoretical training, comprising, among other things, commodity study and laundry knowledge. The theoretical training takes place at a day-school, common for the whole country, and lasts for one month. On completion of this training, the student may apply for appointment as an assistant laundry matron and subsequently for appointment as a laundry matron.

Formerly laundry matrons used to be responsible also for the cleaning of the hospital, but this task has gradually been undertaken by a special supervisor in charge of the cleaning staff.

For the *supervisors in charge of cleaning*, who at first were chosen mainly from among interested assistant laundry matrons, a special theoretical course has now been introduced at the College of Technology.

It generally applies to all the groups mentioned above that their professional organizations will regularly arrange advanced-training courses for their members.

MEDICO-SURGICAL HOSPITALS OUTSIDE COPENHAGEN, 1961

- Central hospitals comprising several departments.
- Other major hospitals.
- Minor hospitals comprising at least two specialities.
- Minor hospitals comprising a mixed surgical-medical department.
- Private hospitals, mainly minor specialities.

EIRE

by

COLM Ó. NUALLÁIN

Training Officer, Institute of Public Administration

I. Introduction

1. Ireland is a small country with a very small population. The total area within the part of the island administered by the Government of Eire is 27,136 square miles. The population at 9th April 1961 was 2,814,703 showing a decrease of 2·9% from 1956.

2. Net emigration over the period 1956–61 was 15·1 per 1,000 while, during the same period, the natural increase in population was 9·2 per 1,000. Almost two-thirds of those emigrating were under 30 years of age. This has inevitably affected the age-structure of the remaining population. There is, in fact, a noticeable inbalance in the distribution of people by age. The proportion in the younger active age-group is low, while there is a relatively heavy concentration of those over 45 years of age.

3. This population pattern has, in turn, had an effect on the incidence and extent of hospitalization, and bed accommodation and occupancy. The effect is, perhaps, most marked in the field of mental health.

4. Because of these results of emigration it has been suggested by some people that, for external comparisons, calculations of bed accommodation and occupancy and patient population should not be based in our case on the existing population, but rather on this figure plus some proportion of those who have emigrated in recent years.

II. Organization and Scope of the Hospital Service

NUMBER AND TYPES OF HOSPITAL

5. Ireland has a total of 426 hospitals and health institutions providing care and treatment which vary widely in both type

and degree. These institutions include general medical and surgical, maternity and mental hospitals, hospitals for infectious diseases, including tuberculosis, orthopaedic and other specialized hospitals, institutions for mentally handicapped, homes for old people, maternity, nursing and convalescent homes and homes for mothers and children.

6. There is accommodation in these institutions for over 60,000 in-patients. For acute treatment (i.e., medical and surgical, infectious diseases, orthopaedic and other specialized treatment) there are over 19,000 beds or 6·86 beds per 1,000 population. There are over 2,700 beds for maternity patients in hospitals and homes and these represent 0·97 beds per 1,000 population. Mental hospitals contain over 20,500 patients on average representing 7·29 per 1,000 population. County homes and other homes for the care and treatment of the aged and chronic sick have a total of 12,400 beds or 4·41 beds per 1,000 population.

7. The great majority of hospitals are controlled and administered by local authorities, and these dispose of almost 42,000 beds. The remaining 18,000 beds are in voluntary institutions. With two exceptions, all types of hospital accommodation and treatment are provided both in local authority and voluntary institutions. The exceptions are:

(*a*) infectious diseases hospitals (other than tuberculosis), which are entirely under local authority control, and

(*b*) homes for mentally handicapped people, which are entirely voluntary.

8. The local authority institutions include many general hospitals which provide a high standard of care for medical, surgical and maternity patients. These hospitals cater for individual counties, which comprise 27 administrative units, or for some specialized forms of treatment for groups of counties. There are also hospitals which specialize in such fields as tuberculosis, other infectious diseases, orthopaedic treatment and maternity. These specialized hospitals cater mainly for regions comprising a number of counties. There is, in addition, a large number of smaller district hospitals which provide, at general practitioner level, general medical, and a limited

amount of surgical treatment. Most of the mental hospital beds are in institutions of local authorities, which also control the county homes where the majority of beds for the care and treatment of the aged and chronic sick are located.

9. The public voluntary hospitals, of which there are over 50 in the country as a whole, include a large proportion of teaching hospitals and of hospitals which specialize in dealing with children, maternity, orthopaedic, tuberculosis and cancer patients and in the treatment of diseases of the eye and ear.

10. The public hospitals, both local authority and voluntary, have semi-private and private accommodation which is small in relation to total numbers of beds. There is also a number of private hospitals and nursing homes with an aggregate of about 2,000 beds, while convalescent homes and maternity homes provide a further 700 beds.

ADMINISTRATIVE ORGANIZATION

11. The administrative authorities are:

(*a*) The Minister for Health and his Department whose functions in relation to local authority hospitals include supervision of the development of hospital service; the control of expenditure and staffing; and the fixing of rates (or limits to rates) of charge for services. In relation to voluntary hospitals the functions comprise the allocation of grants towards revenue deficits and for capital purposes, and regulation of the financial arrangements under which voluntary hospitals provide services on behalf of health authorities.

(*b*) Health Authorities. These are the county councils, except in areas of the four principal cities—Dublin, Cork, Limerick and Waterford—for each of which there is a unified health authority administering services for the joint areas of the city and county in each case. In some cases joint boards have been established, e.g., to operate mental hospitals for two or more counties. Each health authority is responsible for the provision of health services relating to both physical and mental health. Hospital services are provided in institutions administered by the health authorities, and also in voluntary institutions, on a basis of payment by the health authorities to the latter for services rendered.

(*c*) Voluntary hospital authorities. These vary considerably in their constitution. Many authorities are religious communities while others are corporate bodies. The latter are in some cases fully autonomous, while in others their boards are appointed by the Minister. Seven of the voluntary hospitals in Dublin have recently federated in order to optimize the resources and facilities for specialization, and to realize the greater financial and administrative advantages to be derived from unification.

(*d*) The Hospitals Commission, which was established under the Public Hospitals Act, 1933, and ordinarily consists of a chairman and six other members appointed by the Minister.

The circumstances leading to the setting up of the Commission were these:

In Dublin during the decade 1920–30 some of the larger voluntary hospitals were unable to clear their bank overdrafts. In 1930 six of the Dublin voluntary hospitals were empowered by a special Act to organize a sweepstake. A committee was formed which entered into an agreement with Hospitals Trust Ltd. to promote and organize the first sweepstake which was run on the Manchester November Handicap. As a result of this sweepstake £131,797 was distributed to the six hospitals.

Twenty-three hospitals participated on the proceeds of the second sweepstake and thirty-four hospitals in the third. In all, over £1¼ million were distributed to voluntary hospitals within a year.

The Commission which was then set up under the Act of 1933 has the function of advising the Minister on matters relating to hospital facilities, and on the administration of the Hospitals Trust Fund, which was established by the same Act. The Commission collects from the voluntary hospitals estimates and accounts of income and expenditure by reference to which grants from the Hospitals Trust Fund towards revenue deficits are made on the direction of the Minister.

The income of the Hospitals Trust Fund comes also from sweepstakes on horse-racing, and is used both to provide grants to meet capital expenditure and to pay deficits on the running expenses of voluntary hospitals. The administration of the

fund is entrusted to the Hospitals Trust Board, a statutory body appointed by the Minister.

The Hospitals Commission also provides a special service in Dublin in the form of a hospital bed bureau. This bureau, which is staffed on a twenty-four hour basis provides an information service on bed vacancies facilitating the admission of patients to hospital.

FINANCE

12. The percentage of the gross national product spent from taxation, both central and local, on health services amounts to almost 3%. This excludes private expenditure such as private payment for general practitioner, specialist and hospital services, and the purchase of drugs. The total revenue cost of the hospital services to public funds currently amounts to almost £16¼ million a year.

13. One-half of the total net current expenditure of the health authorities on health services—including institutional services—is paid for from the local rates levied by local authorities, and one-half is met from national taxation and is paid by the State to health authorities. Expenditure on capital works is usually met by way of a grant from the Hospitals Trust Fund and/or loans raised by the promoters. Of the total of £16¼ million expenditure from public funds on hospital services, the State and health authorities share equally an expenditure of about £14½ million while the deficits of voluntary hospitals to be covered by grants from the Hospitals Trust Fund are estimated at £1·8 to £2 million per annum.

14. The sum of £14½ million includes the net cost of running local authority hospitals of all types, estimated at just over £11 million, together with the amount payable to voluntary institutions for the maintenance and treatment of patients receiving services under the Health Act, which is estimated at almost £3½ million. This latter sum comprises daily or weekly capitation payments for patients chargeable to the health authorities.

15. The Hospitals Trust Fund has been an important source of revenue for the hospital services. Up to 31st March 1962, the

total receipts into the Fund, mainly from sweepstakes, was about £50·6 million. Grants from the Fund to meet deficits in the running costs of voluntary hospitals amounted, over the same period, to £15 million.

16. After the last war a programme of hospital construction was carried out, involving heavy capital expenditure. In the period from 1st April 1948 to 31st March 1962 capital grants amounting to £26·3 million were provided from the Hospitals Trust Fund, which during this period was assisted by a subvention from the Exchequer to the extent of £6·8 million. The capital expenditure from local authority funds during this period is estimated at about £5 million. This resulted in the provision of about 10,500 beds gross, the net gain in beds being in the region of 7,500. In all, grants totalling £29·8 million have been made from the Hospitals Trust Fund in the period from its inception up to 31st March 1962, to meet capital expenditure on hospital services.

17. The accounts of the health authorities, including their hospital accounts, are subject to audit by local government auditors, whose reports are made available to the Minister. The accounting system of health authority hospitals—which is much the same as that in voluntary hospitals—provides for a subjective analysis of expenditure, and the production of an average daily (or yearly) cost per patient. There is virtually no departmental costing.

BASIS OF ELIGIBILITY FOR INSTITUTIONAL AND SPECIALIST SERVICES

18. Eligibility for these Services is determined in accordance with the provisions of the Health Act, 1953, as amended, by reference to membership of one or other of four broadly-defined classes:

(i) the lower income group, or persons who are unable to provide health services for themselves and their dependents from their own resources;

(ii) the middle-income group, which includes

(*a*) persons insured under the Social Welfare Acts;

(*b*) persons whose family income is less than £800 a year;

(*c*) persons whose livelihood is derived mainly from agriculture and the valuation of whose holding does not exceed £50;

(*d*) the dependants of all such persons;

(iii) pupils of National Schools who receive hospital treatment for ailments discovered at school health examinations; and

(iv) those outside these groups who, in the opinion of the health authority concerned, could not, without undue hardship, provide the services from their own resources.

19. It is calculated that 85% of the population come within classes (i) and (ii). For those who do not come within the ambit of the Health Act Services—and indeed also for those who do, if they so wish—a scheme of voluntary health insurance is available for hospital (excluding normal maternity) services. This scheme was introduced under an Act of 1957, and is administered by a Board appointed by the Minister.

SCOPE OF SERVICES AND BASIS OF CHARGE

20. Services are available to the eligible classes of people in general and specialist hospitals, mental hospitals, and in nursing homes, convalescent homes and homes for handicapped persons. These services include out-patient specialist services. The services which a health authority must provide are made available in public accommodation. The patient may be provided with accommodation in an institution run by the health authority, or he may be referred by the health authority to a voluntary hospital, or to a hospital belonging to another local authority. A health authority may operate an arrangement whereby patients who enter approved hospitals of their own choice are deemed to have been sent to them by the health authority and the health authority in such cases pays the voluntary hospitals the full capitation rate. Where the patient chooses his or her own hospital, nursing home or maternity home a subvention is paid towards his or her expenses by the health authority. The amount of the subvention depends on the particular hospital chosen, and on the type of accommodation, i.e., whether public or private.

21. Hospital treatment for infectious diseases is available free of charge without reference to the means of the patient. Members of the lower income group, and National School pupils receiving treatment for defects or ailments discovered at school health examinations are entitled to hospital and specialist services without charge. There is provision for charges not exceeding 10/- a day for persons in the middle-income group, and higher charges can be made for cases dealt with under the 'undue hardship' clause.

22. The payment made by a health authority to a voluntary hospital for persons treated on its behalf are at rates approved or directed by the Minister. A capitation payment is made to cover maintenance and treatment in the hospital, and special supplementary payments are made for some of the more expensive drugs and appliances. An additional payment is made into a special fund or 'pool' from which the visiting medical staffs of the hospital are remunerated for their services for Health Act patients.

23. The manner of distribution of this pool, which does not form part of the funds of the hospitals, is determined by the staffs participating in it. There are three types of visiting specialists—anaesthetists, radiologists, and pathologists—who do not participate in the 'pool' distribution. These are remunerated from the funds of the hospitals and, in the case of the radiologists and pathologists, partly by local authorities.

III. Administrative Staffing of Hospitals

24. Local authority hospitals, forming part of the health services of the functional areas of the health authorities, are to a large extent managed from the central administrative offices of the health authorities. The lay administrative or office staff of the hospital may be, and indeed often is, quite small. Medical and nursing control as such is, however, retained by the appropriate medical and nursing officers in each hospital.

25. Voluntary hospitals are managed from within, each hospital having its own controlling authority and its lay, medical, and nursing departments wholly within the institution.

26. If we regard the administrative staff of the hospitals as comprising medical, nursing and lay administrators, we can say that while basically there is, in every hospital, somebody responsible for the functioning of each of the three spheres of authority, there are variations in the scope and span of control of each sphere, and, in some cases, in the designations of those in charge. This is true of both health authority and voluntary hospitals.

27. Taking medical administration for example, we find that the medical director is usually a consultant in medical charge of a specialized unit or institution, for example, a cancer hospital. In such a case, the medical director has personal responsibility for the medical care of the patients in the unit or hospital.

28. The medical superintendent, on the other hand, tends to have a wider field of authority or supervision, and he is usually found in a sanatorium or mental or regional hospital. He enters to a much greater extent into the detailed administration of the hospital, and exercises control and authority over aspects of the hospital life which might otherwise be left to the nursing or lay administrator.

29. The medical staff committee, or board, with selection agreed upon by the staff, and with the chairmanship rotating, is generally accepted as the most effective method for internal medical administration in a general hospital, and is in fact, the one generally adopted in practice. In such cases this committee is subordinate to the board of governors or committee of management which, however, includes representatives from the medical staff committee.

30. On the nursing side, the matron, who is the senior nursing administrator, may have varying areas of responsibility. Thus, in many cases, in addition to nursing responsibilities the matron may have overall responsibility for domestic staff, laundry, and in some cases, for catering. The tendency now, however, is to relieve the matron of some or all of these non-nursing duties.

31. So far as the lay administration is concerned we can say that it is in this sphere that there is the greatest difference between the health authority and voluntary hospitals.

32. It may be well, first, to explain briefly a feature of the Irish system of local administration which is not akin to that obtaining in Britain and many other countries. Over the past 30 years or so a system of local administration has been introduced whereby county and city managers discharge most executive functions of the local authority with considerable freedom from intervention by their council or corporation. These managers, in general, exercise the same functions in respect of the health authorities. In fact it is interesting to note that their decisions in relation to what are referred to as 'individual health functions' or functions relating, *inter alia*, to decisions as to the eligibility or otherwise of individuals for health services, and the making or recovery, or amount of any charge for a service made available in respect of an individual, and decisions relating to the recruitment, discipline, promotion, superannuation, etc., of members of the staff are not subject to any control by the elected representatives of the health authorities.

33. The overall administration and control of the hospital services of a health authority is therefore one of the responsibilities of the county or city manager. The discharge of their responsibility in detail is, however, normally delegated. The pattern which emerges is that the hospitals are controlled as follows:

Regional Hospitals:

The Resident Medical Superintendent (in one case a Lay Superintendent is also appointed).

Regional Sanatoria:

The Resident Medical Superintendent assisted by a Secretary/Clerk.

County Hospital:

The County Surgeon and the County Physician.

Mental Hospital:

The R.M.S. and the Chief Clerk/Secretary (jointly).

In each case, the matron or head nurse assists the medical supervision, and, except with smaller institutions, separate clerical assistance is made available in the institution itself. Members of the administrative staffs of the county council as health authority, assist the county manager in the exercise of the controlling functions over the health services administered by him. The status and authority of the lay administrator in the health authority hospital is generally lower than that of the lay administrator in the voluntary hospital.

34. In the voluntary hospitals, while there is not any uniformity in the status, designation and functions of the lay administrators, there has been a noticeable tendency in recent years for them to be given wider responsibility than heretofore, and to have this increased responsibility recognized in their status and salary.

35. As in the case of the health authority hospitals, there is some variation in the titles given to the senior lay administrator in different voluntary hospitals. For example, he or she may variously be referred to as the Secretary, Registrar, or Secretary/Manager of the hospital.

IV. Selection and training of Hospital Administrators

SELECTION

(i) *Health Authorities*

36. It is desirable, at the outset, to say a few words of explanation about a body which is prominently involved in the selection of administrators for the health authorities. Under the Local Authorities (Officers and Employees) Act, 1926, a body known as the Local Appointments Commission was set up—the members of which are appointed by the Government. These currently comprise the Ceann Comhairle, or Chairman of the lower House, and the permanent Secretaries of the Departments of Health and Local Government. This body has the function of recommending candidates for appointment to fill certain offices in the local government (including the health authorities) service. In general, for all the appointments to major or important posts—including all permanent professional

posts—local authorities are required to follow a statutory procedure whereby they request the Commission for a recommendation for the filling of these posts. Local authorities are also required to appoint the candidate recommended by the Commission.

37. In determining the candidate or candidates to be recommended in a particular instance the Commission invites applications by public advertisement from persons who possess the qualifications prescribed for the post, and subsequently arranges to have such persons interviewed by a selection board appointed by them.

38. All medical posts in the service of health authorities—with the exception of short-term temporary posts—are filled as a result of this procedure.

39. Similarly, posts of matron and assistant matron, and the corresponding male nursing posts in mental hospitals, are filled on the recommendations of the Local Appointments Commission.

40. If we take lay administrative posts involved in hospital administration as including all those from county and city manager down, referred to in paragraph 29, then we may say that county and city managers invariably, and secretaries and accountants of health authorities in general, are selected through Local Appointments Commission procedure; and that those at executive level, mainly staff officers, are normally selected locally by competitive interview by a board (appointed by the city or county manager) from members of a basic clerical grade recruited initially by open competitive written examination at university entrance level.

41. In practice, there is a very general tendency for those aspiring to promotion to the executive and higher grades to acquire post-entry educational qualifications, e.g., in arts, commerce or economics at a university, in accountancy or secretaryship, or in the form of a Diploma in Local Administration awarded by the Institute of Public Administration.

(ii) *Voluntary Hospitals*

42. Senior medical staff in voluntary hospitals are, in practice, nominated by the medical staff committee, subject to approval by the board of governors or committee of management.

43. Senior nursing posts are advertised, and filled by selection from the applicants by a joint committee of members of the medical and nursing staff and board members.

44. Senior members of the lay administrative staff are generally recruited by advertisement and interview by a selection sub-committee of the board of governors or committee of management. Minor clerical appointments are generally made by the secretary in consultation with the chairman of the board.

TRAINING

45. Until recently there has not been any formal scheme for the training as administrators of senior medical, nursing, and lay personnel engaged in hospital administration in either health authority or voluntary hospitals.

46. Senior medical staff have, from time to time, attended conferences, lectures and discussions arranged by their own professional bodies in which administrative problems have come under review. Some senior medical staff have also been granted fellowships by the World Health Organization and other international bodies, and have been enabled to study administrative problems and their methods of solution in other countries.

47. Senior nursing staff have, in some cases, had similar opportunities to study nursing administration abroad. In addition, An Bord Altranais, the Irish Nursing Registration Board, which has responsibility, *inter alia*, for nursing registration, and for education and training of nurses, has recently organized and conducted courses for matrons and sister tutors in which various aspects of nursing administration have been dealt with. By arrangement with the National University, a special university course of two academic years' duration has been provided for sister tutors.

48. The Institute of Hospital Administrators, in co-operation with the vocational education authorities, recently introduced a course extending over a period of two years leading to the award of a Diploma in Hospital Administration. Many engaged in hospital administration, particularly on the lay side, have undertaken this course.

49. Within the past year, the Institute of Public Administration introduced a number of short courses in hospital administration for senior people in this field. These courses have met with a considerable and countrywide response, and have been attended by medical, nursing and lay administrators.

In addition, a number of people employed in health authorities have also attended courses in organization and methods, work study appreciation, machine accounting and A.D.P., stores management and purchasing, and supervision, conducted by the Institute.

In view of the extent of the response to these courses, and the evident need for a formal scheme of training for those engaged in the hospital services, the Institute has decided to undertake as a regular feature of its training activities, the provision of a number of courses on hospital administration, and in management and other techniques likely to be of use to hospital administrators.

BIBLIOGRAPHY

The Health Services of Ireland, B. Hensey, IPA, 1959.

History of Medicine in Ireland. Dr. J. F. Fleetwood, Browne & Nolan, 1951.

Annual Report of the Department of Health. Government Publications Sales Office.

Annual Report of the Hospitals Commission. Government Publications Sales Office.

The Statistical Abstract. Central Statistics Office, Government Publications Sales Office.

FINLAND

by

ONNI VAUHKONEN

Chairman of Direction, Foundation for Education in Hospital Administration

1. *The hospital service, its organization and scope*

GENERAL HOSPITALS

For the purpose of general medical care, Finland has been divided into 21 central hospital districts. Each central hospital district is to have its own central hospital. The hospital will be owned and administered by communal federations formed by the municipalities and communes of each central hospital district. Nine central hospitals are already in operation. The rest of the central hospitals will be built during the next 10 to 20 years. The central hospitals offer their services in the most general fields of medicine, i.e., surgery, internal medicine, obstetrics and gynaecology, paediatrics, ophthalmology and otorhinolaryngology. In addition, each central hospital has an out-patient department and adequate special service departments.

The central hospitals attached to the University Medical Faculties hold a special position; at present there are two such hospitals, in Helsinki and Turku, and in the next few years one more will be completed in Oulu. These central hospitals are jointly owned by the University and the communes of the central hospital district concerned, and they are therefore called university central hospitals. In those parts of the country where there are no central hospitals, the inhabitants are still being served by State hospitals.

REGIONAL HOSPITALS

In addition to the central hospitals, there are regional hospitals with departments for at least two special branches of medicine, and adequate special service departments; they may

also have out-patient departments. These hospitals are likewise owned by communal federations. There are 21 regional hospitals of which 15 are in operation and six in transformation into regional hospitals.

LOCAL HOSPITALS

The third group of Finnish hospitals consists of the local hospitals, now numbering 178, which are owned either by a single commune or by several communes jointly. Most of them are smaller and less well equipped than the regional hospitals.

Thus there are three different categories of general hospitals: central hospitals, including university central hospitals as a special group, regional hospitals and local hospitals. Until this network of hospitals is completed, State hospitals, now numbering over ten, will also be in operation. In addition, there are about 35 private hospitals and some 40 communal hospitals operating outside the hospital law and receiving no government aid.

MENTAL HOSPITALS

For the care of mental patients, the country is divided into 18 mental health districts, each having a central mental hospital. The central mental hospital (A-hospital) in each mental health district is owned by the communal federations. In addition to the central mental hospitals, there are also B-hospitals, now numbering 35, administered by the local authorities or communal federations. Besides, there are 85 B-hospitals which are the mental departments of communal homes. They are administered in the same way as the B-mental hospitals in general. The B-hospitals, designed for mental patients who are easy to manage and are dangerous neither to themselves nor to others, have been built as far as possible in the immediate vicinity of the central mental hospitals, which treat acute cases, or at least in places where special treatment can be given.

TUBERCULOSIS SANATORIA

For treatment of tuberculosis, the country is divided into 19 tuberculosis districts, each of which has its own tuberculosis

sanatorium. All these hospitals have X-ray facilities and laboratories of their own.

After the Central Hospital Law of 1943 amended in 1948 and the Hospital Law of 1957 took effect, the construction of hospitals was accelerated. During the last ten years there have been built 30–40 new local hospitals, seven regional hospitals, seven central hospitals, three university central hospital clinics and about 30 hospitals for mental patients. In addition, over 50 hospitals have been rebuilt or expanded with new buildings. Dozens of new local, regional and mental hospitals are being constructed. (See tables on pages 135 and 136.)

2. *The way in which the hospitals are staffed administratively*

The administrative organization of a hospital depends greatly on its ownership. As pointed out in the foregoing, Finnish hospitals are mostly public institutions. The majority are maintained by the communes and municipalities, but the State still has a number of general hospitals.

THE ADMINISTRATIVE ORGANIZATION OF STATE HOSPITALS

Primarily responsible for the overall functioning of any hospital under the administrative control of the State is the *executive director* of the institution, who is invariably a *chief physician.* It is the duty of the executive chief physician to see to it that the laws and decrees currently in effect are adhered to in managing the hospital. He must also see to it that the members of the hospital staff carry out their responsibilities. Furthermore, he is in charge of hiring and dismissing staff members with the exception of leading functionaries. He has an especially important financial responsibility in that he has to control the funds handled by the business manager as well as to approve the hospital budget drawn up and proposed by the latter and to submit it to the Central Medical Board for consideration.

The task of the matron is to supervise the nursing activities in the hospital. It primarily involves organizing and directing the work of the nursing staff and other personnel attending to the needs of patients.

The *business manager* is mainly concerned with economic matters, such as book-keeping, drawing up the hospital budget, ordering supplies and paying bills. His functions include those of superintendent for he has primary responsibility for the operation and maintenance of the hospital buildings and technical facilities. Besides money expenditures and keeping the accounts, the business manager is further in charge of the hospital stores.

One of the chief physicians on the staff is appointed executive director of each State hospital for a term of four years. Inasmuch as the State hospitals are divided into special departments, each department (internal medicine, surgery, children's diseases, etc.) has its own chief physician, who is responsible for the medical services offered in his special field. Under his orders are ward physicians and assistant physicians. If the hospital is big enough, there is a doctor in charge of X-ray department and laboratory, holding the title of chief physician, too.

COMMUNAL CENTRAL HOSPITALS (GENERAL HOSPITALS, TUBERCULOSIS SANATORIA AND MENTAL HOSPITALS)

The communal central hospitals are owned by federations of communes and their organization is based on the same principles as apply to State hospitals. Each special department of medicine has its own chief physician. One of the chief physicians on the staff is appointed in the same way as in State hospitals to take executive charge. The physician in charge is entrusted with administrative duties, but he is not concerned with matters of business management to the same extent as his counterpart in a State hospital. Consequently, the business manager of a communal central hospital has considerably broader authority than that of a State hospital. He also serves as a secretary of the federal board of the federation of communes operating his hospital and generally brings a large part of the economic affairs of the hospital to the attention of the board. The position and duties of the matron are pretty much the same in the communal central hospitals as in State hospitals.

Hospitals and Beds by type and ownership at the end of the year 1960

Hospitals	*Ownership*								
	State	*Urban communes, 1st class*	*Urban communes, 2nd class*	*Rural communes*	*University central hospital federations*	*Federations of communes*	*Private*	*Ahvenanmaa province (Aland Islands)*	*Total*
	BEDS								
GENERAL HOSPITALS	2,108	3,683	246	2,627	2,475	4,755	2,570	105	18,569
State hospitals	2,108	—	—	—	—	—	—	—	2,108
University central hospitals	—	—	—	—	2,475	—	—	—	2,475
Central hospitals	—	—	—	—	—	2,124	—	100	2,224
Regional hospitals	—	—	—	—	—	1,140	—	—	1,140
Local hospitals	—	3,316	207	2,171	—	1,328	—	—	7,022
Communal hospitals outside hospital law	—	367	39	456	—	163	—	5	1,030
Private	—	—	—	—	—	—	2,570	—	2,570
MENTAL HOSPITALS	496	3,119	—	190	123	12,015	—	73	16,016
State hospitals	496	—	—	—	—	—	—	—	496
Mental hospitals, type A (acute)	—	2,318	—	—	123	8,372	—	73	10,886
Mental hospitals, type B (chronic)	—	755	—	190	—	3,627	—	—	4,572
Observation stations (acute)	—	46	—	—	—	16	—	—	62
TUBERCULOSIS SANATORIA	—	803	—	97	—	5,492	—	50	6,442
Central sanatoria	—	773	—	—	—	5,379	—	50	6,202
Other sanatoria	—	30	—	97	—	113	—	—	240
Total	2,604	7,605	246	2,914	2,598	22,262	2,570	228	41,027

Beds at special institutions (institutional hospitals)	
Nursing homes	7,486
Military	1,817
Prisons	556
Other	70
Total	9,929
All beds	50,956

Hospitals and Beds by type and ownership at the end of the year 1960

Hospitals	*Ownership*								
	State	*Urban communes, 1st class*	*Urban communes, 2nd class*	*Rural communes*	*University central hospital federations*	*Federations of communes*	*Private*	*Ahvenanmaa province (Aland Islands)*	*Total*
	HOSPITALS								
GENERAL HOSPITALS	12	44	8	113	2	49	35	2	265
State hospitals	12	—	—	—	—	—	—	—	12
University central hospitals	—	—	—	—	2	—	—	—	2
Central hospitals	—	—	—	—	—	6	—	1	7
Regional hospitals	—	—	—	—	—	9	—	—	9
Local hospitals	—	36	6	87	—	31	—	—	160
Communal hospitals outside hospital law	—	8	2	26	—	3	—	1	40
Private	—	—	—	—	—	—	35	—	35
MENTAL HOSPITALS	3	13	—	3	—	37	—	1	57
State hospitals	3	—	—	—	—	—	—	—	3
Mental hospitals, type A	—	3	—	—	—	15	—	1	19
Mental hospitals, type B	—	8	—	3	—	21	—	—	32
Observation stations	—	2	—	—	—	1	—	—	3
TUBERCULOSIS SANATORIA	—	4	—	4	—	17	—	1	26
Central sanatoria	—	3	—	—	—	15	—	1	19
Other sanatoria	—	1	—	4	—	2	—	—	7
Total	15	61	8	120	2	103	35	4	348

OTHER COMMUNAL HOSPITALS

Besides the hospitals operated by the federations of communes, there are hospitals in Finland owned by individual communes, and, especially, large population centres and cities. In the larger cities municipal hospitals are under the charge of special boards of directors, while in the smaller rural communes the local board of health or some subordinate agency is in charge. The administrative organization of the municipal hospitals in the major cities is by and large similar to that of the hospitals belonging to the State and the communal federations. In the very smallest communal general hospitals, the physician in charge is the local health officer, which means that the only responsible member of the staff regularly on duty is the matron. Matters relating to the business management of such hospitals are often combined with the economic administration of the communes or, then, the position of manager is held on a part-time basis.

At present, the principal responsibility in the administration of the hospitals of Finland still rests with the executive chief physicians. In the communal hospitals, the business managers bear a relatively heavy responsibility and exercise considerable authority in economic matters. On the other hand, there is not a single hospital in Finland with an executive director serving on a full-time basis. In the university central hospitals, which are owned by the communal federations, the executive chief physician works together with a hospital board consisting of professors from the medical faculty of the university. The university central hospitals of Helsinki and Turku have an administrative director. Two of the large communal general hospitals have a business executive.

Even in cases where hospitals have an administrative director, the administrative organization remains dualistic. Responsibility is shared by two executive officers.

The post of executive chief physician requires no special administrative competency. The chief physician of every department of a hospital is regarded as fully qualified in this capacity. Often the position of executive chief physician takes on the character of a 'revolving prize'—being awarded to each chief

physician on the staff in turn. This prize is not, however, much sought after for the hospital director is granted no relief from his medical duties and the extra salary is only nominal. The system of organization on the executive level has thus been left at quite a rudimentary stage.

3. *How the hospital administrators are selected and trained*

The qualifications of business manager vary greatly. The administrative directors is required to have an academic degree, the business manager generally at least a diploma from a commercial college.

The position of matron is the only one that requires a post-graduate course in administration in addition to the professional examination. Such courses are regularly held in State nurses' training schools for aspirants to the position of head nurse or matron.

Candidates for positions requiring an academic degree (also administrative directors and business managers) are obliged to take the regular course of studies at one of the universities or other institutions of higher learning. Ordinarily, preference is given to graduates of a college of commerce and business administration or a law school. Of late, holders of a degree in political science have also been appointed to administrative posts in hospitals.

Since no specialized administrative training is generally required of appointees to executive positions in the hospital administrative system with exception of matrons, acquiring full competency calls for further study. Arranging such opportunities along systematic lines is quite new in Finland. The organization of advanced training has so far been as follows:

1. Every year the Union of Rural Communes arranges in co-operation with the State medical authorities a three-day course of lectures and conferences on questions of current interest concerning hospital administration and business management. The course is taken separately by the executive and managing officers of (*a*) general hospitals and (*b*) mental hospitals and tuberculosis sanatoria.

2. At the end of 1961, the *Sairaalatalousyhdistys r.y.* (the Hospital Business Managers Association) arranged a one-week course of basic education in hospital administration for junior office personnel responsible for the business management of their respective hospitals. It is planned to continue with this training programme on an annual basis.

3. In the autumn of 1961, the Medical Association in Finland, the Finnish Federations of Nurses—the Finnish Nurses' Association and the Hospital Business Managers Association jointly established, with the assistance of the government authorities, a Foundation for Education in Hospital Administration. The aim of this foundation is to promote education in administration among hospital administrative personnel in Finland as well as hospital trustees. The programme includes courses and other educational sessions in administration and leadership, special instruction in hospital management and the performance of executive functions, making recommendations for the elimination of defects in the system and the improvement of prevailing conditions.

The Board of Governors of the foundation consists of representatives of the sponsoring organizations, the government and hospital trustees.

The foundation held its first conference in September 1962, with Prof. T. E. Chester from Manchester as guest lecturer. The main theme of the conference is 'The Application of Modern Ideas and Methods of Leadership to Hospital Administration'.

In the spring of 1962, the Medical Association in Finland arranged on its own initiative a course of basic administrative training for hospital doctors. The course places special emphasis on the administrative functions of hospital physicians in executive positions. It is planned to hold a corresponding course in the autumn of 1962. Preliminary plans have been laid for the organization of a basic course in hospital administration for physicians undertaking to serve a period (as medical assistants) on a hospital staff in order to qualify as specialists. It has become the task of the Foundation for Education in Hospital Administration to synchronize the programmes of basic training in

administration for physicians, business managers and nurses entrusted with administrative duties. It should further be mentioned that the Society of Bachelors of Medicine will arrange its first seminar in hospital policy for members this autumn. This may also be considered the opening signal for the organic linking of training in hospital administration to the programme of medical education in the future.

HELSINGIN SAIRAANHOITAJAOPISTO

(Helsinki College of Nursing)

Department of postbasic education

1962–63

PURPOSE

To prepare nurses for administrative positions in hospital or in public health nursing service.

The studies lead to the competence of a director of nursing services either in hospitals or in public health.

STUDENTS

Graduate nurses with the standing of a head nurse, a public health nurse or a nurse-midwife and a minimum of two years' experience in the field their competency indicates.

LENGTH OF STUDIES

One academic year beginning in September and ending in May.

PROGRAMME

Administration of nursing services*

Public health

Nursing

Psychology

Principles of education

Sociology

Social policy

Finnish

English

* The students are majoring either in administration of hospital or of public health nursing services according to their speciality.

REQUIREMENTS

All students are expected to include in their programme of studies the following courses:

	Total number of hours		*Number of hours*	*Term*
Administration of hospital nursing services	600	General administration	16	A
		Management of nursing services	68	A–S
		Leadership in nursing	32	A–S
		Supervision	32	S
		Hospital planning and construction, nurses' part	32	S
		Field experience	420	A–S
Public health	60	Public health, advanced course	32	A
		Vital statistics	16	S
		Physiology of work	12	S
Nursing	40	Modern trends in nursing	24	A
		Nursing education	16	A
Psychology	36	Clinicial psychology	24	S
		Social psychology	12	A
Principles of education	24	Special course applied to adults	24	A
Sociology	64	Social organization	8	A
		Sociology of illness	8	A
		Hospital sociology	8	A
		Research methods	24	A
		Research seminars	16	S
Social policy	16	Social security	8	S
		Work and employment policy	8	S

	Total number of hours		*Number of hours*	*Term*
Finnish	32	Communication	32	A
English	32		32	

In addition to the above-mentioned requirements the students are expected to include at least two of the following courses in their programme:

	Number of hours	*Term*
Clinical nursing, advanced course	24	A
Clinical physiology	16	A
Developmental psychology	16	A
Group work	16	S
Health education	12	A–S

A=autumn term
S=spring term

General Information

The College of Nursing consists of two departments: the department for basic nursing education—School of Nursing—and the department for postbasic nursing education.

PURPOSE

The School of Nursing offers basic nursing education which leads to State registration as a professional nurse on staff nurse level.

The department of postbasic education offers programmes for professional nurses in order to prepare them for senior positions in special fields of nursing and for administrative and teaching positions in nursing.

For this purpose there are five teaching divisions in the postbasic department. One is for clinical and one for public health nursing. Two other divisions offer advanced programmes in nursing administration and in nursing education. The depart-

ment is also offering professional education in medical and psychiatric social work.

In addition to these regular programmes, refresher courses for public health nurses and for hospital nurses are arranged five times a year.

HISTORY

The Helsinki School of Nursing (basic education) was started in 1889 and was taken over by the State in 1930.

In the 1920's postbasic courses for nurses were arranged under the auspices of private organizations.

When the responsibility for nursing education was taken over by the State a *State College of Public Health Nursing* was established in 1931. Courses in administration and education were to begin with, arranged at the Helsinki School of Nursing. Out of this in 1947 a separate *Postbasic College for Nursing Education* was established. In 1951 these two State institutions offering postbasic education for nurses were combined.

The last change took place in 1958 when the former Helsinki School of Nursing and the Postbasic College joined and formed the present *Helsinki College of Nursing.*

ADMINISTRATION AND FINANCE

The College of Nursing is financed by the State. It has a full-time director and a board, consisting of representatives of senior members of the teaching staff, experts in education, medicine, nursing and social work. The State Medical Board supervises the College through a Director of Nursing Education subordinate to the chief of the department of Public Health.

TEACHING STAFF

The director of the College bears the responsibility of the total teaching programme of the College. She is assisted by two directors, one for basic and one for postbasic education. The ordinary teaching staff consists of 28 full-time nurse-teachers with advanced studies in their teaching subjects. Also two full-time teachers, experts in social sciences and in nutrition, belong to the teaching staff.

In addition a number of part-time special lecturers—many of them university teachers—are employed as well as field supervisors.

The School of Nursing

According to the amendments in legislation the school offers since 1957 a 2½ years' programme for basic nursing education.

Entrance requirements for basic students are: 19–29 years of age and university matriculation (Baccalaureats). Aptitude tests are arranged for applicants.

**The Department for Postbasic Education*

TEACHING DIVISIONS

Clinical nursing. Instruction is offered in the following branches of nursing: medical, surgical, operating room, paediatric and psychiatric nursing. The students can choose one of these specialities for their major subject. Ward administration is included in the programmes. The studies give the competence of a head nurse.

Public health nursing. Programme is offered in generalized public health nursing, which includes also industrial nursing. The studies give the competence for public health nursing positions.

Medical and psychiatric social work. This division gives education in social work and in its application in the field of public health. The studies lead to the competence of a medical and psychiatric social worker.

Nursing administration. In this division, offering advanced programmes, the main subject is administration and the application of administrative and supervisory principles either in clinical or in public health nursing services. The studies give the competence for administrative positions in nursing.

* Every nurse, who graduates from the basic school is registered in the State Medical Board as a registered professional nurse. According to the completed postbasic studies and passed examinations the State Medical Board gives the nurses competence for special nursing positions, mentioned above, and keeps registers of nurses according to their competence.

Nursing education. Teaching in this division is centred on principles of education and teaching. The students may choose between their application in teaching clinical nursing or public health nursing or midwifery. The studies give the competence for teaching positions in nursing.

Besides these ordinary studies leading to a competence, *refresher courses* are arranged. Both types of refresher courses (public health and clinical nursing) offer a six-weeks' programme covering background subjects and current trends in either field of nursing.

CURRICULUM

All divisions have a programme of nine months' length—one academic year. The year begins in September and ends in May. Class teaching is supplemented with field instruction. Only the division of nursing education has a different arrangement: between the two terms at the college, the students practise teaching as interns in schools of nursing in different parts of the country for a period of two terms.

STUDENTS

The students are professional nurses with a minimum of one year of practical experience after previous studies, be it basic or advanced. Baccalaureats are preferred. Aptitude tests are arranged for applicants at all levels of education.

Facilities

The college has its own building, where in addition to classrooms, laboratories, offices and a library, also a dormitory is available. Students do not pay a tuition fee, but pay for food and lodging. A free health service is available for all students.

FRANCE

by

LOUIS PEYSSARD

Inspecteur Général au Ministère de la Santé Publique et de la Population

The Hospital Organization

1. Hospital legislation and organization in France have been evolving rapidly since 1941. The two causes of this evolution are the progress of medicine and the new requirements of the social system. I give here an outline of the re-organization resulting from the recent legislation of 1958.

2. Until the beginning of this century a hospital was a place where the poor were given free treatment, whilst people of means obtained treatment at home or in private nursing homes. More and more people today are going to hospital for treatment because it is there that the best doctors and the most efficient equipment are to be found.

3. In the past, hospitals were founded by princes, nobles, religious orders and, sometimes by local authorities. No national planning or standards accompanied their establishment.

Attempts at control date back to Louis XIV (1656). The Revolution of 1789 took responsibility for hospitals and benevolent institutions away from private authorities and conferred it upon 'the Commune'. This principle is still very much alive; the great majority of public hospitals in France are placed under the authority of the municipality, or, in other words, 'autorite communale'.

4. The Empire under Napoleon I, preoccupied as it was with centralization, subjected hospitals, as well as 'communes', to prefectorial control; that is to say that the decisions of the advisory councils which manage hospitals ('commissions administratives') can only be put into effect with the consent of the 'prefect'; this officer is the person who administers a

'département' in the name of the Government. (It must be remembered that France is divided into 90 'départements').

These arrangements are still in operation.

5. Nowadays, this statute refers to general public hospitals, of all categories. There are approximately 1,800 of these. Psychiatric hospitals are governed by another statute; the majority of them are 'départmental' (relating to the 'département'). None of them is related to the 'commune'. The only exception is that 'psychiatric departments' exist in certain general hospitals. The administration of psychiatric hospitals, therefore, comes directly under the control of the 'prefect' of the 'département' and the 'departmental assembly' (still called the General Council of the 'département'). Sanatoria, too, are endowed with a particular statute, as are the majority of hospitals controlled by a 'département'. There are roughly 100 psychiatric hospitals in France housing approximately 105,000 patients; and 66 public sanatoria providing approximately 15,000 beds. Finally, regional centres for the fight against cancer, approximately 20 in number, are not public institutions, but are managed by an Administrative Council of a lay character, having as president the 'prefect' of the 'département' which is the seat of the regional administration. (France is divided into 17 regions for medico-social purposes.)

It must be added that France has a considerable number of private hospitals. Apart from the 340,000 beds provided by general hospitals and public infirmaries, there exist also some 68,000 private beds.

I shall concern myself here in detail only with the organization of general public hospitals.

6. *Foundation and Discontinuance*

The foundation and discontinuance of public nursing establishments is according to governmental decree, whilst all matters of detail fall within the province of the 'commune' which has asked for a hospital to be built. Alterations in the designation of a particular part of a building are decided by deliberation of the 'local committee' and approved by the prefect.

7. *General Working Rules*

The working of French hospitals is characterized by their financial autonomy, by their individual independent legal entity, e.g. who can sue and be sued, etc. and by the absence of any hierarchical network towering above them which strengthens their independence by endowing each one of them equally with a kind of isolation; finally, by their communal character, created not by subordination to the municipal council or to the mayor, but through the composition of the consultative committee and by the limitation of practical working.

8. *The 'Commission Administrative'*

All general hospitals and infirmaries are administered according to the same general rules, although they are classed variously as regional hospital centres (23), hospital centres—one or two for each 'département'—(68), hospitals (490), rural hospitals (351) and, ordinary infirmaries (887).

All these establishments are administered by a small deliberating assembly generally called a 'Commission Administrative' and sometimes, a 'Conseil d'Administration'. It is this body which has authority in the establishment. The executive officer of the body is the directeur (in hospitals of more than 200 beds), or the directeur-econome, in hospitals of less than 200 beds).

The influence (not the authority) of the 'commune' is indicated by the composition of this 'commission administrative', of which the mayor of the 'commune' or of the town is always chairman.

According to the importance of the establishment this committee is composed of 4, 8 or 12 members, besides the chairman.

(*a*) *Rural Hospitals and Infirmaries:* the mayor, chairman;

4 members as follows:

1 elected by the municipal council

1 elected by the general council (the administrative assembly of a 'département')

2 designated by the prefect from people resident within the catchment area of the hospital who are known for their competence and enthusiasm in matters concerning hospitals and benevolent institutions.

(*b*) *Hospitals and hospital centres: the mayor, chairman.*

8 members as follows:

2 elected by the municipal council

1 elected by the general council

5 nominated by the prefect, 2 of whom represent social security bodies, one is a doctor from the establishment elected by the medical body of that establishment, another is a doctor elected by the 'departmental council' of the order of doctors (l'Ordre des Médecins) and by the medical syndicates, and the last is a member selected from people known in the catchment area of the hospital for his competence and public spirit.

(*c*) Hospital centres (and university centres, that is to say hospitals associated with a faculty of medicine).

The mayor, chairman.

12 members as follows:

The dean of the faculty of medicine.

A professor of medicine elected by the faculty council.

A supplementary representative of social security bodies.

The other members are the same as those enumerated for the preceding class. Social security bodies may have an additional representative in the various committees described above since they contribute, by means of considerable subsidies, to the work and equipment of hospitals.

(*d*) Three regional hospital establishments have different councils consisting of an unusual number of members—these are the hospices civils of Lyon, the Administration de l'Assis-

tance Publique in Marseilles, and the Assistance Publique in Paris.

The members of these councils and committees are designated by the prefect and nominated for four years after which period they may be re-elected. Their services are unpaid.

Any citizen may be a member of a commission administrative if he fulfils the customary conditions. There exist nevertheless restrictive regulations dealing with persons with an interest in private nursing-homes which might cause conflict within the hospital. Tradespeople who supply the hospital may not participate in the committee. Finally, precautions are taken to limit the number of doctors on the committee.

The commission administrative assembles, according to place, custom and business necessity, every week, every fortnight or every month. It is ruled that it should meet on an average once a month.

9. *The functioning of the 'commission administrative'*

The 'directeur', responsible for managing hospital affairs, submits the agenda to be discussed to the chairman. The agenda is headed by an invitation to each member to attend. Business to be discussed may cover a wide range. To be more specific it may include the creation of posts; budgets, additional credits and annual accounts; acquisitions, sales, exchange of properties and their designation for particular functions; work projects, building, major repairs, demolition; leases; loans; decisions concerning the purchase of various supplies and in general all decisions affecting the running of the hospital.

The municipal council of the commune or the town must then publish its consent to any decisions concerning the sale of estate or concerning loans.

After the meeting and the written tabulation of decisions, all deliberations are referred to the prefect of the département. The latter makes known his consent or refusal within 40 days. In principle, the prefect approves or rejects on the advice of two governmental officers attached to him to control business of this sort in the département; the officer of health of the

'département'—a doctor—and the officer of population and social services for the 'département'—a hospital administrator and a hospital accountant.

Refusal to approve a decision, which makes it impossible for it to be carried out, is not an arbitrary act on the part of the prefect; it may be motivated by a project which is contrary to law, to the regulations, to public welfare, to financial stability or to the higher interest of the hospital.

10. Two consultative councils function in co-ordination with the 'commission administrative'; these are the medical consultative committee, through which the medical body of the hospital may express its views, and the 'comité technique paritaire', which is a means of expression for the non-medical staff of the hospital.

Liaison between the 'commission administrative' and these two councils is effected by the directeur. The latter in effect assumes the post of secretary to the three bodies; he takes care that the medical committee and the 'comité paritaire' are consulted and formulates their advice on questions concerning the medical profession or general staff respectively. However, the 'commission administrative' is not obliged to follow the advice thus proferred.

11. *Financial Autonomy*

The budgeting of a hospital is completely independent of the general government budget, as it is indeed of those of the département and of the commune. The hospital has a fixed source of revenue from which it defrays its expenses.

The income of a hospital, like that of any public service, comes in the form of payments by beneficiaries for services rendered. In-patients and out-patients pay for any stay incurred and for treatment received. If they are without means or if they are 'socially' insured—which is so in the great majority of cases—payment is not, in fact, effected by the patient himself but by the social security insurance fund (Caisse de Sécurité Sociale) with which he is enrolled, or by the 'département' in which he lives; these payments are, however, effected individually against the presentation of a separate bill for each

patient, on which are entered details of the dates of periods spent in hospital and treatment given. Bills are drawn up on the basis of the cost of a day in hospital.

12. It is convenient at this stage to explain the term 'prix de journée'; it is for any particular hospital, the cost demanded from the patient per day spent in the hospital. It is calculated at the time of the annual budget. There are definite charges per day for medical treatment, drugs, midwifery and board. Sometimes also other more specific costs per day are calculated such as that entailed by the incubation of premature babies.

Each year the cost is calculated anew to conform to the estimates for the year. Over and above the 'prix de journée' which covers all the expenses of board, treatment and nursing the patient is required to pay medical fees which are calculated separately and paid through the hospital and not directly to the doctors.

If expenses rise, so too does the 'prix de journée'. When a hospital carries over a deficit from the previous year it incorporates this deficit in the calculation of the 'prix de journée' for the coming year. In this manner the hospital cannot undergo financial loss.

The 'prix de journée' of hospitals are fixed on the recommendation of the 'commissions administratives' by a prefectorial decree. Once this cost has been fixed, the prefect has no more say in the income of the hospital, which must devise its own means for the recovery of its debts by direct negotiation with its debtors, either individual patients or 'third-party' patients. This necessitates a considerable book-keeping department in each hospital.

13. As far as the relations of each hospital with the Ministry of Public Health and Population are concerned, it must be stressed that they are not of a direct hierarchical nature. Neither the mayor nor the 'directeur' are directly subordinated to the Ministry or to a regional or departmental officer of the Ministry. The Minister has no orders to give to the hospital. As premier guardian of the hospital he exercises his guardianship through the intermediary of the prefect, but this is more often than not in the form of negative measures, refusals of

consent, and only very rarely takes the form of positive directions. Even these are merely injunctions calling upon the 'commissions administratives' to discuss, for example, the construction of a casualty department, since the 'commune' is situated near a dangerous road where accidents are numerous. The hospital administration can refuse to act upon such an injunction and the ministry has no speedy means of enforcing its co-operation.

It must be said that examples of such resistance are rare. Nevertheless the fact that they are legally possible is an indication of the 'communal' character of the hospital; the French 'commune' is independent for purposes of administration.

14. Ministerial authority is equally and more efficiently expressed since the enforcement of the recent hospital legislation of 1958 concerning degrees of co-ordination.

Hospital co-ordination is a process of planning whereby the Ministry sanctions and favours the building of hospitals where they will be of use, and the kind of service offered, and bans the building of public or private nursing establishments and the expansion of existing public or private hospitals, where adequate facilities already exist. The aim of this policy is to avoid unnecessary expenditure which would be a waste of national resources.

It is on this basis that the Ministry favours the building or the development of 23 'university-centred hospitals', provided with a full range of medical and pharmaceutical equipment in towns having a faculty or a school of medicine; thus each region or each part of a region will be within 90 miles (150 km.) of a self-sufficient hospital manned by full-time doctors and a staff qualified to meet all eventualities. The hospitals here referred to are the C.H.U. (Centres Hospital—Universitaires) at Lille, Nancy, Rennes, Pane, Strasbourg, Nantes, Clermont-Ferrand, Lyon, Bordeaux, Toulouse, Montpellier, Marseilles, Tours, Grenoble, Amiens, Rouen, Caen, Reims, Dijon, Besançon, Angers, Poitiers and Limoges.

In each département, according to size of population, one or two hospital centres (centres hospitaliers), not attached to a

university are being organized or completed to provide proper facilities for nursing over a range of some 40 to 80 miles (50–100 km.). Ordinary hospitals are so organized as to cover a radius of 20 to 40 miles (30–50 km.). As far as 'rural hospitals' are concerned they have small medical and maternity departments, but they do not, as a general principle, practise surgery.

Any building which, if completed, would cut across this system, be it on private or public initiative, is forbidden under the Act of Co-ordination (la loi de co-ordination) which the Ministry is responsible for enforcing.

15. *The administrative machinery and staff of the French hospital*

The individual legal entity, the financial autonomy and, consequently, the independence of the hospital, from any other authority or institution, necessitate a fixed and stable administration. Since it must itself formulate regulating procedures, which, in a classical, hierarchical network—such as that of the Army and the Civil Service—are exercised from outside.

The motivating and regulating elements within the hospital are as follows: the 'commission administrative', from which stem original proposals and final resolutions; the mayor (chairman) who has certain powers of his own; the 'directeur', who looks after the day to day running of the hospital; the 'econome' (in a hospital of more than 200 beds), who assumes particular responsibilities; the 'receveur-percepteur', who handles the funds and all matters relating to income and expenditure; the engineer and, in a large hospital, the architect. Lastly, as advisory committees, there are the two bodies which have already been mentioned, whose advice has to be made known and interpreted by the various authorities mentioned above. These bodies are the medical advisory committee and the 'comité technique paritaire'.

16. The opinions and wishes of the medical advisory committee are transmitted through the medium of the 'directeur', who attends their meetings in the role of minute-taker, to the 'commission administrative', the prefect and also to the 'departmental' and regional representatives of the Ministry of Public Health and Population. At these meetings the directeur

is thus able to meet the medical staff of his hospital, and to hear them discuss general or special questions within their competence. It provides him with an excellent opportunity of knowing and understanding all aspects of their work.

17. Likewise, the 'directeur' sits on the 'comité technique paritaire', when he is accompanied by several members of the 'commission administrative'. In this way hospital administrators meet representatives of the various staff unions. These meetings afford a close study of the methods of work and the numerous difficulties which now and then weigh heavily on the functioning of a hospital. The committee's advice is communicated to the 'commission administrative' for attention.

18. *The Mayor*

As chairman of the 'commission administrative', the mayor has specially designated authority: he personifies the Establishment, he represents it in courts of law and civil life; this is so in all hospitals. Moreover, in hospitals with less than 200 beds, where there is a 'directeur-econome', it is the 'maire président', and not the 'directeur' who appoints staff albeit on the 'directeur's' recommendation. Similarly, it is the mayor who exercises the functions of 'ordonnateur', that is to say he only has the authority to sign orders of payment.

On this subject, attention must be drawn to the importance attached in France to this role of the 'ordonnateur', which is completely detached from the role of the 'comptable': in financial affairs one differentiates between resolutions concerning income and expenditure, even between the handling of ready money which constitutes material income and material expenditure. Resolutions come within the realm of the 'ordonnateur'. He orders payment or receipt by means of a 'mandate of payment' or an 'entitlement to receipt'. The actual transaction is effected by the 'comptable' who carries out the 'ordonnateur's' ruling, that is to say his order, to collect.

In a hospital of more than 200 beds the 'directeur' is the 'ordonnateur'. In lesser hospitals it is the mayor in his capacity as chairman. In all cases the functions of cashier and pay-

master are entrusted to a 'percepteur-receveur' delegated by the Ministry of Finance (Exchequer).

19. *The 'Directeur' or 'Directeur Econome'*

Setting aside the powers of the mayor, the directeur supervises the daily life of the hospital. He looks to the general running of it. The personal commitments of the mayor and the members of the commission administrative throw upon the directeur the burden of preparing and co-ordinating the questions to be submitted to the committee, advice to be sought from advisory bodies and the relations to be maintained with the departments and bodies of authority which form the administrative environment of the hospital: prefect, town hall, social security insurance funds, etc.

The directeur is also responsible for internal order and discipline. It is he who must make internal administration respected and deal with matters regarding personnel and finance. He gives the initiative for and later completes the draft budget, and estimates the 'prix de journée' proposed to the prefect. He controls the accountancy for income and expenditure. Even when the mayor is 'ordonnateur' it is the 'directeur' who authorizes and verifies bills and makes out receipts before presenting them for the mayor's signature.

He effects daily contact with the doctors and sees to it that all hospital facilities function in a co-ordinated and harmonious fashion.

20. In hospitals with more than 200 beds the directeur is assisted in his task by an econome. In smaller hospitals he, himself, assumes the role of the econome. Whatever the case may be it is the econome who looks to the material well-being of the hospital; the purchase and control of all equipment, and the hotel services, that is to say the organization and supervision of everything connected with a patient's stay, his reception and the care taken to provide for his comfort (accommodation, food and heating, etc.). He is responsible for the upkeep and maintenance of buildings and equipment. Finally, he controls stores and supplies. The directeur is the head of administration, and of the staff of all departments; he provides

the doctors with 'agents de soins'. The econome is in charge of the hotel services with their technical annexes: kitchens, boiler-house, laundry, etc.

When the directeur-econome assumes both these roles it is reasonable that the mayor will be responsible for authorizing payment: it is not proper that the person who places orders with the suppliers should also be the one to issue 'mandates for payment'.

Each year the directeur balances the accounts for the financial year (that is to say the year just completed). Stock-taking is directed by the econome.

21. According to the importance of the hospital the administrators are helped on questions of industrial, mechanical and electrical techniques by an engineer, an assistant engineer or at least by a foreman who advises on maintenance to be undertaken, recruits labour and supervises work done by outside contractors.

22. The same can be said for the architect. Few hospitals can employ a full-time architect. The majority take out a contract with a municipal architect who assists the directeur and the commission administrative in the study of varied problems of building, alteration, modification and large-scale renovation.

23. As far as the nursing profession is concerned it is surprising perhaps to hear no mention of the 'matron': she does not appear in all hospitals. One could even say that the majority of French hospitals do not have a matron. Where she does exist she is responsible, under the authority of the directeur, for the smooth running of nursing services, including the time-tables of sisters, nurses and people employed in the ward who are placed at the disposal of the consultant of each specialty.

Where there is no matron the directeur or his assistant fulfils this function. It being understood that for each group of beds constituting a consultant's specialty it is he, assisted by his nursing superintendent, who directs and controls the detailed nursing care.

24. As regards the doctors there is no recognizable chain of command in French hospitals. Each consultant is master within

his own specialty which generally comprises 2 to 4 wards of about 30 beds each. He is responsible then for anything from 60 to 120 beds. These beds are grouped together on a floor or wing of the hospital—thus, the administrative unit is self-contained. The consultant is not answerable to any medical supervisor. He is officially placed under the general authority of the directeur, except within the realm of purely medical affairs since directeurs are not doctors. The consultant's attitude and behaviour are governed only by his professional ethics.

If incidents should occur, or failures in co-ordination manifest themselves it is the responsibility of the directeur to deal with them with the assistance of the medical advisory committee, the commissions administratives and also the health inspector of the département, who himself a doctor, has the authority to intervene in any hospital matter, if the interest of the patient or of the hospital requires that he should do so.

25. On the subject of medical auxiliaries attention must be drawn to the pathologist, the pharmacist (generally full-time) and the radiologist. All these are directly responsible to the directeur, as are the heads of all other medical departments, for all general matters. They are not answerable to anybody in their professional capacity.

26. Under the directeur and the econome, trained staff are responsible for particular tasks, their number varying according to the size of the hospital: chief clerks for admissions; the accounting of the cost of treatment and stay; for the settlement of accounts; and for the management and payment of staff; also chief storemen, etc.

27. *Internal Administration*

In a well-organized hospital the 'directeur', 'econome', and their assistants, if any, are responsible for enforcing the 'Internal Rulings'. The principal sections of the 'Internal Rulings' specify the areas of control of the administration, the 'commission administrative' and the advisory committees; the duties, responsibilities and powers of the 'directeur', the 'econome' and their assistants, and the medical and nursing staff and working-hours.

They stipulate also the conditions regarding holidays; religious services; the keeping of accounts and the various registers; departmental organization; illnesses treated and patients admitted in the various parts of the hospital or for out-patient consultation, as well as in the 'Hospice'; the number of beds allocated to each specialty; the regulations for the admission and discharge of in-patients; the measures to be taken in case of death; the eventual arrangement of work of certain patients; catering; order, discipline and internal security, etc.

These internal rulings are formulated by the commission administrative on the advice of the advisory bodies and approved by the prefect on the advice of the Ministry.

28. The choice of directeurs is the prerogative of the Minister; he appoints them.

There is a directeur général at the head of the large regional hospitals. He generally has an assistant.

The directeurs généraIs and directeurs of hospitals of more than 2,000 beds have a deputy (directeur adjoint).

Moreover, certain hospital administrations which comprise several separate buildings have one or more 'directeurs d'établissements annexes' who are similar to 'sous directeurs' with district geographical responsibility. Hospitals of more than 500 beds have one or more sous directeurs. Those who manage an institution of more than 2,000 beds are designated directeurs grade I; 500–2,000 beds grade II; 200–500 beds grade III; 100–200 beds grade IV; 50–100 beds grade V; and under 50 beds grade VI.

29. Econornes have the title of econome général in the big regional hospitals. They may be assisted by one or more sous econornes in hospitals of more than 500 beds. There exist four grades of econornes depending on the size of hospitals:

Grade I more than 2,000 beds

Grade II 500–2,000 beds

Grade III 200–500 beds

Grade IV for special hospitals which are exceptions and have less than 200 beds.

SELECTION AND TRAINING: APPOINTMENT OF DIRECTEURS IN FRENCH HOSPITALS

Selection

30. French administration in general is very attached to the idea of selection by examination. It is one of the firmest principles of public administration that one only becomes a government official or an official of a public institution—by this is meant a designated officer with all the powers attached to that title—after having successfully passed officially organized competitive examinations comprising written work, interviews and oral examinations. These examinations are advertised according to the number of places open to competition. The examining board is officially constituted by a government decree, according to the stipulated condition for each examination.

31. 'Directeurs' of hospitals are not exceptions to this procedure. They are recruited either from the administrative ranks of the Ministry of the Interior or of the Ministry of Public Health, upon leaving which they are appointed as 'directeurs' without any special examination—but they have passed a previous examination to become officials of these Ministries: or by a special examination for 'directeurs-economes' for which the requirements have been defined recently by the Ministry circular of 24th November 1960. It is not customary in France for doctors to be 'directeurs' of general hospitals.

32. Candidates are drawn from three sources. Firstly from universities—men and women who are university graduates, secondly from administrative services (civil servants holding the baccalauréat and having worked at least three years in hospital employment or in the Ministry of Public Health), thirdly those with more than six years' experience working in hospitals or at the Ministry of Public Health as directeur, econome grade VI, econome, head of administrative services, secretary, head clerk, assistant econome, or assistant to the hospital staff (all minor posts but posts in which one can gain experience which helps to compensate for the lack of university qualification).

33. The competitive examinations are difficult. In a first written series the candidates must cover four subjects, administrative law, economic policy, hospital law and social legislation. Each of those papers lasts four hours, which gives a measure of their difficulty.

A second series of oral examinations awaits the candidates who have passed the first series. The most difficult test is a 20 minute interview with the examining body on a general sort of subject relating to the syllabus that we have mentioned in connection with the written examination. The confidence and soundness of the candidate are evaluated at this stage.

Afterwards comes the oral examination on knowledge of administrative law, on organization and working of hospitals and on the applied financial legislation.

34. No one can sit if he is over 30 years of age.

Nature of Selection

Like all selection by written examination this does not bring personal qualities to light. It rather concentrates its attention on the intellectual qualities, on presentation and on general knowledge.

This is, however, characteristic of all the recruitment examinations in French administration. The risk is greater in connection with the candidates who come directly from the universities. For the others who come from the hospital administrative service and from the public health service, their years of experience have acquainted them with the responsibility that they will have to assume. Those who do not like responsibility or who have no taste for a life in which one never ceases from taking grave decisions do not offer themselves as candidates. On the other hand those who have but recently graduated are ignorant of the way of life of hospital management. As far as these are concerned selection is more difficult.

On the subject of intellectual qualities and general knowledge the selection procedure is more straightforward. We look for candidates capable of arguing for the interests of their hospital against a prefect, a mayor and a management committee. We

want administrators capable of speaking to the doctors with appropriate confidence. The relationship between the doctors and the administration is always delicate, admittedly.

The building of university hospitals henceforth obliges us to select administrators capable of subsequently becoming general administrators of a standing which should make them into speakers whose word will be heeded by the dean of the medical faculties and by the professor of medicine. Such is the purpose of the examination in general culture and general knowledge.

The French hospitals are under the control of a shared authority rather than a single head. The directeur in order to formulate and carry out the sum total of the decisions and projects of the committee must be a cultivated and enlightened man able to express himself clearly verbally and in writing. The examinations are held with this in view.

N.B.—The detailed syllabus appeared in the Journal Officiel, 1st December 1960.

35. The examinations are annual. They begin generally at the end of spring, in April and May. The successful candidates are called 'administrative trainees' and are taught at the National College of Public Health. They take a year's theoretical and practical training there before taking up a post. They are paid on the scale of 'Directeur Econome Grade V' at a salary of about 800 NF (£60) per month. The annual examination is generally held for 30–35 places.

Training

36. The National College of Public Health organizes the training of the administrative trainees for a period of 12 months from which one must deduct an annual holiday of 30 days, leaving 11 months. This time is divided into two almost equal parts between theoretical instruction and practical instruction in actual working conditions.

37. The first two weeks are devoted to a period of induction in a medium sized hospital. The trainees are distributed in twos and threes among different hospitals chosen for their satisfactory standard and for the interest in training shown by their

administrators. After this the trainees have a theoretical training for 20 weeks, the syllabus for which we give below. This period is broken by two interruptions of a week in the course of which the trainees are sent out once more to hospitals other than those of their first attachment in order to acquire information on the questions on a list which has been given them. The first of these stages of training is particularly concerned with catering affairs; the other with general management, financial affairs and the 'prix de journée'.

38. At the end of the 20 weeks theory the trainees are put in a post of responsibility for 5 months. They are then sent on into the field and appointed by the Minister to a provisional post either as econome in hospitals where the posts of econome are vacant or as a supernumerary as deptuy directeur in hospitals where heavy work justifies additional administrative officers. They are paid by the establishment to which they are attached.

39. For the last four weeks of their training they return to the College to receive their final instruction in the form of discussion on actual case-studies that they have experienced during their training. They present papers to their colleagues and criticism of these papers allows for practical conclusions to be drawn.

Finally each trainee devotes the last ten days of these four weeks to delivering lecture-reports.

40. In fact from the first weeks of their training each of them has had to choose a subject for an original study, that is to say a question concerning hospitals and during the course of his training he studies it, gathering together material and documentation and composes an extended essay of 50–60 pages double spaced, or 1,500–2,000 lines of typescript, or in other words 15,000 to 20,000 words. The best reports are not the longest. The lecture-report consists of explaining the aims of the essay and in summarizing the salient idea. After which the members of the examining body supervising the report publicly criticise the work and ask the trainee to reply to these criticisms. Each member of the examining board puts questions (the board has five or six members). The other trainees attend these

sessions which often provide the opportunity for the administration to explain its position on matters in question. It is a very instructive period for the trainees.

41. After the lecture-reports the trainees submit a written paper to verify their knowledge—they have to draft a report on a practical problem that they might be called upon to deal with before their management committee.

42. Marks for their lecture-reports, extended essays, written examinations and working attachments are taken together for the purpose of arriving at a classification. Appointments will be made to posts after selection from the order of classification.

43. Subjects for theoretical instruction in the 20-week period are concerned with hospital affairs in their entirety. Considerable importance is attached to instruction in financial matters, in statistics and in book-keeping and accountancy which occupy at least 4 sessions per week. It is a 5-day working week. Lectures do not take place on Saturdays. There are 4 teaching sessions per day: 2 in the morning and 2 in the afternoon. Each session lasts $1\frac{1}{2}$ hours, the lecturer or discussion group leader taking about 45 minutes to give his address and stimulating discussion for the remaining 45 minutes. In principle, one half-day in each week is devoted to a visit to a hospital or a social or public health service. On the following day a session is given over to an assessment of the visit and to discussion. Apart from accountancy, subjects are concerned with the general organization of the public health service in France and elsewhere in the world; with social services and with hospital and social welfare law where it relates to hospitals. Following this comes instruction in hospital procedures in detail; hospitalization; out-patient treatment; medico-technical departments; casualty; dietetics; technical equipment and appliances; kitchens; laundries; hospital architecture; statutory conditions of work of the medical personnel, paramedical and ancillary staff.

A third series of lectures is devoted to a specific study of the principles of administration, of personnel management, of the duties of the econome; buying and receiving various supplies

through the open market or by contract; industrial activities of the hospital; principles of storekeeping; industrial psychology.

44. A small number of the lectures are given by the staff attached to the College. Most, however, are given by Ministry officials and by hospital personnel according to their particular abilities and their enthusiasm for the given topics.

Lectures in practical financial matters, statistics and accountancy are given by officials of the Ministry of Finance.

45. The supervision of training in the hospitals themselves is insured by a very close liaison between the directeurs of the designated hospitals and the College. An inspector from the College visits the hospital during the course of the long attachment and assesses the trainee's progress. He takes the opportunity of consulting about the preparation of his report, so as to enable him to avoid oversights and time-wasting.

46. *Appointment*

Upon leaving the College the trainees are given posts by the Minister which are in effect full working appointments. Therefore, if a trainee is unsuited in any way it is important that this should be discovered during the course of his stay at the College or at the time of his lecture-report and final examination.

47. *Cost of Training*

The cost of training is paid by the National College of Public Health which is an autonomous public body whose budget is supplementary to the Ministry of Health's own budget. The trainee's salary is paid partly by the College and partly by the hospital to which he is seconded during his 5 months' practical training experience.

After the final appointment the hospital in which the trainee becomes an actual directeur repays the College the proportion of his salary which it has paid.

As regards travelling expenses and various subsistence costs of the trainees when they are on their initial training period and

visits, they are repaid by the College as are the travelling expenses and fees of lecturers coming to speak from all parts of the country.

Since September 1962 the National College of Public Health has been established at Rennes in Brittany. It owns a new 120-room building there and includes a restaurant, conference rooms, administrative quarters and lecture rooms. All this makes the trainee's stay a comfortable one.

WESTERN GERMANY

by

DR. S. EICHHORN,

Manager, German Hospital Institute

THE HOSPITAL SERVICE

A. Population Statistics

The area of Western Germany without West Berlin numbered at 31st December 1960, 53·8 m. inhabitants. The ratio of males to females was 100:112. In an area of about 248,000 km² the population amounted to 217 inhabitants per km². Since 1950 (194 inhabitants per km²) population density has increased considerably. West Berlin at the same time had 2·2 m. inhabitants. The total population increase between 1950 (48·2 m.) and 1960 amounted to 5·6 m. or 11·6%. It consists of 51% increase in births and about 49% immigration increase. In 1960 there were 9·3 marriages, 17·7 births and 11·3 deaths for every 1,000 inhabitants. The infant mortality per 1,000 inhabitants amounted to 34 (i.e., died during the first year of life). Taking into account the births and deaths there is a total increase in births of 6·4 per 1,000 inhabitants. 9·4% of the population are children below the age of six, 12·1% are children from six to 14 years, 68% are persons of employable age from 15 to 65 years and 10·5% of the population are persons of 65 years and above. The number of old people beyond the age of 65 has constantly increased during the last decades. While it amounted in 1910 only to 5% of the total population, it reached 7·8% in 1939, 9·3% in 1950 and finally 10·5% in 1960 (men 9·2%, women 11·7%). According to the estimates of the probable population development it is reckoned that the number of old people will amount to 15% by 1980. Employed persons account for up to about 50% (men 64·1% and women 33·8%).

B. Organization and Administration of the Health and Hospital Service

The German Federal Republic is a federative government. In the field of the health service all executive power is assigned

to the 'Länder'. The Federal Republic is only in charge of legislation as far as the following tasks are concerned:

measures against diseases of human beings and animals either infectious or dangerous to the public,
permission for medical or other healing professions,
control of medicines, drugs, anaesthetics and poisons,
protection in handling food, semi-luxuries and necessaries,
public welfare, including the public health service.

It is the Health Ministry which is responsible for the health service for the Federal Government. Furthermore at the federal level there is the Federal Board of Health which particularly carries out research work in the field of public health service and provides additional statistical data. The Federal Health Council, which is composed of 50 non-professional members of scientific and professional associations, local institutions for public welfare, etc., assists the Federal Government in drafting health acts.

In the 'Lands' (Länder) the interests of the health service are in each case taken care of by a central board of the health administration. The health departments of the 'Lands' are directed by a Chief Medical Health Officer, who is in the case of the City States (West Berlin, Bremen and Hamburg) directly subordinated to the Senator for the Health Service and in the other 'Lands' to the responsible Minister. The central Land board prepares the Land Acts, gives instructions as to their execution and ensures that they are carried out in accordance with the law.

The local boards of health are affiliated to the city and rural districts, and are the lowest administration authorities. The boards of health are under a medical health officer. He is in charge of the following medical tasks: health of the police, public health instruction, school health service, mother and child consultation, care of tuberculosis, venereal, physically handicapped, chronic sick and addicted persons. To these duties may be added further voluntary tasks in the field of public health service. As part of their compulsory duties, the boards of health also supervise all hospitals. In most of the 'Lands' the supervision of the local boards of health is not the

direct responsibility of the medical health officer of the 'Land', but of the Department of Health Service of the President of the administrative district.

The character, organization and structure of the ambulant and hospital services are determined by the so-called 'social insurance'. The social insurance is a special form of social security—in which insurance principles and the needs for social adjustments are brought together. A further distinguishing mark of the social insurance is its compulsory character. It arises from the social insurance acts of 1881 and includes health insurance, accident insurance, pension insurance, unemployment insurance and unemployment relief, children's allowance and pension insurance of farmers.

The body responsible for the health insurance—which is our prime concern here—is the health insurance fund and also the 'Land' insurance institutions in respect of those tasks which are executed jointly for the district of a 'Land' (insanity, tuberculosis). The German health insurance is based upon compulsory insurance. Subject to obligatory insurance are all labourers and employees and certain independent persons engaged in gainful activity if their regular annual salaries or wages do not exceed DM. 7,920—also widows entitled to pension, widowers and orphans. Under certain preconditions a voluntary insurance with the legal health insurance or a voluntary continuation of insurance of persons who are no longer liable is possible. Including the family-members who participate in the insurance the social health insurance includes approximately 80% of the population of the Federal Republic.

The right of the insured to ambulant medical treatment is guaranteed by the health insurance through qualified medical practitioners and dentists. Apart from treatment in urgent cases not all qualified medical practitioners are admitted to ambulant treatment of the insured, but only those who are granted a licence by so-called 'licensing committees'. In total, there are in the Federal Republic about 74,600 employed physicians (as well as 30,600 employed dentists), 44,500 of whom are general practitioners and about 30,100 are specialists. About 46,700 physicians are self-employed persons and about 21,450 are full-time employees of hospitals. About 7,150

of the self-employed physicians have a part-time employment in hospitals. Some 44,263 of the self-employed physicians (approx. 60%) are permitted to give ambulatory medical treatment to panel patients. Although the provision of hospital treatment is according to legal provisions a permissive performance, in practice the insured claim it as a right. The health insurances grant their insured persons hospital treatment in hospitals of their own choice. As a rule the health insurances conclude general contracts with the hospitals. The charges of the hospitals, agreed upon in these contracts, are paid by the health insurances directly to the hospitals instead of being reimbursed to the insured persons.

There is no legal obligation in the Federal Republic for the provision of hospitals. Such obligations are only in part incorporated in some of the 'Land' acts. However, there are special regulations for the provision of epidemic beds. Thus there is only a limited amount of compulsory construction of hospitals. The local authorities are only on account of regulations regarding the control of contagious diseases obliged to provide hospital beds. The social insurance institutions have to provide for hospital beds for the medical treatment of casualties. For the treatment and nursing of indigent and psychopathic persons and cripples the 'Land' welfare organizations have to provide the appropriate accommodation.

The establishment of general hospital beds is preponderately left to the local authorities, the local authority organizations and to non-profit organizations. To a larger extent than in most other countries the hospital beds in Western Germany are supported by non-profit organizations. The public hospitals are mainly in the hands of local authorities (districts and towns).

The 'Lands' confine themselves to the provision of psychiatric and cripple beds, while the Federal Republic only provides hospitals for disabled ex-servicemen. The interest of the social insurance institutions in public hospitals is only important in case of tuberculosis-hospitals. The burden of general hospitals is borne by various bodies. For example, hospitals are run among others by religious communities, parishes, ecclesiastical

and secular communities. Those carrying responsibility for private hospitals are mostly members of the medical profession.

The public and voluntary hospitals do not require any government licence, since they are not business enterprises. Private hospitals need a licence, which is granted to the owner personally. All hospitals, regardless of their kind, are subject to governmental supervision. The latter is executed by the boards of health. Psychiatric hospitals are subject to special supervision. However, the medical health officers have no material influence upon the working of the hospitals, except for general police interests in case of danger.

C. The Existing Hospital Resources

1. HOSPITALS, HOSPITAL BEDS, HOSPITAL INSTITUTIONS

The number of hospitals in Western Germany without West Berlin amounts to 3,451 with a total of 553,424 hospital beds. Thus the rate of hospital beds per 1,000 inhabitants amounts to 10·4. This ratio of hospital beds varies between 8·6 in Bremen and 11·2 in Bavaria. Still greater are the regional differences of the number of hospital beds within the various 'Lands'. These regional differences in the number of hospital beds available, however, do not permit the drawing of any definite conclusion as to a regional variation of requirement for hospitals, since it has to be taken into account that some of the hospitals are of more than local importance (university hospitals, larger municipal hospitals, above all special hospitals, such as tuberculosis sanatoria and nursing homes). Through the superimposition of the various catchment areas, the regional differences in the total amount of beds are partly balanced, mainly within the various 'Lands'.

Fifty-six per cent of all hospital beds are in public hospitals, 37% in voluntary hospitals and 7% in private hospitals. The number of hospital beds in public hospitals reduced somewhat during the past few years, whereas the number of hospital beds in voluntary hospitals and in private hospitals increased. Statements as to the breakdown of hospital beds available among the larger groups of hospital institutions in Western Germany do not exist. Table 1 shows the breakdown of

hospitals and hospital beds per hospital institution in North-Rhine-Westfalia as on 31st December 1955. Table 2 gives a survey of the classification of hospitals as to working capacity. According to table 2 the point of main emphasis is on hospitals of 100 to 200 beds (19·9%). They are followed by hospitals of 200 to 300 beds (14·1%) and by hospitals with 300 to 400 beds (10·4%). 18·1% of all beds are in hospitals with more than 1,000 beds (university hospitals, larger municipal hospitals, tuberculosis sanatoria, mental hospitals and homes, etc.). As regards public hospitals 46·6% of all hospital beds are in hospitals with 500 and more beds. With voluntary hospitals the concentration lies with hospitals of the largest class, of 400 beds (72·1% of all hospital beds). 66·1% of all private beds are in hospitals up to 100 beds. The interesting point is that against previous years the number of beds in smaller hospitals decreased and in larger ones increased. The most outstanding thing of all is the increase in the number of beds in hospitals of 200 to 500 beds.

2. REQUIREMENTS AND OBJECTIVES OF HOSPITALS

52·5% of all hospitals in Western Germany are general hospitals. They unite in each case several special departments (surgery, internal medicine, gynaecology/maternity, and departments for throat, nose, ear and eye diseases, etc.). The special hospitals (also designated nursing-home, asylum and sanatorium) account for 47·5%. They are either specialized in the treatment of certain kinds of diseases or groups of kinds of diseases (surgical hospital, lying-in hospital, orthopaedic hospital) or in special ways of treatment (observation hospitals, sanatoria). In terms of beds the proportion is as follows: general hospitals 58·5%, special hospitals 41·5%. Table 3 shows the breakdown of hospitals according to their classification (medical-nursing objects).

As to questions of hospital bed requirements, the regional distribution of beds available, the bodies or institutions responsible for hospitals and payment it is usual to distinguish between hospital beds for the so-called 'general hospital service' and the so-called 'special hospital service'. Hereby the hospital beds for tuberculous persons, cripples, psychiatric persons, and

addicts, as well as those for chronic diseases rank amongst special hospital service. They are characterized by the fact that they have a predominantly long average stay period and are as a rule of great supra-regional importance. The bed-ratio for the special hospital service amounts to 3·2 per 1,000. Any other hospital beds in general and special hospitals class as general hospital service. These hospitals are characterized by a predominantly short average stay period and are mostly of limited regional importance. The bed-ratio for the general hospital service comes to 7·2 per 1,000 population. Statements as to the number of beds for the various medical specialties for the total area of the Federal Republic do not exist, but only for individual 'Lands'. For the 'Land' North-Rhine-Westfalia the number of beds per medical specialty is given in table 4.

3. PERFORMANCES OF HOSPITALS

Approximately 7·0 m. in-patients were given treatment in 1960 and the nursing days amounted to about 188·6 m. For each 1,000 inhabitants there are some 131 patient-admissions and some 3,500 hospital days. Every hospital bed on average has been occupied for 339 days, the average occupancy thus came up to 92·9%, the average stay period being 28·3 days. The high average value for the stay period is due to the very long stay period in some special departments (particularly tuberculosis, psychiatry and orthopaedics). The general hospital service shows an average stay period of about 21 days. Studies as to the stay period revealed that the length of the patient's stay in hospital is not only determined by medical reasons. The age of the patient, the sex and question of accommodation (single persons stay normally longer) are in this context of considerable importance. Of further significance is the question, whether the patients themselves have to pay for their stay in hospitals or whether the social health insurance takes over the costs (self-paying people on an average stay a shorter time). The number of patients treated under the general hospital service on a Federal average amounts to 110 per 1,000 inhabitants. This number has constantly increased during the past years (1949: approx. 103).

4. HOSPITAL STAFF

The hospitals of the Federal Republic employ about 21,450 full-time physicians and about 7,150 part-time physicians. Furthermore there are about 350 auditing and unpaid physicians as well as about 3,050 medical assistants. The number of nursing employees totals 100,665 plus 23,253 nurses in training. According to the object and size of the hospital the number of employees in the individual hospital varies considerably. For the most important groups of personnel the situation is as follows: The number of patients attended by one physician fluctuates between 12 and 30. The number of patients to be cared for by one nursing employee fluctuates between three and five. The number of hospital beds per one orderly varies between nine and 12. The number of beds as per administrative employee varies between 20 and 35. The number of patients per one employee of the kitchen personnel varies between 25 and 40. The output of labour of the laundry personnel fluctuates between 40 and 60 kg. dry-wash per each employee per day. The relation of the total employees to the patients to be cared for fluctuates approximately between 0·8 and 2·0. Table 5 shows a survey of the average monthly salaries for the most important groups of personnel.

5. ORGANIZATION AND MANAGEMENT OF HOSPITALS

The management of the hospital is the responsibility of the board of management which is composed of the medical director, the matron and the director of administration. The full-time employed physicians are in charge of the medical service. Only 848 hospitals within Western Germany are so-called 'Beleg' Hospitals, in which self-employed physicians attend their patients without being responsible for the technical and economic organization of the hospital. Every special medical department is directed by a leading physician. One of the leading departmental physicians acts at the same time as a medical director of the hospital with the task of general medical supervision in medical-hygienic matters. The subordinated medical service is performed by full-time senior physicians and medical residents. Furthermore there are so-called medical assistants, who after finishing their studies work in hospitals until they

acquire the qualification of a physician (two years). The conduct of the nursing service is in the hands of the hospital matron. The matron nowadays mostly has a one-year's special training course at a nursing college. The nursing service as a rule is so organized that small groups of patients (14 to 17 persons) are to be looked after by one nursing team (staff nurses, practical nurses and student nurses). Several such nursing teams (if possible all nursing teams of one medical department) are combined organizationally and are subject to the control of a head nurse. Head nurses must also be trained at a nursing college. The nurse-training lasts three years, and is executed in nursing schools recognized by the government, which are attached to the hospitals. The training is concluded with a governmental examination. Besides the staff nurses there are auxiliary nursing personnel, so-called practical nurses and nursing aids with a different general background and training. The training of these persons as a rule lasts one year. The administrative management of the hospital lies with the director of administration.

6. COSTS AND FINANCING OF HOSPITAL MANAGEMENT

Exact statements as to the financial economy of hospitals in Western Germany are not available—neither as to total expenditure nor as to turnover, nor as to fixed assets. Only the expenditure of the social health insurance for hospital services and stay at a spa is known. Expenditure for some 60·4 m. patient days amounted in 1960 to approximately 1·57 milliards, as against a corresponding cost of about DM 440 m. in 1950, an increase of about 270%. According to the medical-nursing needs of the hospitals the costs per patient day vary between DM 20 and DM 40. Taking an average value of DM 25 as a basis, the result is an annual turnover in the hospitals of DM 4·7 milliards.

About 50 to 55% of the operating costs are in respect of personnel. The cost of material goods (medical requirements, food, water, power, laundry requirements, other requirements and administrative requirements) amount to about 30 to 35% of the operating costs. Of these, the cost of food, about 10 to

19%, is of great weight. This is followed by medical requirements with 8 to 12%. About 15 to 18% of the total costs are in respect of costs of depreciation and maintenance. The costs of financing amount to 1 to 2%. During the past years the costs of the hospitals increased considerably, some above 100%. Particularly striking is the large increase in salaries and wages and the increase in costs of medical requirements (intensification of treatment and nursing—shortening of the stay period).

The individual costs making the total cost thereby varied to some extent, but the sequence of the individual costs, however, hardly changed. For about 80% of the population associated with social insurance, the social health insurances take over the costs for the hospital stay. About 10% of the population has a legal claim of another kind to medical treatment (e.g., public welfare, armed forces, etc.). The remaining 10% are self-paying persons, i.e., they have to bear the costs for hospital treatment themselves. The larger part of these patients belongs to private health insurances. The social health insurances take over the costs of hospital stay for 78 weeks. If necessitated through the financial position of the patient, the public welfare bears the hospital costs after termination of this period.

Apart from the self-paying private patients (6 to 8% of all patients), the daily charges (charge per day per patient) are price-controlled by means of legal regulations. According to the 'Federal Government Hospital Costs Regulation' of 31st August 1954, the determining of the daily charges (for all patients except for the self-paying private patients) has to be based upon the costs within the meaning of this regulation. But the 'regulation prime costs' differ from the actual prime costs for the purpose of price calculation. Neither the interest on borrowed capital nor depreciation may fully be taken into account. The difference between the actual costs and the returns resulting from daily charges is covered by means of unsystematic contributions of the owners or public authorities, as well as by means of private contributions or through withdrawals from the hospitals' real assets. This considerable gap in the current financing of hospitals is still further aggravated by two factors. On the one hand the social insurances may argue that they, with regard to their difficult financial position,

are not in a position to reimburse the hospitals the 'regulation costs'. On the other hand the valid daily charges of the current accounting period are based upon the actual costs of the last accounting period, very often even the preceding one, which are in part as a result of the upward trend of prices considerably below the real costs. The most important difference to the actual costs, however, is due to the fact that the usually paid public contributions, i.e., such as those fixed by parliamentary bodies and shown in the regular public budgets, may not be considered in the prime cost calculation of the hospitals. This regulation is in particular a heavy burden for the municipal hospitals. At present there are three proposals for the termination of the financial difficulties of the hospitals under discussion:

1. Full cover of costs through the daily charges and an increase in the health insurance contribution.

2. Full cover of costs through the daily charges, constant health insurance contributions, with financial support of the health insurances through subsidies from the Federal Government.

3. Division of the daily charges; reimbursement of the current operating costs through the health insurance, and reimbursement of depreciation, maintenance and interest charges through the government.

The hospitals claim full reimbursement of the prime costs through the daily charges, since they fear that if they accept a part of the daily maintenance rate as such from the State, the government will exert its influence on the management of the hospitals who would thus lose their independence.

7. HOSPITAL PLANNING

Adhering to the principle of voluntary self-help there is no governmental planning in Western Germany for the operation and construction of hospitals. The planning is up to the individual hospital and to the regional planning groups of several hospitals. Any new planning of a hospital is as a rule preceded by an estimate of the future demand for hospital beds. The studies necessary comprise mainly the catchment areas for any planned medical specialty, the ascertainment of beds available,

and otherwise planned additional hospital beds, the number and kind of hospital cases to be expected, the probable duration of the in-patient stay and the minimum, optimum and maximum of the future bed-occupation. A number of further factors influences the result of the estimate, among other things migration and immigration, the age structure, the social and industrial structure, the traffic conditions, the housing conditions and the frequency of accidents. Due to medical, nursing and economic reasons it is necessary to graduate the total number of beds available according to the demand. On a lower level hospital beds are available for the kind of treatment which can be spread over a large region. Moreover on a central level those beds that do not allow a wide dispersal must be available. On the upper level special beds and equipment have to be provided which are used relatively seldom and which therefore have, out of medical, nursing and economic reasons, to be centralized. The density of this network of hospitals with different requirements has to be in conformity with the population density and the traffic connections. On account of this graduation the following types of general hospital developed:

Minimum service: Comprising at least the following main services (directed by a full-time hospital physician): surgery and medical department and starting with a minimum of 120 beds.

Basic service: Comprising additionally as subsidiary services (looked after by a part-time employed independent physician) gynaecology and obstetrics, throat, nose, ear and eye diseases. The minimum number of beds is around 200.

Regular service: Its minimum requirement is surgical and medical departments, gynaecology, obstetrics, as well as paediatrics, as main subjects, and as subsidiary facilities throat, nose, ear and eye diseases, special technical equipment and personnel aid such as radiologist service, with extra beds and full pharmacy. The minimum number of beds is about 400.

Central service: As against the regular service it is supplemented by the main subjects of urology and neurology, with a total

of 600 beds, furthermore by additional technical equipment such as special laboratories and pathology.

Maximum service: Comprises all, or at least a great number of general specialties as main departments, furthermore all technical equipment and personnel with a minimum number of about 1,000 beds.

Besides, there are the small hospitals with less than 120 beds for an additional service. Special hospitals are according to their objects, size and structure as the case may be associated with one of these six types.

The voluntary conformity and classification of the various hospitals into this network of general hospital service is supervised and supported by the government, subsidising the construction of hospitals with public funds (contributions by the 'Lands' amount to 30 to 70% of the total building costs). In case of financial applications, the health authorities as a rule examine the question of requirement and the suitability in relation to the whole network of hospital service.

The individual construction of a hospital is as a rule methodically and intensively planned. Members of the planning team are: hospital management, architect, physicians, hospital nurses, hospital consultants and special technicians. Planning and building of a hospital comprises the following steps:

1. Ascertainment of bed requirements.
2. Determination of the medical nursing objects (number and size of the medical departments and treatment equipment).
3. Drawing up of a working programme (performances, staff problems, division of work, working process, places of work).
4. Setting out the building programme (functional continuity, functional space co-ordination, accommodation, requirement *re* site area, working spaces and room areas).
5. Planning the hospital building.
6. Execution of the hospital building.
7. Opening.

8. BUILDING HOSPITALS

Within Western Germany, in order to concentrate treatment facilities and on grounds of economy, hospitals are reverting from the pavilion building method back to the block building method. The block building is at present constructed in T-form, Y-form, H-form or in comb form. The hospital establishments are constructionally divided into a nursing, a treatment and a supply section plus a personnel accommodation section and if the occasion arises establishments for teaching, research work, and extra services. The basic constructional conception of hospitals now prevailing is that the wards and the corresponding treatment facilities are combined horizontally (for instance beds of the surgical department on the same floor as operating rooms, surgical out-patient department, central sterilization, etc.). In order to meet the varied requirements of functional continuity and of the dissimilar corridors in the nursing and treatment section, nowadays the two-floor system is largely chosen for the ward block as well as treatment block. Whereas in the treatment section, lighting and ventilation are mostly artificial, it is preferred to solve the lighting and ventilation problems in the wards by means of large interior courts. Altogether one endeavours in planning a hospital to provide all the prerequisites as regards the building, the equipment and furnishings for an efficient hospital service, i.e., to give the best possible service to the patient, to limit expenditure and to give favourable working conditions for staff. With the development of the modern hospital service, the building costs for hospitals have risen steeply. The space necessary per bed fluctuates at present between 140 and 220 cubic metres interior space per bed, the building costs between DM 140 and 200 per cubic meter interior space. To this according to requirements is added 15 to 25% for the cost of equipment and furnishings and about 10 to 15% incidental expenses. Thus the building costs per hospital bed, without the costs for the site and the opening up, vary at present between DM 30,000 and 65,000. About 55% of the total costs fall to the nursing section, 30% to the treatment section and 15% to the supply section (excluding staff accommodation, facilities for teaching and research work). The hospital beds are mainly financed through contributions '*a fonds*

perdu' of the government, to some extent through own funds, through loans at a reduced rate of interest granted by the government or private persons, through other borrowed capital or private contributions. The present relation of building and working costs is that the current working costs reach the initial investment costs after about three to five years. This circumstance justifies the effort to save current working costs by additional capital expenditure, for instance through mechanization of transport, through the use of labour-saving devices, through the centralization of all supply services, etc. A reduction of the running costs of DM 300, per bed and year (DM 1 per patient day) would in a 50-year period balance a larger capital investment of about DM 4,900 per bed.

When planning and building hospitals the general legal provisions (technical building provisions, DIN-standards, provisions of professional organizations) have to be observed. Furthermore minimum requirements for hospitals are prescribed by police regulations, or regulations as to the design, building and fittings of hospitals, which differ within the various 'Lands'. Above all they relate to the position of the site, the total layout, the nursing units, traffic questions, the lavatories, the supply facilities, the removal of sewage, etc. Additional regulations exist furthermore for surgical departments, lying-in departments, children's departments, infectious diseases departments, tuberculosis departments, chronic patients' departments as well as departments for neurotic and mentally ill persons.

D. Hospital Administration

1. TASKS

Administration, management and supplies for the hospital are the responsibility of the hospital administrator. As per spheres of operation they are classified as follows:

1. Reception: information, telephone service.

2. Registration: acceptance and transmitting of particulars about patients, ascertaining of the person liable for payment, cost protection.

3. Booking office: acceptance and execution of payments.

4. Accounting office: registration, compiling and payment for patients' treatment.

5. Book-keeping office: financial and operating book-keeping control, audit, statistics.

6. Personnel department: staff records, wages and salaries.

7. Supply department: ordering, purchasing and administration of stocks, stock control.

8. Business management: supervision and control of all business activities of the hospital, planning and organization.

The management of the hospital administration is the responsibility of the so-called administration manager, who in larger hospitals is also called director of administration. One departmental head is in charge of one or several spheres of operation. In the past the hospital administration has seen its main task in the administration of the assets of the hospital, in registering receipts and expenditure, in purchasing and keeping records. With the development of the hospital to a complicated operating organization, the task of hospital administration further developed along managerial lines. Nowadays planning, organization and control of operating activities are the main task of the hospital administration including co-ordinating the works and spheres of activity of the nursing, treatment and supply sections with the officer in charge of the respective services (medical service, nursing service, supply service). The registration in terms of figures, the description and the control of all activities is the task of the accounting department, which by the recording of receipts and expenditure has developed as a decisive tool of management.

This change of the character of hospital administration is still in an elementary stage. Above all in establishments, where the administration manager mastered the tasks from the point of view of his general background and personality, it was possible to transform mere hospital administration into real hospital management.

2. TRAINING OF ADMINISTRATION MANAGERS

The general background of the administration managers was quite different in the past. Partly they came from the public service, partly from industry. In the first case they had an administrative training, in the second a commercial training. During the past few years, however, the hospital authorities have been led to believe that the position of an administration manager depends upon special knowledge of the science of business management, upon technical and medical knowledge and thus upon a special general background. Moreover they found that it cannot be a matter of chance to find the proper personality for this position. Thus for a couple of years endeavours have been made to systematize the training of hospital administrators. There are two possibilities:

1. Theoretical training of younger experienced members of the hospital staff at a university seminar.

The 'Deutsche Krankenhausinstitut e. V.' and the Seminar for Social Policy at the University of Cologne run a two-year course for hospital administration. For this purpose the participants come four times for a period of four to five weeks to the University of Cologne, in order to become acquainted by means of lectures, seminars and exercises with the basic facts of the science of hospital management, of economics, of business financing, of jurisprudence, of medicine, of building and of technology. In the meantime special practical work and written exercises have to be executed. The total number of lectures and seminar lessons within the two years amounts to about 480, 270 of which comprise the science of business management, 70 economics and business finance, 90 jurisprudence and 50 medicine, building and technology.

2. Theoretical training on university lines and practical training of university graduates (economists, jurists, physicians).

The hospital authorities are aware of the fact that in view of the manifold tasks of hospital administration—mainly in larger hospitals—a university training is desirable for the future hospital administrator. Therefore one envisages that, immediately after having finished their studies, university

graduates (experts on business management, jurists, physicians) would be made acquainted by means of lectures, seminars and exercises at Cologne University, with the special problems and questions of hospitals. Moreover these applicants for hospital administration would gather experience in especially chosen and appropriate training hospitals as management assistants. Also these applicants for hospital management would undertake a larger (scientific or practical) work in the hospital field. The total training term is of about three years. This second, however, very important way, to regulate the general background and training of hospital administrators, is up to the present only in a state of planning and testing.

E. Development Tendencies of the Hospital System

Seen from the present situation the following development tendencies for the German hospitals may be recognized:

1. PRESERVATION OF DECENTRALIZED ADMINISTRATION OF GERMAN HOSPITALS

The present structure, according to which the hospital service is no concern of the government, but a task of voluntary self-help, is to be preserved at all events.

2. SATISFACTORY SETTLEMENT OF THE QUESTION OF FINANCING THE WORKING OF HOSPITALS

Since it is generally accepted that the costs of hospitals have to be reimbursed, a reasonable way for the raising of the necessary funds has to be found, which is acceptable both to the hospitals and the health insurances.

3. INTENSIFICATION OF REGIONAL HOSPITAL PLANNING

The individual hospital authorities need to work more closely together than hitherto to form regional planning groups, in order to shape the structure of hospital beds available in an optimum way.

4. INTENSIFICATION OF OPERATIONAL PLANNING OF THE HOSPITAL

The previous endeavours for a strict planning, organization and control of all hospital activities should be intensified.

5. FUNCTIONAL ADJUSTMENT OF HOSPITAL BUILDING

Still more than up to now hospital building should be adjusted to the operational requirements of the hospital.

6. INTENSIFICATION AND SYSTEMATIZATION OF THE TRAINING OF HOSPITAL PERSONNEL, ABOVE ALL FOR HOSPITAL MANAGEMENT

The hitherto rather unsystematic endeavours of individual professional associations as to the training of hospital personnel should be systematized and intensified. Above all instructions and uniform arrangements should be provided for the leading hospital professions (medical director, administrator, matron).

Table 1. The hospitals in North-Rhine-Westfalia according to hospital institutions (1955)

Institutions	*Hospitals*			*Hospital beds*		
	Number	%	%	*Number*	%	%
Public Hospitals	163	100	20·4	61,085	100	37·2
Towns	28	17·2		15,867	25·9	
County Municipalities	45	27·6		6,303	10·3	
Rural Districts	18	11·0		3,873	6·3	
Landschaft Associations	27	16·6		20,178	33·0	
Other Municipal Administrative Associations	5	3·0		1,687	2·8	
'Lands'	11	6·8		5,266	8·7	
Land Insurance Institution	14	8·6		2,796	4·6	
Other (e.g., Professional Associations)	15	9·2		5,115	8·4	
Voluntary Hospitals	558	100	70·2	100,716	100	61·6
Caritas (a charitable institution)	439	78·7		72,989	72·9	
Home Mission	92	16·5		23,935	23·9	
German Red Cross	8	1·4		697	0·7	
Other	19	3·4		3,095	30·9	
Private Hospitals	75	—	9·4	2,514	—	1·6
North-Rhine-Westfalia in total	796	—	100	164,315	—	100

Table 2. Hospitals and Hospital Beds According to the Operational Size (1960)

Size of Hospitals as per Number of Hospital Beds	*Hospitals Number*	*Hospital beds as planned— Number*	*Hospital beds as planned— %*
— 25	483	6,840	1·2
25— 50	627	22,520	4·1
50— 100	780	54,640	9·9
100— 150	480	57,067	10·3
150— 200	304	52,916	9·6
200— 300	327	78,247	14·1
300— 400	169	57,316	10·4
400— 500	92	40,534	7·3
500— 600	47	25,678	4·6
600— 800	41	27,314	4·9
800—1,000	35	30,448	5·5
1,000—and above	66	99,904	18·1
Total	3,451	553,424	100

Table 3. Hospitals and Hospital Beds According to Classification (1960)

Purpose Determination	*Hospitals*	*Hospital beds*
General Hospitals	1,823	324,188
Hospitals for General Medicine	122	12,256
Hospitals for Infectious Diseases	4	245
Babies' and Children's Hospitals	77	11,430
Tuberculosis Hospitals	268	38,651
Surgical Hospitals	172	11,324
Orthopaedic Hospitals	39	4,678
Gynaecological Hospitals/Maternity Hospitals	170	8,416
Lying-in Hospitals	38	363
Mental Hospitals and Homes	76	68,067
Psychiatric Hospitals	51	23,284
Neurological Hospitals	19	1,676
Hospitals for		
Addicts	6	756
Throat-Nose-Ear-Diseases	40	897
Eye Diseases	45	1,743
Skin and Venereal Diseases	13	1,313
Roentgenology	8	369
Chronic Diseases	20	4,103
Sanatoria	382	32,059
Other Special Hospitals	40	5,377
Prison Hospitals	38	2,229
Total	3,451	553,424

Table 4. Bed Rates (Hospital beds per 1,000 inhabitants) according to special Medical Departments in North-Rhine-Westfalia (1960)

Specialty	*Number of beds per 1,000 Inhabitants*
General Beds	0·5
Surgery	2·0
General Medicine	1·9
Infectious Diseases	0·3
Skin and Venereal Diseases	0·1
Gynaecology/Maternity	0·8
Babies and Children	0·5
Psychiatry/Neurology	2·0
Throat/Nose/Ear	0·2
Eyes	0·1
Urology	0·1
Roentgenology	0·04
Other*	0·1
Total	8·64

*Among others beds for silicosis patients, dentistry, orthodontics, sanatoria, prison hospitals.

Table 5. Summary of Average Monthly Salaries of Hospital Personnel

Professional group	*Salary in DM*
Chief Physicians	2,050
Head Physicians	1,750
Medical Residents	1,350
Matrons	900
Probationers	580
Nurses	550
Nursing Helps	480
Midwives	650
Medical-technical Assistants (female)	620
Gymnasts/Masseuses/Bath Attendants	550
Supply Manager/Kitchen Manager	1,000
Cooks	750
Dietitians	650
House-maids	450
Administration Manager	1,400

ITALY

by

PROFESSOR FELICIANO BENVENUTI

Professor of Administrative Law in the Catholic University of Milan

THE STRUCTURE OF ITALIAN HOSPITAL ORGANIZATION; DEVELOPMENT AND CONTEMPORARY PROBLEMS

1. In Italy the present organization of hospitals is not uniform: in spite of some reforms the present structure results from a group of institutions which were founded one after the other at different times and with different purposes, and which, for the most part, have maintained unaltered their fundamental characteristics.

Hospital organization is based on local public bodies called 'Charitable and Public Assistance Institutions'; in modern terms this might be called 'nationalization' of hospital services, hospitals previously having been either private or religious institutions.

In the beginning hospital assistance had been undertaken by the Church or by private associations which had collected all legacies bequeathed by wealthy citizens for the care of the sick and needy in their areas.

The technical idea of the hospital as it is today, did not exist and hospital activity was concentrated largely on medical treatment and assistance for the sick and needy.

Thus hospitals, as general medical care institutions, were subordinate to 'Charitable Institutions' and there the part played by the Church was paramount.

The law of 17th July 1890, no. 6972 (the bill was presented to Parliament by the then president of the Council of Ministers, Francesco Crispi) converted the previous Charitable Institutions into public bodies. The administration of these bodies was entrusted either to the 'Charity Congregations' then existing (which were a kind of committee of citizens concerned with public charity in general) or else to boards already provided for under the 'statutes'.

Therefore, each hospital came under the control of local public bodies. Nevertheless the fundamental distinction was maintained between the 'Charity Institutions' as the administrative bodies and 'Hospitals' as the administered institutions providing medical services. Because of this distinction the Government has been empowered by the law of 1890 to amalgamate the various charity institutions, which were often too small to be economically or technically efficient. In practice, State intervention was extremely limited because of the difficulty of amalgamating not only the charity institutions, but even the hospitals. In addition to these technical and economic reasons, there were political and administrative obstacles which were difficult to overcome.

The above mentioned law of 1890, with a few modifications introduced in 1923, is still the fundamental law governing the administration of the funds of charitable institutions. This allows the development of hospital activities, the functioning of the administrative agencies and the State supervision of these authorities.

The organization of hospitals however (as a complex of technical and medical services) for the admittance and medical assistance of sick persons (whether poor or not) is governed by the Royal Decree, 30th September 1938, no. 1631, which lays down the general rules for the medical services and the staff of the hospitals, excepting those engaged in the administration.

This law, which led to the classification of hospitals under the control of all kinds of public bodies, including those under the control of local assistance and charitable institutions, detailed the standards to which every hospital had to conform in order to meet hygienic and technical requirements. The same law made a distinction between general and specialized hospitals, the former divided into three categories according to the number of patients, and made subject to certain compulsory regulations; each hospital unit was then divided into departments for which a maximum and a minimum number of beds was fixed.

The same law regulated the selection standards for hospital physicians, and also their tasks, rights and duties. A medical

director was appointed as the technical co-ordinator for each hospital. In each hospital department a chain of command was set up. At the top is a chief physician (responsible for all his department services) followed by his assistants and nursing staff.

Thus, although the various types of hospitals, many of them of long standing, were kept and continued to be governed by their statutes as regard the administration of their funds and the appointment of their boards, their administration is now regulated by certain fundamental rules, one of which provides for unified State control (these rules are contained in the law of 1890). The standards of medical and technical services, however, were made uniform by the decree of 1938.

In this way satisfactory results were achieved: a pluralist structure was efficiently allied to administrative uniformity and equality of services; local communities were given the assurance that their hospitals were democratically organized, while over-centralization, that would have made hospitals top-heavy and deprived them of initiative, was avoided.

On the other hand, the uniform regulation of hospital services which applies to any public body managing hospitals was extended to new hospitals of the great social insurance bodies. Indeed, sanatoria, set up by INPS (the National Institute for old-age pensions and TB insurance) the traumatological hospitals run by INAIL (the National Institute for Industrial Accidents Insurance), the medical services organized by INAM (the National Institute for Health Insurance), were adapted to the same principles as the hospitals managed by the local Charitable Institutions.

Only two fields of activity have been omitted from the system: first, psychiatric hospitals which exist in all provinces and which are subordinate to the provincial administration on the basis of general principles laid down by the law of 14th February 1904, no. 36 and homes for abandoned children, which also come under the authority of the provinces; secondly, university clinics which, when they do not rely on agreements with local hospitals, are governed by the principles laid down in the laws concerning the universities.

To sum up, hospital organization in Italy is dependent either on local *ad hoc* bodies (Charitable Institutions) or on the provinces and social insurance institutions. Uniformity is guaranteed—for the first group both by the law of 1890 as regards the administration and by the decree of 1938 as to medical practice, and for the second group either by special laws (lunatic asylums, homes for abandoned children, universities) or by the same decree of 1938.

2. Here it is important to explain the purpose of these hospital organizations.

It has already been said that formerly charitable institutions aimed at helping the sick and needy and, indeed, even today the law defines as a charitable institution any body whose partial or total aim is to give assistance to the poor.

Following from this, even charitable institutions that offer hospital care are bound to admit poor patients free of charge; but this is no longer one of the most important purposes of hospitals and not even they are obliged today—except in special cases—to give free assistance to the poor.

As regards the latter, the same law of 1890 established what was called the 'assistance by place of residence'; that is, the 'commune', or official district of residence of the poor persons concerned, had to be identified and was made responsible for the cost of medical treatment and other expenses sustained by a charitable institution.

In fact, the duty of hospitals to give free assistance and treatment to needy persons concerns only cases of serious illness, when the patient has no right to 'assistance by place of residence' or to insurance sickness benefit.

Thus we have come to a subject which, at this moment, is much talked about in Italy: that of the relations between hospitals, 'communes' and the insurance organizations with regard to hospital expenses.

In theory, the situation is simple, hospitals are entitled to exact payment of charges either from the patient (if he has to pay for himself) or from the 'commune' (if he is a poor person who has a right to the 'assistance by place of residence' rule) or from the insurance organizations (if he is insured).

Obviously, it is not necessary to dwell upon uncommon cases, such as those in which the commune disclaims responsibility or passes it on to another commune; or when a commune alleges the existence of an insurance liability or vice versa.

In such cases of disagreement between hospitals on one side and subjects expected to pay on the other, Italian law provides for special procedures designed to guarantee a rapid solution of the problem, so as not to leave hospitals too much at the mercy of undischarged debts.

The most serious case is that in which the insurance organizations refuse to pay the hospital charges of one of its clients.

There are, of course, a lot of pretexts but the one which has given rise to the greatest number of disputes was the refusal, on the part of INAM, to recognize the decisions taken each year by the hospitals, to increase their charges.

The law now lays down that charges should be fixed in accordance with total expenditure during the preceding year, thus arriving at an estimate which is likely to cover future commitments.

At present, the greatest number of patients consists of insurance beneficiaries. While, therefore, it is bad enough when there is a refusal to recognize the charges approved by the hospitals, it is even worse when the insurance organization refuses to pay compensation allowed by its own terms.

This has indeed brought about an extremely difficult situation both because of the many legal controversies and because hospitals have been deprived of a part of their regular income and have therefore run into a heavy debt.

It may now be asked why there has been and is no intervention by the State; that is by the Ministries, whose business it is to supervise both hospitals and insurance organizations.

It is possible to give a formal reply to this question by pointing out that administrative authorities cannot intervene on problems concerning rights, the solution of which belongs only to judges, and that the autonomy of the various organizations had to be fully respected when such a right is claimed against a third party.

In fact the Government did not intervene because they have no clear idea of a solution to the problem of relations between hospitals and insurance organizations.

Disagreement between the two sides is due to the attempt by insurance organizations—and particularly by INAM—to take upon themselves the control of the charitable institutions. They attempted to do this by infiltrating their own representatives into the board of management of the institutions in order to engineer changes in their statutes and thereby gain control of them.

Thus, we have a repetition of the struggle between the State and private or religious bodies, which, as already recounted, ended with the law of 1890, in the victory of the State and marked the end of private assistance in favour of public assistance.

The problem now consists in seeing whether participation by insurance organizations in hospital management can be limited to purely insurance matters, or if they can interfere with day-to-day management in order to cut down costs. If the former principle can be established, the insurance organizations will leave technical considerations and the treatment of the sick to the hospitals themselves.

It is obvious that there is one major reason for the struggle between the two bodies: that is, the attempt by insurance organizations to cut the costs for which they have to pay.

3. We are, then, in Italy, faced with a crisis in hospital services and it is necessary, at this point, to give some further explanation: this means that we must take into consideration how general hospitals fulfil their functions (we can ignore special hospital establishments, like for instance, lunatic asylums, homes for abandoned children, sanatoria, etc.).

It is well known that these general hospitals are now feeling the effects of new medical discoveries and techniques.

For large hospitals of the first category (as for instance large town hospitals) it has not been difficult to adapt services to the new techniques of treatment and, apart from the classical departments of medicine and surgery, to

establish specialized sections, and it can be said that the average standard of performance is fairly high. But the hospitals of the second and third category (such as small town or rural district hospitals) are today in serious straits.

Finances (for the most part corresponding to the number of beds already available) do not permit the establishment of new departments, and in general in second category hospitals, obstetrics, radiology and a traditional specialization like ear, nose and throat diseases or ophthalmology are the only departments in existence. Third category hospitals—having a daily average of 30 to 200 patients—are limited to general medicine and surgery, relying on the nearest and better equipped hospitals for specialized treatment and consultation.

Under such circumstances, it is obvious that it is necessary to reorganize the hospital service; third category hospitals are, in reality, little better than sick-bays, that is places where medical treatment is limited to what is easiest and centres for diagnosis or transfer of patients to better equipped hospitals.

Next, the problem arises as to the changes to be introduced in second category hospitals (from 200 to 600 beds daily) which have either to be developed, in all their departments, or to be highly specialized, in order to link them with higher units at the provincial level. Thus the problem of costs could partially be solved.

But all this encounters one great difficulty, the autonomy of hospital institutions does not allow outside interference with their functions as laid down in their statutes. There is also the important sociological factor of local prestige; this would not permit either closing the hospital or any specialization which might mean its ceasing to be the hospital of the local commune and regarded by everyone as such.

4. Taking into account these requirements, the Italian Government has worked out a bill for the reform of hospital organization, which was introduced in the Chamber of Deputies on 10th November 1961.

By this reform all medical institutions are divided into hospitals, hospitals for the chronic sick and convalescent homes.

As to the first of these, the Government report on the bill stresses the fact that a rational hospital organization must be in a position to assure not the same treatment at all levels, but the same quality of treatment at each level.

This means that the distinction drawn between the various types of hospitals must take into account the range of treatment available rather than the method of treatment, since this—in both small and large hospitals—is supposed to be the same.

From this point of view the bill provides for the following categories:

1st Central hospitals
2nd Principal hospitals
3rd Hospitals

The first category must be self-sufficient in all respects and must include the departments of medicine, surgery, obstetrics and gynaecology, paediatrics, infectious diseases, ophthalmology, ear, nose and throat diseases, traumatology and orthopaedics, dermosyphilopathy, urology, neurology, dentistry and stomatology, unless some of these specialized treatments are provided for by local institutions.

Moreover, they must also have separate services for radiology, physiotherapy, pathological anatomy, chemical, clinical, microbiological and virus researches, anaesthesia, reanimation and transfusion.

In their turn, principal hospitals are expected to have the same departments as the central ones, except for neurology, dermosyphilopathy, dentistry and stomatology, for which some services will be enough.

Both central and principal hospitals must also have medical auxiliary services and, in any case, a residential school for professional nurses and a school for male nurses.

In third category hospitals, apart from the services of radiology and analysis, of anaesthesia and reanimation, and of transfusion, separate sections of general medicine, surgery, obstetrics and gynaecology and paediatrics are expected to exist.

In order to permit a more rapid adaptation to the requirements of the hospitals in existence, the Governmental bill for the reform of hospital organization lays down that the provincial medical officer, who is the representative of the Health Ministry in the province, draws up a 'provincial hospital plan', in which he defines the range of activity of every institution in order to co-ordinate it with the others operating in the province. Furthermore every financial engagement of the institutions themselves is subject to the approval of the provincial plan.

This bill has given rise to many discussions and controversies, since some believed it too revolutionary, and some too moderate. In reality, it does not tackle the fundamental problems of the Italian hospital organization.

To solve these problems, it would be necessary not only to institute a classification of hospitals, but also to completely transform them. Such a transformation, however, cannot be brought about by a plan worked out in the office of the provincial medical officer without the co-operation of all those interested in hospital organization.

This bill, however, is bound to come to nothing if regions are established in Italy. Indeed by Art. 117 of the Constitution, regions would be entrusted with legislative authority regarding 'charity, medical and hospital assistance'. It is obvious that every region, being a democratic institution aware of local needs, will be able to draw the lines for future development of hospital organization within the limits of the general principles established by the national Parliament.

5. Up to now, we have considered the principal lines of hospital organization, and contemporary problems. It is now necessary to point out both its elective and administrative structure.

As we saw before, each hospital is in general governed by a charitable institution and therefore, in practice, the hospital is administered by the board of management of the institution itself. The only exception is the case in which the hospital is dependent on a commune rather than on a charitable institution. This means that it is administered by the commune representatives; all measures are taken by resolutions of the town council, which acts as a board of management.

In the charitable institutions, however, the boards of management are appointed in several different ways. As it was mentioned before, the institutions are autonomous bodies having their own special statutes. Except in a few cases (i.e., the exclusion of governmental and communal employees from membership) the law is fairly liberal, so that it is not possible to find a uniform scheme for the membership of charitable institutions. It must be added that members of these boards are always appointed by some public authority and are not directly elected by the people; thus, for instance, a board of management consists of two representatives appointed by the town council, two others appointed by the provincial council and one appointed by the prefect; in other cases this power of appointment belongs to other authorities such as the provincial assistance and charity committee and sometimes even to local church authorities. However, physicians employed in the hospital never take part in the board of management; only infrequently are freelance physicians admitted. So there is no direct link between board management and technical services.

However, a liaison between the two is made possible by permitting the administrative secretary (who, in some statutes, is also called the secretary-director, the managing director or the general secretary) and the medical director (a physician) to attend meetings of the board of management. This privilege is limited to formal attendance and the right of an advisory vote (in some cases the latter is compulsory).

Thus, the managing director must subscribe to all proceedings of the board, thus taking upon himself their responsibility, but he may be relieved of his responsibility if he directs that his dissent is recorded in the minute.

The medical director, in his turn, submits the measures concerning the medical and nursing staff to the board and expresses his opinion on the subject of appointments, job allocations and disciplinary measures; together with his own observations he gives the reports of the health officers. Finally, he gives advice regarding the selection and purchase of apparatus as well as anything else which might be required in the hospital.

With the advice of the two directors—the most important being the managing director, who co-operates with the president, who is the executive of the hospital administration—the board of management takes all measures concerning the hospital activity. When, however, these measures concern balance sheets, investment of funds, the size and character of the establishment of internal regulations they must be submitted for approval to a State agency, namely the provincial charity and assistance committee, which is composed of the prefect, who acts as a chairman, of other State officers and also of members elected by the provincial council or appointed by the trade unions.

The scope of administrative supervision is rather limited, although, in practice, hospital administration tends to increase the number of measures to be submitted for approval to the boards, in order to be relieved of some of their responsibilities.

Here it is necessary to point out that the prefect can always demand that a resolution of a charitable institution be submitted to him and he can cancel it if he thinks that it is unlawful. The prefect can also send commissioners to defend the institution's interests, if a hospital administration, even after a warning from the prefect, continues to disregard the regulations of law or to prejudice its own interests. In the most serious cases, the board of management may even be dissolved and then the commissioner assumes temporarily (no longer than three months) all the powers of the dissolved body. These powers are then transferred to the new administration.

This system of hospital administration, dating back to the law of 1890, is based on the liberal *laissez-faire* principles of that time. In the different social, economic and political climate of today, there is much greater need for the State to lay down broad general principles to bring about better co-ordination and stimulate development by those bodies responsible for national medical services.

It is just for that reason that today—as we mentioned before—the idea of giving planning authority to governmental bodies has become popular. This would remove some of the major disadvantages to be found in the autonomous system of Italian hospital organization of today.

It is not possible to say much about the internal organization of Italian hospitals, since this depends, to a large extent, on the size of each hospital and individual requirements.

As a general rule, there are many departments subordinate to the secretary-director: namely, the accountant's department, the steward's office (purchase and distribution office), the reception and admittance office, with financial office (which is concerned with patients' fees), the personnel office, etc. This matter, however, is regulated by each hospital. They also regulate the procedure to fill vacant posts by a system of public and internal competition (the latter being reserved for employees of the hospital concerned).

The same procedure is followed when appointing a general secretary-director, while there are legal regulations governing public competition for the appointment of the medical director.

It would, however, be desirable that, at least with regard to the appointment of the secretary-directors, the State laid down the general rules of procedure and the qualifications required.

6. This lack of uniformity in hospital organization, resulting from the autonomy of the various charitable institutions controlling them, also explains why schools or training and finishing courses for administrative employees do not exist. Only recently have the two organizations concerned with these matters—on one side the hospitals and on the other the secretary-directors—taken the initiative by holding courses and study meetings every year.

NETHERLANDS

by

DR. J. B. STOLTE

Medical Director, St. Elisabeth-Ziekenhuis

THE HOSPITAL SERVICE IN THE NETHERLANDS AND THE MANAGEMENT OF ITS HOSPITALS

It is rather difficult to describe the hospital situation in a country in such a way that comparison with the situation elsewhere becomes possible, the over-all organization of medical care being so diverse. The components of medical care are closely interrelated, as they are of course with the social conditions in general. Only the complete picture would do to prevent misunderstandings. It would be prohibitive in length however.

Therefore I will have to confine myself to highlighting some points that seem vital to me in order to understand the organization and scope of the hospital service in the Netherlands.

The Netherlands are very densely populated. In 1960 they numbered 344 inhabitants per square kilometre, making for about 11·5 million in total. Some 10% are less than five years old, 9·1% are 65 and older. The expectancy of life at birth was 71 years for males and 73·9 years for females. The death rate in 1960 was 7·6 per 1,000 inhabitants, the birth rate 20·8. Only 27% of the deliveries took place in hospital, 22 of them under supervision by a doctor and five under supervision by a midwife.

It is estimated that of any 1,000 inhabitants about 33 are under medical treatment each day; three of them are in a mental hospital, 20 are taken care of by the family doctor, 10 by a specialist. About 35% of those who are under the care of a specialist are in a hospital. There were 4,350 family doctors and 3,750 specialists in 1960 (as against 4,550 'other' physicians, 2,500 dentists and 900 midwives). The family doctor is able to take care of many patients in their own homes because of an excellent system of district nursing care run by the so-called

'Cross-organizations'. In the majority of cases the patient comes under specialist care only by referal to him through the family doctor. The distribution of family doctors and specialists over the country is fairly equal. In 1900 there was one physician in every 2,540 inhabitants, in 1930 one in 1,720 and in 1961 one in 900. In 1942 there was one specialist as against every four family physicians, in 1961 they almost equalled them in number.

In 1953 about 3·6% of the national income was spent for health care, as against 4·4% in 1958.

In 1959–60 about 6·5% of the family-expenses were for hygiene and medical care (1·6% for hospital care). The percentage has been slowly increasing for the last decade (6·3% in 1955–56).

Employees with an income under f. 7,450 a year are compulsorily insured against the cost of curative medical care with the 'sick funds', private insurance companies on a non-profit basis of which there are 115. Self-employed with a similar income can insure themselves voluntarily. All people of 65 years and older may insure themselves with the same sick funds at a substantially reduced rate if their income is under f. 3,590 a year. In 1961 about 73% of the population were insured with the sick funds.* The insurance covers the cost of medical care almost completely. There are virtually no medical indigents. In 1959 the sick funds spent f. 616 million; f. 83 million went to the family doctors, f. 98 million to the specialists and f. 205 million to the hospitals.

Of the 27% who are not insured with the sick funds at least three-quarters have taken some kind of insurance against the cost of curative medical care with commercial companies.

In 1959 there were 35,000 beds in mental hospitals, 6,000 in TB hospitals and 53,500 in general and special hospitals.† The beds in the mental hospitals are used throughout the year to

* They represent 55% of the national income.

† When the word 'hospital' is used in the Dutch literature these general and special hospitals are meant.

almost full capacity, although there is a shortage of nurses.* The TB hospitals have to turn into other directions to keep their accommodation to good use. Some have been closed, but others have taken on the treatment of other pulmonary diseases, of chronic disease or they have turned to rehabilitation.†

There were 276 'hospitals' (225 general and 51 special ones) in 1959, the last year statistics have been published about. Although there were still 105 hospitals with less than 100 beds the small hospital, particularly that with less than 75 beds seems to be on the way out. There are almost no very large hospitals; only six had 750 or more beds in 1959. About 20% of the hospitals (with about 25% of the beds) are run by government or local authority. The other ones are private or voluntary hospitals, run as non-profit institutions.

In 1959 the over-all occupancy rate was 88·74% (in the general hospitals it was 90·64%). The occupancy rate in the small hospitals was substantially lower. The average stay in hospital per case has been about 20 days for the last seven or eight years. It is of interest in this respect that diagnostic work-up is done in the out-patient department in the great majority of cases. The percentage of patients who died in hospital has been about 3·5% in the last decade. It has been increasing steadily but slowly, showing that relatively more people are coming to hospital to die.

The use people make of the hospital accommodation may be expressed in the number of days spent in hospital per inhabitant per year. In 1959 it was 1·62 days as against 1·42 in 1957 and 0·85 in 1948. This figure has been increasing continuously throughout the period after World War II, due on the one hand to the growing amount of hospital beds available and on the other hand to the fact that the sick fund insurance had removed the financial barrier. The absolute and the relative numbers of hospital beds are still increasing in spite of restrictions posed on the hospital building programme by the government in order to divert most of the building facilities to house-building, this

* Homes for the mentally defective and institutions for the morally insane are not considered to be hospitals in the proper sense. Neither are the boarding schools for the training of the blind and the deaf.

† The mortality and TB morbidity are amongst the lowest in the world.

having got the highest priority. On 1st January 1960, there were 4·68 beds per 1,000 inhabitants in the Netherlands. Some authorities on the subject think that this should be almost sufficient at the present high occupancy rate. It seems doubtful however that this occupancy rate is right in the long run. There is little doubt that the pressure for more hospital beds has eased somewhat in the last two or three years. This could indicate that the saturation point is almost reached, at least with the present condition of medical care. Of course the possible influence of future medical discoveries cannot be taken into account. Three points are of interest however. The first is that the distribution of hospital beds over the country is rather uneven. In the Northern provinces of Groningen and Drente there are $3\frac{1}{4}$ beds per 1,000 inhabitants, in Zeeland 6·0. The second point is that there are as yet but a few hospitals for chronic sick or nursing homes. The problem does not lie with building but with staffing them. Nevertheless their number is increasing, easing off the load on the hospitals. The third point lies with the inherent tendency of the Dutch to arrange every aspect of life according to creed. In the hospital field (as with the 'Cross-organizations') it makes for a tendency to provide two or three or even more hospitals in a given area, each to take care of the members of a religious group. In the whole there are the three larger groups: the Roman Catholic one, the Protestant one and the non-denominational (often called 'Humanistic') one, the Protestant being divided into several sub-groups. They all have their hospitals and it will happen that a religious group is trying to provide for more beds although there are plenty of beds in the area. In the years after World War II the government has been able to keep this movement in check up to a certain point by exercising its power to withhold allocation of building permits. There is a strong tendency to set up legislation to make the running of a hospital without a licence unlawful, but a law in this respect has not yet been passed.

The steady increase of hospital usage is particularly due to an increase of the number of admissions into hospital. The next table does show this for those who are insured with the sick funds.

	admissions 100 *ins. pers.*	*pat. days* *admission*	*cost* *pat. day*	*cost* *ins. pers.*
1951	6·35	16·7	f. 8·80	f. 9·35
1955	7·34	18·5	f. 12·54	f. 17·05
1959	8·16	18·7	f. 17·17	f. 26·15
1961	8·40	18·7	f. 19·85	f. 31·20

Hospital usage varies from district to district. The admission coefficient (number of admitted patients per year × 100: number of inhabitants in the district) varies between six and nine, whereas the over-all coefficient for the country was 7·96 in 1959. The reasons for the variation are unknown. Possibly sociological factors are at work, as in many districts the situation has remained virtually the same through the last 15 years.

The rising cost of hospital care as shown by the table has caused quite a lot of anxiety, although the reasons for the phenomenon are obvious. Devaluation has been partly responsible.* Wages have gone up too, of course, but in the hospital field the increase has been even far more important than elsewhere because of the backlog caused by the influence of the 'charitable' atmosphere in former years, because of the shortening of working hours, because of the relative increase in personnel made necessary by the greater intensity of the work and because of the fact that the religious orders provide far less a percentage of the workers than formerly. Then again depreciation is taking a larger toll† as the building of hospitals like any building is becoming more costly every year. The cost is estimated roughly to be between f. 65,000 and f. 75,000 a bed at the monent (about f. 200 to f. 225 per cubic metre). It is of interest in this respect that the building of most hospitals is financed with money lent from the public or from insurance companies and the like against a normal interest. In only a few cases local authorities or the government subsidise a hospital to a certain extent, but in most cases the hospitals have to make do with their income from payments by in-patients (in most cases

* Between 1948 and 1958 it may be estimated at about 35%.

† In the price of a patient-day the older hospitals can only include part of the depreciation (rebuilding value) where as with the newly built hospitals almost full depreciation is included. The tariff varied from f. 6.90 to f. 26.35 a day (1.1.1960), depreciation accounting for up to f. 8.00 a day.

covered by insurance) and from out-patients (mostly for the use of laboratories, X-ray department, out-patient-operating theatres, etc.).

The ever rising cost of the hospital service is also shown in the increasing percentage it gets of the total amount of money spent by the sick funds, as may be seen from the table below:

	1948	1953	1959
Hospital service	17·9	27·0	29·1
TB hospitals	5·3	5·6	2·7
Specialists	11·0	15·0	14·7
Family doctors	15·2	17·1	13·1
Dentists	5·6	5·9	7·0
Drugs and appliances	16·3	14·9	14·0

It has to be taken into account that the salaries of the physicians and surgeons working in a hospital on the 'doctor-in' basis are included in the cost of the hospital service.

The doctor's fee is included in the cost of a patient-day only in some of the hospitals (the 'all-in' or 'doctor-in' situation). The doctor in these cases is paid a fixed salary by the hospital.* In some hospitals this is only the case in regard to the sick fund patients, whereas the doctor charges the private patients directly. In still some other hospitals the hospital and the doctor both charge all the patients separately (the 'all-out' or 'doctor-out' situation). Both in the 'doctor-in' as in the 'doctor-out' situation the hospital may be a closed one, only admitting patients for those doctors who are on its staff or an open one, where the patient is quite free to have any licensed doctor of good repute. Most hospitals are closed for a greater part and open for a small one, particularly that for the private patients. More and more hospitals are joining the group of (at least partly) closed hospitals. About one third are still completely open.

The doctors in the hospitals are either specialists or trainees in the various specialties. Only 70% admit family doctors and then in most cases only for (normal) deliveries.† In the closed

* Virtually all mental and TB hospitals are run on the 'doctor-in' basis.

† In quite a few midwives are also admitted.

hospitals the specialists are appointed as members of the medical staff by the board of the hospital or its equivalent.

Most hospitals in the Netherlands are private hospitals, run on a non-profit basis by boards. Many of these boards are self-perpetuating, some are appointed by the owners of the hospital (in most cases a religious order) or by a religious authority. In a few cases the owner, e.g., a religious order, runs the hospital himself. The boards consist of prominent citizens. Sometimes they still maintain an atmosphere of utter respectability but most of them have changed with the times and consist of people of many ways of life although the male element is still very predominant: there are industrialists and officials of labour-unions amongst them, lawyers and engineers, parsons and priests. Only very few doctors are board-members. The board is expected to indicate what the general policy of the hospital will be, it will appoint the major officers and the members of the medical staff, it will approve the yearly budget and demand a periodical account of the state of affairs, both financially and functionally. Its predominant function is to see to it that the population served by the hospital really gets its due; the best possible care at the lowest possible cost. As the members of the board lack specific knowledge they depend upon their expert officers for guidance particularly as to development and planning. The final decision however is theirs.

The hospitals belonging to the State or local authorities may have a board, appointed by the authorities or they may come directly under an alderman or another official, who may be assisted by a committee of members of the city council.

The boards and committees are not dependent solely on the advice of their own executives. They also may turn to their respective hospital associations. There are some nine such associations. Together with associations of hospital executives, e.g., of medical directors, of matrons, of nurses, of the heads of the departments of accountancy and economics (in many ways the equivalents of the 'secretaries' in Britain); they are bundled together in two larger associations, the 'Stichting Het Nederlandse Ziekenhuiswezen',* comprising the Protestant, the non-denominational and the public hospitals and their

* The Foundation of the Combined Dutch Hospitals.

executive officers and the 'Centraal Bureau voor het Katholieke Ziekenhuiswezen'* through which the Catholic hospitals and their officials channel their combined efforts. Both have won a high esteem in the post-World-War-II-days. Their influence as a pressure group is becoming more and more apparent although lack of enough funds is still putting a drag on their performance. Only very few hospitals are not organized with any of them. Of the 276 general and special hospitals (1959) 112 were Roman Catholic (with 42·4% of the beds), 114 were non-denominational or public (with 40·5% of the beds), 49 were Protestant (with 17·0% of the beds) and one Israelic (with 0·1% of the beds).

At least some 80,000 people are working in the Dutch hospitals,† 58,312 of them in the general and special hospitals (in 1959). The relative amount of employees is steadily increasing as is shown in the following table:

	1956	1957	1958	1959
Number of pat. / Number of employees	0·98	0·95	0·92	0·90
Number of pat. / Number of nurses	2·04	2·01	1·95	1·94

The number of employees does not include the doctors and the management, the number of nurses does include the student-nurses and the nursing-aids.

To co-ordinate the efforts of all these people 776 executive officers were entrusted with the management of the 276 general and special hospitals in 1959. In 203 a medical director was in charge, either as a full-time official (62) or combining the job with medical practice (141). In 48 of the 73 other hospitals the board had a medical adviser. Some 29 hospitals had an 'economical director' on an equal rank with the medical director, in 191 an 'economist' of a slightly lower rank. In 15 hospitals a priest or a parson is (one of the) director(s). In 65 hospitals the matron or a male head of the nursing service either is in charge or is of equal rank with other officials in the management. The situation in some of the Catholic hospitals is

* The Central Bureau of the Combined Catholic Hospitals.

† This is 1·8% of the total working force of about 4·5 million.

less clear in this respect, the mother superior sometimes being the only one in charge, sometimes however she is responsible only for the spiritual guidance of the nuns.

In the past two or three decades the composition of the managerial section in the hospitals has been strengthened considerably. More people have been enrolled to perform the complicated task in question. The medical influence in the management is still increasing as judged from the growing number of medical directors but the part in management taken by non-medical men, known as economical directors or economic administrators* has been growing rapidly. In most hospitals the head of the nursing department always has had an important influence on the day-to-day management of the hospital either because of the fact that she was in charge, which was relatively seldom, or through the medical director. The part taken by the priests and parsons in the management of the hospitals is diminishing rapidly as is that taken by the mother superior. This is probably caused by the change of the hospital service from a charitable enterprise into a public function.

An interesting development in the last decade has been the formation of executive bodies, called 'directorium', particularly in some of the larger hospitals. Day-to-day management in these hospitals is put into the hands of a body, consisting of the heads of the medical, the nursing and the economical 'services' (or 'departments'). In a few instances the head of the domestic service and the clerk of works (the head of the 'technical service') are included. The members of the directorium are jointly responsible to the board for the day-to-day management of the hospital. At the same time they have to supervise and co-ordinate the work of the employees in their respective 'services' or 'departments'.

A somewhat similar directorium exists in some of the Protestant hospitals, consisting of the parson-director, the medical director and the matron (administrative nurse); in some cases there is a no medical director.

* The word 'administrator' is used for the head of the 'administrative' department, administration being equivalent in the Dutch hospital to internal accountancy and statistics plus purchasing.

Selection of hospital administrators has been a haphazard affair until now. Most full-time medical directors have been recruited from the ranks of the general practitioners, some have been specialists, a few had some experience in the hospital field when in military service. Some were trained as assistant or adjunct of a medical director of a larger hospital. Most medical directors who combine their administrative jobs with medical practice only have had their in-service-training. The same holds true for the lay-administrators. More and more graduates from the faculties of economics are appointed to these jobs. Others come from the industrial field, having acquired managerial experience there. The nurses (matrons) come up from the ranks, acquiring managerial experience through increase of responsibility. Since about 10 years they may profit from training courses designed to enlarge their knowledge and acumen in coping with administrative problems.

Only in the last two years has the problem of training for management in this special field been approached more seriously. Although it is felt that possibly a graduate university course is needed, both in the medical and in the economic faculties, it was thought more appropriate to start with a post-graduate course, aiming at a more profound and extensive knowledge of the managerial problems in the hospital service in its various aspects. The course, sponsored by three universities (Nijmegen, Tilburg and Utrecht) and by both hospital associations, brings together both medical and lay-administrators and matrons from all over the country and from all kinds of hospitals, providing for a meeting ground where the different experiences may be interchanged. It was deemed necessary to have only the one course because of the small number of hospitals and because of the fact that in this way the experiences gained in the different fields could be put to a more general use.

The hospital situation has not yet reached a certain stability. Because of that it is far from easy to prognosticate and to plan for the future. It is clear however that precisely because of this situation the training of competent hospital administrators with knowledge, imagination, and flexibility is vital. It is a fine thing that this fact has been ascertained and acted upon by the

hospital-people themselves according to the cherished tradition of the Dutch who always have preferred private enterprise to governmental action. It is to be hoped and to be expected however that the State will assist the private efforts because of the consequences for the general weal.

NORWAY

by

DR. HERBERT PALMER

CONSTRUCTION, ORGANIZATION AND ADMINISTRATIVE ASPECTS OF THE NORWEGIAN HOSPITAL SYSTEM

Construction and Organization

The XIIth International Hospital Congress at Venice in 1961 had as its main theme: The Changing Hospitals in a Changing World. It emerged clearly there that hospital systems all over the world are in a state of constant change at an ever-increasing tempo—in an attempt to keep in step with the substantial development in top-level international medicine producing new and better facilities of treatment for patients, and also in step with the almost revolutionary re-organization in social standards. The picture, however, is far from being uniform, and there is also evidence of numerous other factors, notably, perhaps of a national character. Some countries, with regard to hospitals, are today at a stage which other countries have long since passed. And looking at the world as a whole, it would even today be possible to follow almost the entire practical history of medicine and hospital systems.

Taking a small section of the globe represented by the West-European countries these great differences will disappear. In many ways the outlines by and large will be similar. But nevertheless, national conditions will undoubtedly leave their stamp on the hospital system. And in judging the hospital situation in the individual countries it is in my opinion necessary to point to this fairly obvious background. Ingrained habits, called traditions, cannot be ignored, and factors such as geography and density of population are of great importance in a country like, for instance, Norway—that long, narrow country far north which, if we imagine it turned around, its southernmost point would reach to the Mediterranean—and which has only 3½ million inhabitants. It is clear that such circumstances have a decisive influence on the shaping of the

hospital system and what this entails as regards aspects of building, organization, administration, transport and economy. The low density of population and the long distances, especially in the northern parts of Norway, suggest smaller hospital units and simpler conditions. The high density of population and shorter distances in the southern part of the country provide larger hospital units and the same administrative problems shared by other countries with a high density of population. This unevenness in conditions is not without practical interest for the running of the hospitals, particularly with regard to personnel.

I wanted to present these remarks as a short illustration of the background for the review of the Norwegian hospital system which I have been asked to give.

I presume that the origin and development of the hospital system in Norway in the earliest times did not deviate greatly from the pattern of most other European countries. It was the Church and religious institutions who carried out their acts of charity on the basis of alms, and the distinction between sickness and poverty was not quite clear.

There was, of course, no question of a hospital system in the modern sense, but this form existed from the first hospitals we hear of in 1164 and close up to the turn of the century 1800. The hospitals we then hear of are isolation hospitals for lepers and hospitals for the treatment of syphilis.

All this is now only of historical interest and will be by-passed here. But as the diseases mentioned receded, there was a considerable development in general and curative medicine which created the need for infection hospitals, general hospitals and also special hospitals, chiefly mental hospitals. These demands gathered increasing strength towards the turn of the century 1900. To begin with it was private institutions who initiated, built and ran the general hospitals—apart from the military hospitals and a few others established and run by the State and the provinces. Of the latter was, for instance, the University Hospital at Oslo, established in 1826.

However, in connection with the introduction of the Mental Health Act in 1848 the State built several mental hospitals,

and so did the provinces in the years immediately after the turn of the century.

The year 1909, however, is an important milestone in the development of health administration, and also for the hospital system. Because that was when the Norwegian Storting passed a law on sick insurance and on obligatory and voluntary membership of sick insurance schemes. This law on sick insurance, which was later developed to include the entire population, has been of the greatest importance for the care of the sick in hospitals, and in the last few years also for nursing in the homes.

After this law came into force in 1911 it was possible to develop the general hospital to a larger extent. From that date the running of hospitals was economically secured in principle. The hospital fees were fixed by the owner of the hospital in relation to the hospital's expenditure, and the fees, or part of them, were paid direct to the hospital from the sick insurance fund.*

The hospitals which were built were to begin with quite simple. The primary aim was to provide surgical treatment. But as time went on they developed into so-called 'mixed hospitals', i.e., hospitals with a mixed complement of patients, but with a surgeon as chief medical officer and administrator. This type of hospital exists to some extent today—especially in parts of the country with a low density of population and long distances.

While towns, municipalities and provinces thus were able to raise hospitals, the State also showed great initiative in building hospitals for the widespread diseases such as tuberculosis and mental illness.

This fruitful development of the hospital system went on till the general economic depression in the 1920's up to the middle of the 1930's made itself felt and subdued all enterprise. When we were getting out of this trough we were already on our way into the Second World War which paralysed all hospital

*The main sources for this account are information from The Norwegian Health Directorate and especially publications by Dr. Karl Evang, Director of the Norwegian Health Directorate.

development and also involved the destruction of a number of hospitals in various parts of the country, notably in the north and west. There was, however, one positive side to this period which deserves to be mentioned, namely that the administrators of the acute-hospitals in those hard times organized their scant resources and rationalized the administrative apparatus in such a way that it was effective after the war. The interest in efficiency developed during the war continued when resources and materials increased afterwards. At the same time everyone was aware how much had been missed during the isolation, and how the free world, in spite of the enormous pressure of war, had developed medical progress in an epoch-making fashion, creating an almost explosive demand for development of the hospital system to a degree unknown in our former hospital history. There was not only the question of extensive repair and replacement work, but also of building new hospitals on a large scale to compensate for the lack of hospital building during the war and to keep up with the increasing population and its needs. On the other hand there were greater demands for greater differentiation of the hospitals by the introduction of more special departments, in some measure also special hospitals, for instance rheumatology, geriatrics, epilepsy and so on. There was, in other words, a demand for a quantitative as well as a qualitative development.

In this way several of the earlier mentioned mixed hospitals were converted into so-called 'trisected hospitals' which have in fact subsequently become a *standard type* of district hospital in Norway. These hospitals have a section for surgery, one for internal medicine and one section for radiology—the size being from 60–160 beds, some may also be larger. But if the number of beds is larger there is a tendency to add other sections, for instance for obstetrics-gynaecology.

It has, in fact, always been the practice to separate the various categories of patients—the surgical and the internal medicine patients when the hospitals reached a certain size, on the pattern of the teaching hospitals. Placing different categories of patients together in the same ward, as is general in the U.S.A., occurs in Norway only in the small mixed hospitals, which today seldom exceed 60 beds, mostly fewer. By this tendency to

differentiation also in smaller hospitals, the number of mixed hospitals has dropped to a minimum. I may mention here that in particularly thinly populated areas with very long and difficult means of access there are a number of small simple hospital units of 10–20 beds, the so-called cottage hospitals. These are generally under the administration of the official doctor (the district doctor) and designed to receive patients with simple acute complaints, childbirths and so on. They are, however, also intended to serve as transit stations for patients en route to a hospital and to provide some after-care. These cottage hospitals are today located in the northernmost parts of the country and in comparatively isolated island communities. These cottage hospitals are very important. By way of a concrete example I may mention that such a cottage hospital may serve a population of under 2,000 distributed over a land area of 3,000 square kilometres, i.e., a population density of 2/3 per square kilometre.

The swing in the types of diseases, with a drop in epidemic diseases and an increase in, for instance, cardiovascular complaints, have led to a greater demand for diagnostic departments within radiology and clinical laboratories. At the same time the general desire to contribute to medical standards and development has promoted demands for places and aids for medical research not only in the teaching hospitals, but also in general hospitals.

This has led to the development of the so-called *central* hospitals of which there are eight today apart from those in Oslo and Bergen. These central hospitals with several specialist departments are intended to look after patients who cannot be treated in the smaller peripheral hospitals and the district hospitals, and to take patients from the areas belonging to the central hospital. The aim is to have one central hospital in each of the country's 20 provinces.

In Oslo and Bergen we have combined central hospitals and university hospitals, whilst the pure university hospital, Rikshospitalet, has the task of caring for special patients from the whole country.

The strong demand for a rapid and extensive development of hospitals after the war led to a considerable hospital planning

which has continued later and great demands have been made on economic resources to meet this planning. At the same time there was, during the first years, shortage of materials and the brisk building activity in all fields, not only in the hospital sector also led to shortage of labour in the building industry. As practically enormous sums, by Norwegian standards, were involved, private hospital owners were able to keep up with this development only to a small degree. It was left to the authorities, notably provinces and municipalities, but also the State, to take on the part of active builders. Over the years this led to the majority of hospitals in Norway today being owned and run by provinces and municipalities. In this field a complete reorganization has taken place. Some private hospitals do exist, most of them small, and they are owned and run mainly by religious and humanitarian bodies. On the other hand, private organizations own and run a fair number of nursing homes of various types, and cottage hospitals.

Given the great demands I have mentioned for a rapid and extensive development of the hospital system a co-ordination of plans was felt to be desirable. And the country's Director of Health therefore requested, through the Ministry of Social Affairs, already in April 1946, the provinces to set up a plan for hospital development with a view to achieving a national plan for this development. Norway is, however, in the position of not having a hospital law—and the Directorate of Health has therefore no authority to *direct* anyone to build hospitals. But through its authority of approval it has occasion to exercise decisive influence on plans which have to be presented before they can be put into practice. Another matter is that the Directorate of Health as the central authority is consulted in all hospital matters and can thus exercise its influence so that desired plans will be adopted. In the meantime the actual position has been that there was a very great desire to develop hospitals in Norway.

It was, however, the Health Director's idea with the national plan I have mentioned, to obtain the best possible survey of the needs both as to quantity and quality with regard to hospitals and hospital beds—and to have this *independently* of abilities and possibilities of putting such a plan into practice. It is evident

that such a plan has considerable guiding value in the long run. In order to assist the central health authorities in this work and to evaluate the actual plans the so-called Hospital Council was established in 1946. As indicated by its name, this is a consultative body not meant to have any direct directing function.

The initiative to build new hospitals has been chiefly at local level—counties and municipalities—and most frequently it was the hospital doctors who were the primary initiators on behalf of medicine and the patients. The results of the efforts were in most cases compromise solutions between demands made and economic ability.

In 1947 the Directorate of Health reckoned that there was a comparatively acute demand for the building of 350,000 square meters of hospitals—and in the course of these years, notably in the last 10 years, this has been practically fulfilled. The result has been that Norway since the war has got 35 new general hospitals and a number of special hospitals—such as mental hospitals. But new hospitals are constantly being built. I may mention that at present 3 central hospitals are being built as well as 3 'trisected' county hospitals. Furthermore, large specialist departments are being built at Oslo municipal hospital, Ulleval, which is now also a teaching hospital. A university hospital is being planned in Bergen, provisionally calculated to cost about 140 million kroner.

A total of about 800 million kroner has been invested in Norway since the war in new hospitals and hospital departments, in the first years after the war comparatively modest amounts owing to rationing—thus in the 5-year period 1945–50 about 60 million kroner. But later increasing sums were invested, so that now about 100 million kroner a year are invested in new hospitals. This is by and large money which the people have paid through ordinary taxation.

In very few cases have hospitals been built by means of collected money. This applies to the Norwegian Cancer Hospital which cost 20 million kroner, when the State and municipalities renounced their claims for taxes on money donated for this purpose.

Immediately before the war it was calculated that the general hospitals cost about Kr. 10,000–15,000 per bed; immediately after the war about Kr. 40,000; today the estimate is about Kr. 100,000 per bed. But while this is a price development in real terms, we must take into consideration that the hospitals are gradually much more comprehensive than previously. In addition to the increased demands for comfort, offices, equipment and so on, the medical-technical departments such as the radiological and clinical laboratories, blood banks, anaesthetics departments and so on, have come into the picture in no small degree and take their share of the sum total. Policlinics have also been partly developed.

The total of hospital beds proper is 30,500. In addition are nursing places in some institutions such as nursing homes, nursing homes for the mentally ill, convalescent homes and so on with about 6,500. For the nursing of the sick there is thus today a total of 37,000 places at our disposal. Of these there are about 80% in public institutions (State, counties and municipalities) and 20% in private institutions (mainly nursing homes).

Looking at the individual sectors the number of *general* hospital places after the war has increased from 15,500 to 20,500; places in mental hospitals from 6,000 to 7,765; places in psychiatric clinics from 230 to 850; places for child psychiatry from 0 to 195; places in nursing homes for mentally ill from 350 to 3,300; places for mentally undeveloped from 500 to 3,750; places for epileptics from 66 to 170, just to mention some examples.

At the same time the number of places for tuberculosis patients has *dropped* from 3,400 to 1,150.

How large the uncovered demand for hospital places is has not been worked out. It all depends on what type of hospital place one has in mind.

With regard to general hospital beds in acute-hospitals the general opinion is that further requirements are not very great, even though a demand undisputedly exists. The position is in fact that not a few of the beds in acute-hospitals today are occupied by long-term patients who might well be nursed in

simpler institutions. This is particularly the case in the towns where social factors such as housing conditions come into the picture.

The most pressing problem is therefore now in the first place to get more of the simpler hospitals to alleviate the acute-hospitals. We want more of the so-called B-hospitals for an immediate alleviation. They are hospitals which are situated close to the acute-hospitals, are more simply equipped, but sufficiently for a large part of the after-care to be undertaken there. This applies to patients with bone fractures, ulcer patients and so on. There is, however, a further large need for development of institutions which can take long-term patients of all categories. It is in this field that some of the main tasks lie. And if such alleviation institutions were available to a sufficient degree, we presume that certain parts of the country would be covered with places in acute-hospitals.

It is without doubt, however, that there would still be a need for new acute-hospitals. This applies to special parts of the country which are not so far advanced in their hospital development, and in order to keep in step with the growing population.

When a country's saturation point has been reached with regard to hospital beds may be a subject for considerable debate. A so-called bed-factor of 10 has been set as a satisfactory norm, i.e., 10 beds per 1,000 inhabitants. In this figure is also included places for mental patients. Today there are 30,500 pure hospital beds (not including beds for long-term nursing) and the population is, as I have mentioned, $3\frac{1}{2}$ *million*. That means that we have reached a *bed-factor of* 8·7. In the deficiency of 1·3 are included, according to general opinion, partly new places in acute-hospitals, but mainly more places for treatment of mental patients. In that connection the Norwegian Storting has voted 100 million kroner for further development of psychiatric observation departments in general hospitals. This is also to be considered as the State's contribution to the provinces when they, according to a new law of 1960 put in effect from 1961, shall take over the administration including the building and running of psychiatric institutions.

The further task with regard to the acute-hospitals is to

differentiate them further, so that they are better equipped to meet the many great requirements demanded by modern medicine.

The existing programme on this front now in the process of realization is as follows:

(*a*) To introduce more special departments for categories of patients, partial division of the existing departments for internal medicine and surgery. Among these departments I would mention cancer departments in large central hospitals with a view to the geographical conditions, departments for rheumatic diseases, departments for allergies, rehabilitation departments, cardiological, orthopaedic, paediatric departments, and so on.

(*b*) A development of the medical-technical departments—i.e., radiological departments, anaesthetics departments, pathological and clinical laboratories. Of these departments, both before and, later, after the war, the radiological departments were best developed. The anaesthetics departments are being developed rapidly but much remains to be done, and there is also some divergence of opinion as to how these departments should be developed. The divergence is specially about the question of the so-called 'recovery' departments, whether they are to be planned in the direction of 'intensive wards' to care for all types of very sick patients—a trend, one gathers, not generally favoured by Norwegian hospital doctors—or whether they are to be only so-called waking-up departments for operation patients, including poison cases.

With regard to the hospital laboratories there has been some development since the war, but there is still a lot to do.

Pathological-anatomical laboratories have in Norway only been connected with the very largest hospitals and have therefore been few in number. In the course of the last few years only one new laboratory has been added. The hospitals have therefore arranged for biopsies to be sent to these laboratories for histological examination, while the regular doctors in the hospitals must do the autopsies. For this reason the average autopsy frequency is not very high and the hospitals do not

benefit from the frozen section examinations and the considerable other contributions which such laboratories make to the medical standards of a hospital. Concrete plans are, however, in existence for the establishment of several pathological-anatomical laboratories, expected to be in operation in course of the next few years.

With regard to *bacteriological-serological laboratories* a valuable development has taken place. It is true that there are also very few hospitals with their own bacteriological-serological or microbiological laboratories, and they are therefore obliged to send samples to the central laboratories. But the State has begun building so-called *district laboratories* for microbiology including blood type serology. These laboratories are connected with large central hospitals throughout the country, but their task is also to assist the publicly appointed and private practising doctors and specialists within a certain district. Six such State laboratories are planned, of which three have been completed and have recently become operational.

The Norwegian hospitals have generally had small clinical laboratories for simple examinations of body fluids, secretions and excretions, preferably led by doctors of internal medicine. The great advances made in clinical chemistry and clinical physiology have led to strong demands for a considerable development of these laboratories. Hitherto we have had ten clinical-chemical and physiological hospital laboratories run on modern principles under the leadership of their own specialists, who in Norway are doctors with specialist training. In Norway, as possibly in other countries, there has been much discussion as to who should lead such laboratories. But the general opinion is that they should be doctors, because the laboratory should not only be the site of the analytical machinery, but should also take part in discussions about patients together with the clinicians and discuss the position with regard to diagnosis, treatment and prognosis from a laboratory-medical point of view.

I should mention that we have not in Norway that collective specialty called clinical pathology involving parts of all laboratory services. With us the specialties follow the separate subjects which is both an advantage and a drawback. One

advantage is that the various sections are taken care of on a wider basis and that the specialist concerned is able to master his subject to a greater degree. On the other hand, the medium-sized and small hospitals have had difficulties in establishing a satisfactory laboratory service for economic reasons. In professional quarters there is no great enthusiasm for the introduction of the specialty clinical pathology—and the possibility of having ambulating laboratory specialists is now therefore being discussed. That, too, offers many problems—and it is possible that one will be forced to vent the question of laboratory specialists combining all laboratory subjects. Even at present laboratory leaders have to combine some subjects such as clinical chemistry, clinical physiology, haematology and blood type serology.

It must be admitted that there is a heavy task in front of us in the field of laboratories before conditions will be completely satisfactory. But I would point out that clinical-chemical and clinical-physiological laboratories in the modern sense actually constituted a new departure in Norway after the war. It may therefore well be that the importance and role of these laboratories have not quite penetrated into the public consciousness, which is a prerequisite for satisfactory grants being made.

I will mention, however, that a development in this field is under discussion and in the process of being realized. Thus the hospital laboratories, their tasks, means and conditions, were one of the main themes at the last national conference of the Norwegian Hospitals Association last June—and were discussed by a large assembly representing all sections of Norwegian hospital life.

I have allowed myself to discuss the problem of the medical-technical hospital departments in such detail also because, apart from being an important part of the usual hospital work, they are also important aspects of:

(*c*) *The policlinical activities at the hospitals*

How this activity is to be carried out has been much discussed in recent years, and no complete agreement has yet been reached. The one thing about which there is no disagreement is that the hospitals must have a policlinic for accidents, and all

acute-hospitals have one in one form or another. These policlinics also serve as places for after-care for patients treated in the surgical departments. Some, comparatively few, hospitals have established policlinics for internal medicine and obstetric-gynaecology. All these policlinics are, however, 'closed' policlinics. This means that the patients themselves cannot directly apply to the policlinics—as is possible in other countries where they have open policlinics. The patients must be referred to the policlinics, either by a private practising doctor or by the hospital's own doctors, with regard to after-care. Only in traffic accidents or other accidents can patients be brought to the policlinics without a doctor's reference.

These policlinics do not usually employ their own doctors, but this does occur, for instance, at Rikshospitalet. The doctors are attached to the hospital departments and are at certain times in charge of the policlinics. Many hospital doctors maintain that the system of the policlinics should be that the patients applied to the hospital doctors as private patients. Thus, the patients would be ensured the direct personal contact with the individual doctor whom the patient wants, and this contact would remain throughout the duration of the sickness. With the policlinics system such a relationship is difficult to maintain. The patient will be treated by one doctor one day, and the next day by another. As for the doctor, he will not be able to acquaint himself with problems of the individual patient as well as desirable, and the patient on his part feels that he is being handed from one to another.

The other view which is maintained, not least by the hospital owners, is that the policlinics, with good equipment and with easy access to medical-technical departments, can provide a better service for the patients. The hospital owners' economic considerations also enter the picture without doubt, possibly also a calculating principle concerning the private and total income of the hospital doctors, but I shall not touch on those problems here. It is, however, my impression that the trend will be in the direction of developing the hospital policlinics, but within the frame of the 'closed' system.

(*d*) The demand for rehabilitation departments in general hospitals has been mentioned earlier. Apart from the purely

general needs for such departments which make themselves felt in the daily work, these departments are on the development programme also because many people, owing to illness, accidents and so on, are unable to earn a living by working. These people today come under the *disablement insurance* which, in accordance with certain rules, provides means for their existence. The degree of disablement, which may vary from time to time, problems of re-education and so on, are often complex and difficult problems to sort out. It is therefore necessary to have special departments to carry out this evaluating function on a medical, psychological and socio-medical basis. Hitherto one such special department has been established in one general hospital. Otherwise these investigations are carried out in all general and special hospitals, but on varying premises. It is therefore estimated that we would get a better and more adequate patient service in the new departments.

(*e*) I mentioned that the number of *places for tuberculosis patients* had dropped by two-thirds of the original number. It is expected that the number will decline further. The many tuberculosis sanatoria that have been closed, and will be closed, are being converted for other purposes—in the first place into homes for the mentally ill.

It is, however, hardly correct to interpret the situation to the effect that tuberculosis is almost extinguished—or can be assumed to become quite extinct. We must, therefore, reckon with having places at our disposal for tuberculosis patients at any time. In the meantime the increased life expectancy, among other things, has led to lung diseases of other kinds making themselves felt. Formerly, the tuberculosis hospitals—the so-called sanatoria—were, in accordance with opinion of the time, placed away from densely populated areas, often in beautiful districts with forests and mountains and a comparatively dry climate, and far from the acute-hospitals. The modern view is that such departments should be connected to the acute-hospitals in order to benefit from the general and special service these hospitals can provide. Therefore, the State has now proposed to close the former tuberculosis sanatoria and build well-equipped lung departments at the central hospitals. These departments are not designed for those with lung

tuberculosis solely, but for lung diseases on the whole. At present a couple of such departments have been established, but others are waiting their turn.

In the centre of the Norwegian hospital system with regard to patient service are the acute-hospitals. As they are being developed with more specialist departments they will be like the spider from whom all the threads emerge.

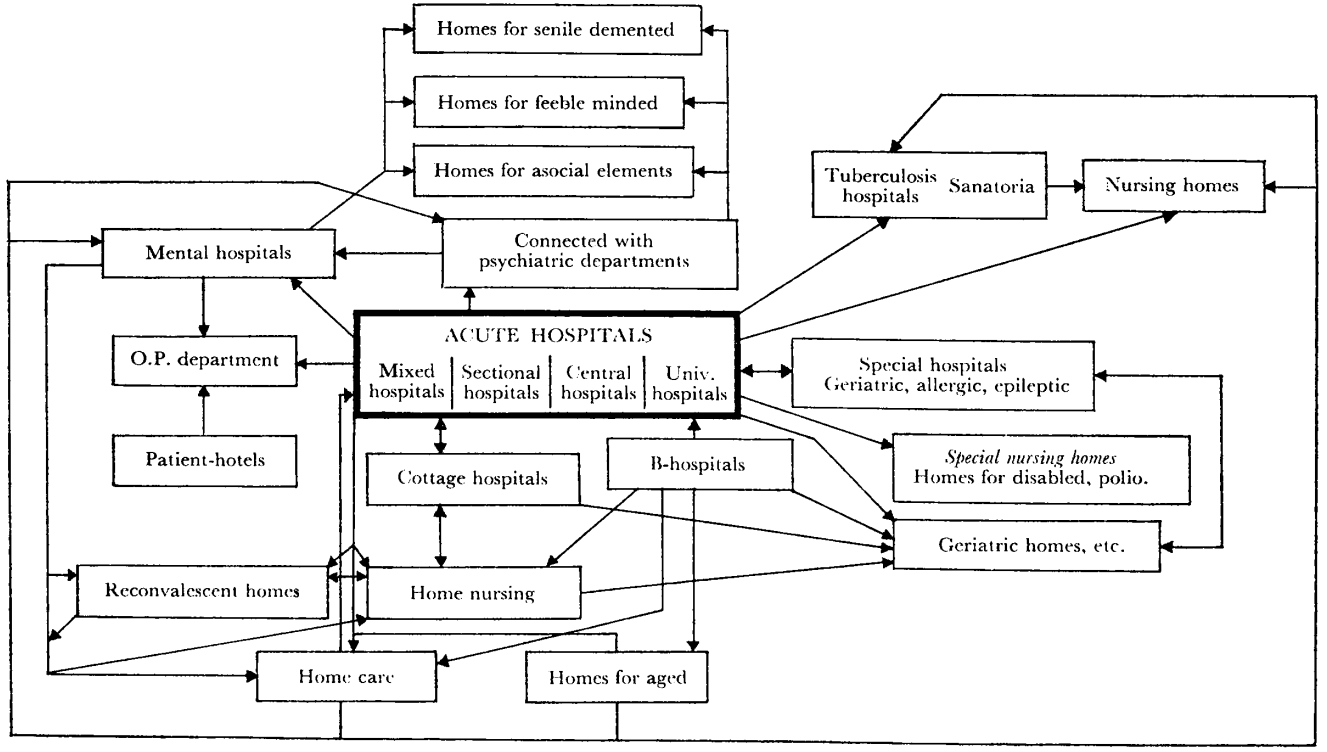
I have attempted to clarify this in the *chart* overleaf. The connecting lines between the various institutions are, however, to a large extent showing arrows pointing in both directions indicating that there is a close interplay between these institutions. In the connections have also been incorporated the various forms of nursing homes, as well as nursing in the homes, which will most certainly, much more than at present, play a part as alleviation links for the acute-hospitals. The financial foundation for a valuable development in this field was provided by an addition to the sick insurance law of 1959.

Administrative aspects

The *commitment* of patients is done chiefly by requisition by *private practitioners and specialists* and by publicly appointed doctors who also practice, and the patients have a completely free choice of doctor. The doctor concerned at the same time makes out a requisition to the sick-insurance fund for a guarantee for the patient's stay in hospital. The application for the patient's entry is made from the doctor direct to the hospitals, in Oslo via a local government intermediary—the so-called *emergency station* (laegevakt), and the doctor is informed when the patient can be received. In the event of immediate aid the patient is sent to the hospital at once—and on the voucher for immediate aid which is made out the sick-insurance fund guarantees the hospital stay afterwards.

After the patient's discharge information is sent to the committing doctor concerning diagnosis, treatment and guidance for possible further treatment or observation of the patient. The committing doctor may then himself undertake the further treatment or observation if he is competent to do so, or the after-care may be effected in the policlinic of the hospital as

GRAPHIC DESCRIPTION OF THE NORWEGIAN HOSPITAL SYSTEM AND RELATIONS WITH REGARD TO PATIENT SERVICE



mentioned, or by a specialist, or the patient may be transferred to a special institution or a nursing home.

In certain cases social curators actively enter the picture at the discharge.

Both at the admission and the discharge of the patient the committing doctor is a central figure.

Apart from looking after the patients with all the means at their disposal, the hospitals, as they increase in size, have been given other functions—in the first place to serve as training centres. I shall not go further into the obligations of the university hospitals to train future doctors and specialists and to carry on medical research. But a fair number of other hospitals have nurses' colleges attached. Most nursing colleges are today run under the auspices of private organizations, for instance the Red Cross, Norwegian Women's Health Association, the National Association for Tuberculosis, for popular health, religious organizations and so on, but also the State, provinces and municipalities have nursing colleges. In the meantime the training plan is uniform for all colleges, prepared jointly by the Norwegian Health Directorate and the organizations who run the colleges, which ensures even and high standards. By a new law, which comes into force on 1st January 1963, the nursing colleges will become independent units and will thus not be subject to the administration of the respective hospitals.

By this law public authorities are required to establish and run nursing colleges, but this authority may be delegated to organizations which already run nursing colleges—and this is being done to a large extent. Under the new arrangement the State will pay the cost of teachers and teaching materials, whilst other expenses for the running of the colleges, such as the keep of and remuneration to the pupils, will be charged to the owners of the hospitals where the colleges have their practical training. Under this new training plan the pupils will not be used for practical work in the hospitals to the same extent as before, which will undoubtedly enhance the training, but it will mean an added problem for the hospitals with the great shortage of nurses.

In this situation the Health Directorate has raised the question of training of nursing aids in the hospitals by developing schools for them. It is hoped that this will not lead to a lowering of the nursing standards, on the contrary. It will be attempted as far as possible to maintain a sufficient number of fully trained nurses. And I may be permitted to state here that Norwegian nursing is at a very satisfactory level which we are very reluctant to see reduced.

In addition to these forms of training there is also training for maternity nurses, children's nurses, midwives, laboratory technicians, and as from 1st January 1963, training of blood bank nurses will also begin.

Furthermore, during the past ten to eleven years there has been an increasing tendency to summon practising doctors and specialists for short, intensive courses in the hospitals. At present there is a plan for the introduction of a postgraduate school for practising doctors in hospitals. The first experimental course of this kind will be held in the spring of 1963—not at the university clinics, but at one of the larger hospitals (incidentally, at Drammen Hospital) and mainly with its own doctors as teachers.

The whole question of training of various categories for hospital personnel is at present being eagerly debated and developed and will considerably influence the hospitals' range of activity—in a favourable direction for the professional standard, but will mean a certain charge on the economy of the hospitals. In this connection I would mention that the Norwegian Health Directorate has recently acquired a property which has been fitted as a postgraduate teaching centre. A number of courses are already under way, not only for personnel connected with the public and administrative health service, but also for hospital personnel, and further plans in this field are in existence.

Although there is no officially established principle that hospitals other than the university hospitals should carry out medical research, there is increasing awareness that the hospitals should be given such opportunity. Some hospitals have, therefore, for several years been carrying out a certain amount

of research, in a wide sense of the word, notably in a clinical direction. But with the development of the hospital laboratories the field of research has been widened, and a fruitful collaboration has been established between the interested departments. The means for this work is granted by scientific funds in the form of scholarships, but no such means have yet been available through the ordinary hospital budgets. Such a development is desirable. This has also been expressed in the highest quarters, the Health Director, Dr. Evang, having expressed the hope, when speaking at the 25-year Jubilee of the Norwegian Hospital Association, that in the future there would be a more rapid growth in the understanding of the hospital owners of broadly based academic and educational tasks of the hospitals.

As already mentioned most hospitals are publicly owned, some smaller hospitals, notably nursing homes, are privately owned—and are run by these various institutions.

Formerly the hospital fees provided by the sick-insurance funds covered the hospital actual costs, and the patients have free hospital treatment by tradition.

Since the war an economic arrangement, based on political lines, has been established so that the sick-insurance fund pays up to a certain sum per patient per day, varying according to the category of the hospital—the greatest contribution to the acute-hospitals, less for the simpler hospitals and least to nursing homes. With the great demands which medicine and social conditions today make on hospital activity—with a growing number of doctors, new categories of hospital personnel, rising prices and wages, whilst the working hours of the personnel is reduced—the hospital fee rates fixed for the sick-insurance fund's contribution by the prices and wages authorities of the State no longer cover the actual expenditure of the hospitals. The difference which arises, and which over the years has shown a constantly increasing trend, has grown quite large and may amount to as much as 50% of the real costs. This difference must then be covered through ordinary taxation. This has led to considerable worries for the hospital owners, who feel hard pressed and over-burdened by the financial demands made—often at the expense of other just demands

such as road building, power stations and so on. In some provinces more than 50% of total revenue is spent on hospital and health services. In consequence the hospital owners have looked round for possibilities of cutting the running costs in hospitals—naturally enough. This is not easy, the medical needs being considered imperative in the public mind. The direct administrators of hospitals in this way come between 'the devil and the deep sea'—on the one hand to have to satisfy the demands of medical development, on the other to try to meet the demands of the financial authorities to apply the brake on cash expenditure. For this reason public committees have been appointed to report on these matters, and efforts have been recommended to rationalize, to greater efficiency, the introduction of labour-saving machines, instruments and work methods. And much has also been done. Some provinces and municipalities, who own hospitals, have set up, only this year, a hospital department (the hospital department of the Town and Country Districts Association), which will among other things discuss economic conditions.

Owing to medical and social demands, however, the hospitals have gradually become very complicated institutions. Many problems, which before were clear and simple, have been given a new content. Both with regard to building, running and administration of hospitals so many factors have emerged which we are not sure how to tackle. It is thus logical to look round for methods to analyse the various aspects of the hospital service.

The Norwegian Hospital Association, which represents the entire Norwegian hospital world—hospital owners, hospital administrators, all categories of hospital personnel, hospital architects and engineers—and which takes up topical hospital problems for *joint discussion* informally and without regard to prestige, is at present working to establish an institute for making research into hospitals and hospital functions. This is considered necessary and rational in order to avoid irrelevant factors such as creed, personal opinion and more or less well-founded assumptions resulting in emergency solutions or other unsatisfactory solutions, which in the long run, would constitute

an unnecessary economic burden, being a charge on the hospital service. This plan has won approval in wide circles.

I shall mention shortly something about the administration of the hospitals. As the hospitals are owned and run by State, provinces, municipalities and private organizations respectively, it will be these institutions who themselves are the top administrative organs. Apart from the fact that the Health Directorate may indicate some guiding lines and makes recommendations among doctors applying for hospital positions and thus exercises some influence, it is left to the hospital owners to be in charge of the running of the hospitals. The situation is actually that to a greater extent than before the provinces are taking over the running of hospitals. The various public and private institutions have therefore their hospital committees and hospital boards. The composition of these bodies is often on political lines. In large town municipalities there is one administrator of all hospital services which come under the elected hospital committee. A similar administrator will, no doubt, be given to the provinces when they are to undertake the financial responsibility for more hospitals by a new administrative arrangement which decides that the towns, with the exception of Oslo and Bergen, are to be incorporated in the provinces as from 1964. One of the provinces (Akershus) has already got such an administrator or co-ordinator.

Each hospital is governed by a managing director, who in Norway is traditionally one of the head doctors at the hospital. Only very few hospitals have administrators with a different training. And only few hospitals have managing directors in whole-time occupation. For most of them administration is a part-time position. While this by and large has worked very well, it is probably due to the fact that the administrators have shown great interest and, to a large extent, have delegated much of their authority to lower levels, to bursars, stewards, administrative nurses, and to the senior doctors of hospital departments. But the one responsible to the authorities is the managing director. This delegation has also the advantage that the other grades take an interest in the administrative aspects of the running of the hospital. But the condition for the success

of this system is that the managing director has an intimate knowledge of general and particular administrative rules and keeps the various leaders well informed of the problems of the hospital. But with the hectic work of a leader of a hospital department today it is not always easy to combine administration and medical work, especially when the hospitals are large.

The great economic problems have led to hospital owners raising the question as to who should be hospital administrators. From these quarters has come the demand that the hospitals should be led by business-trained administrators, whilst one of the hospital doctors should be responsible for medical-administrative work. There has been no outcome of this debate which goes on. From the old days it was laid down that administrators of mental hospitals must be doctors, but that principle was abolished this year.

There is no selection of hospital administrators based on special training or experience in hospital administration, as there has been no organized training in this subject in Norway hitherto. The Norwegian Health Directorate has held courses for active hospital administrators. But there are now plans for the establishment of a school for hospital administration.

There are regular courses for hospital bursars and stewards at Norway's Municipal and Social School. There are also courses for head cooks.

Medically, each hospital department has its head doctor, in some cases also an assistant head doctor (department doctor). They are established. At the university hospitals the assistant head doctors are employed on contract. All other doctors are employed by contracts varying from four years to one year. These junior medical positions may be regarded partly as training positions, formally they are working positions. Trisected hospitals and larger ones, but not the university hospitals, have in latter years got doctors who have completed their university training, but need one year's service in a hospital to obtain their licence to practice.

With regard to the nursing personnel, that, too, has a pyramid form of organization, like the general pattern in hospital administration.

At the head is a matron or administrative nurse, followed by head sisters, ward sisters, assistant sisters and all kinds of special sisters.

The matron reasonably plays a very important part in organizational work in hospitals. It so happens that most nurses in higher hospital positions have a comparatively good training in administration, including hospital administration, as, in order to obtain such posts, they must have passed Norway's Higher Nursing School's administration section of one year's duration.

It is therefore somewhat paradoxical when there is today no organized training for hospital administrators, whilst the higher nurses get quite a good administrative training.

The hospital system has a very central position in the Norwegian health service. This is shown, among other things, by the fact that there are 1,800 doctors' positions at the hospitals, while the total number of doctors in the country is 4,000. One of the problems today is how to get a sufficient number of doctors for the hospitals.

As it will have appeared from the above the Norwegian hospital system largely follows an orthodox pattern, in which we seek to improve the existing and to develop desirable specialties and branches of medicine, within the framework, however, of curative medicine. In this way the Norwegian hospital system is somewhat isolated within the total health service, and it is pointed out that preventive medicine should be fitted into the hospital activities to a greater extent.

In 1957 the Norwegian Storting appointed a committee to report on all matters relating to the hospital system—planning, organization, administration and economy. The complexity of the matter is great and the appointed committee's work has been enormous.

It is possible that the conclusions of the committee may have considerable consequences for the hospital system and its development, and may alter parts of the picture I have tried to present. But the committee's recommendation has not yet been laid on the Government's table—and is therefore not accessible.

PORTUGAL

by

DR. C. A. FERREIRA

Director General of Hospitals, Ministério da Saúde e Assisténcia

1. THE PORTUGUESE CONCEPT OF HOSPITAL

1. Throughout the centuries the Portuguese hospital, as a social institution, was influenced by the fundamental traits of each epoch; it was dispersed, theocentric and technically rudimentary in the Middle Ages; it was concentrated, humanized and administrated by representatives of the Crown in the Modern Age, the epoch of the concentration of political power and trade bourgeoisie; it was secular and scientific in the centuries of liberalism and positivism; it is national and social in the present epoch.

2. The present concept of hospital is summed up in the following extract from an Act now being debated in the National Assembly (the Statute of Health and Public Assistance) which reads in Section XII as follows:

'The aim of hospital activities is to provide, in hospitals or in connection with them, medical care and medical rehabilitation and to collaborate in preventive medicine and social and professional rehabilitation. The nature of the activity of general hospitals, as well as of hospitals specializing in any branch of medicine, must be simultaneously medical and social and, when practicable, hospitals shall co-operate in teaching and medical research. Therefore the following must also be considered as aims of hospital activity:

(*a*) To co-operate with social services in all aspects of problems relating to illness;

(*b*) To provide a field of demonstration and practice for training schools in any way connected with the medical profession and health.'

3. On analysing the above legal extract, which has been integrated and developed in the plan for the new Hospital

Act, also in preparation, the Portuguese concept of hospital can be drawn up as follows:

(*a*) The hospital is an institution having not only a medical but also a social character;

(*b*) It has its own duties and an obligation to participate in other activities;

(*c*) Its own duties are to provide medical care and medical rehabilitation;

(*d*) Its participation in other activities cover the aid the hospital must give to:

preventive medicine;
professional rehabilitation;
teaching and scientific research.

4. Hereinafter I will try to set down the most essential details of each of the aforementioned functions, explaining how they are conceived and carried out in Portugal.

2. THE PORTUGUESE HOSPITAL AND MEDICAL CARE

1. The bulk of medical care in Portugal is carried out by the hospital through its in-patients department, out-patients departments and domiciliary services.

2. There are general hospitals and hospitals specializing in maternity care, tuberculosis, psychiatry, etc., the latter being dependent on special 'Institutes' which co-ordinate the respective services.

3. The Social Insurance System, through the Ministry of Labour, has a wide network of centres in which about 2,000,000 people have the right to first aid or to consult a doctor. These centres have no in-patients department.

There is an agreement between the Social Insurance Service and the hospitals whereby the latter admit and treat patients covered by Social Insurance, the cost being settled by the said insurance. For the time being, however, this agreement applies only to general surgical operations.

4. The doctors on the hospital staff can have their private patients admitted to special rooms in the hospital reserved for private patients.

5. The salary of the doctors on the hospital staff is composed of two parts: a fixed salary according to the doctor's category on the staff and a floating salary resulting from the division of fees paid by his patients. (It should be pointed out that it is not only the doctor who benefits from this division of fees but also his technical auxiliaries and the nursing staff.)

6. The main lines on which our hospitals are run are summarised in Section VII of the new Hospital Act which reads as follows:

'Section VII--1. Hospital care shall adhere to the following guiding rules:

(1) The main aim is the medical care and the medical rehabilitation of the patient. All other aims are to be considered as accessories to this main aim.

(2) Patients shall only be admitted to hospital when they cannot be treated as out-patients or at home.

(3) The specialization either of hospitals or of services shall be restricted to the cases in which this is technically indispensable but the need for close collaboration between the general hospitals and the specialist hospitals must always be borne in mind.

(4) Continuity of treatment shall always be carefully assured when the patient has to be transferred to another hospital or to a different department of the same hospital.

(5) The criterion for priority for admission to hospital shall be based on the medical and social needs of the patient. Under no circumstance whatsoever shall the amount payable by the patient, either directly or indirectly, be used as a reason for granting priority.

(6) Treatment will not necessarily end just because the patient is allowed to go home. It is up to the hospital to keep in touch with the patient until he is fit to return to work, or even afterwards, in order to establish an efficient follow-up of the case.'

3. THE PORTUGUESE HOSPITAL AND MEDICAL REHABILITATION

1. As Portugal did not enter the last war, the problems arising from mutilation, lesions and other forms of physical disabilities are not so great as in other countries. The attention of the Government has been drawn to this sector of medical and social activity, however, by the increasing number of accidents on the road and at work and by the possibilities which modern science can afford for the elimination or reduction of sensorial, physical, motor or visceral incapacities.

2. The hospital has taken upon itself not only the phase pertaining to medical care and medical rehabilitation but has also committed itself to collaborate in social and professional rehabilitation.

3. The plan, already partially in operation, comprises the following:

(*a*) *In the hospital:* medical care and medical rehabilitation services;

(*b*) *Outside the hospital but in liaison with it:* special centres for physical medicine and rehabilitation.

4. All hospital services are being encouraged to take part in the new orientation being given to medical rehabilitation, particularly in connection with orthopaedics, traumatology, neurology and neurosurgery and physiotherapy.

5. Apart from the usual funds allocated to the hospitals by the Government, 50% of the net proceeds of the 'Football Coupons' have been set aside for the treatment of the physically handicapped. (It should be pointed out that the Football Coupons are run under the auspices of the State.) This grant will finance not only the medical phase of rehabilitation but also the non-medical phase which comes under the Public Assistance Board.

Three physical medicine and rehabilitation centres are being built at the moment, one in each of the hospital zones into which the country is divided.

4. THE PORTUGUESE HOSPITAL AND PREVENTIVE MEDICINE

1. Health is, in itself, a unitary concept. It is essential that services dealing with health problems should bear this concept in mind.

2. Bearing this principle in mind, Portuguese health legislation allows public health officers to work, in their capacity, in hospitals. In the more outlying districts, these officers have more responsibilities: Therefore:

3. Section XXXIII of the new Hospital Act predicts that there shall be a representative of the public health service on the board of directors of the hospitals.

4. On the equivalent of the British regional hospital board ('Comissão Inter-Hospitalar'), as is explained hereinafter, there is always a representative of the public health service from the area in question.

5. Health centres, dependent on the public health service, will operate in the country hospitals, known as sub-regional hospitals, in installations granted them specially for this purpose.

5. THE PORTUGUESE HOSPITAL AND TEACHING

1. As has been seen from the guiding rules quoted above from Section VII of the Hospital Act, the main aim of all hospitals is the medical care and medical rehabilitation of the patient. All other aims, including teaching and research, are considered as being secondary.

2. There are, however, special teaching hospitals where medicine, nursing and other subjects connected with health services, are taught. These hospitals are called 'teaching hospitals'. There are three in all, one in Lisbon, one in Oporto, and one in Coimbra, functioning in liaison with the respective faculties of medicine.

3. Teaching hospitals, like any other hospital, are integrated in the general organization for medical attention in this country and also come under the Ministry of Health and Public Assistance which administrates them through a staff appointed by the Minister.

4. There is always a representative of the faculty of medicine on the board of directors of these teaching hospitals. Under Portuguese law, the administrator of a teaching hospital may be a professor of medicine, but not necessarily, and is appointed in agreement with the Ministry of Education. On the other hand, the faculties of medicine have representatives with the right to vote both on the board of directors and on the medical committee. Lastly, the direction of each of the hospital departments goes by right to the professors of the corresponding chair in the faculty of medicine. If there is no chair corresponding to the hospital department in question, the Ministry of Health, when appointing a director for the department, gives the post in preference to professors or doctors in medicine.

6. HOSPITAL REGIONALIZATION IN PORTUGAL

1. The first Act establishing the basis for hospital regionalization in Portugal was Act 2011 dated 15th April 1947. Under this Act, the country was divided into three zones (North, Centre and South), the capitals being the university cities of Oporto, Coimbra and Lisbon. Each zone is divided up into regions which normally correspond to the districts of the administrative division of the country. Each region is further divided up into sub-regions which also normally correspond to an area coming under local municipal authorities. At the head of each hospital zone, there are central hospitals which are the most advanced in the organization and must therefore aid and guide the regional hospitals. Some of these central hospitals are also teaching hospitals.

At the head of each region, there is a regional hospital and at the head of each sub-region, a sub-regional hospital.

2. We feel justified in calling the Portuguese regionalization system an advanced one seeing that the hospitals are, so-to-speak, on a scale and are classified according to the standard of medical treatment they must provide. The medical duties of each hospital are concerned not only with its own functions but also with those of the hospitals under it. The hospitals at the top of the scale give every aid and backing to the hospitals lower down the scale.

3. The sub-regional hospitals are at the bottom of the scale. Their function is to provide their area with general medical and surgical care, obstetrics and, when necessary, accommodation for isolation cases.

These sub-regional hospitals are situated in the municipal areas.

4. The regional hospitals are in the middle of the scale and provide, for their area, general medical and surgical services, obstetrics and isolation, as is the case with sub-regional hospitals, and also all current specialist treatment. These hospitals treat the patients from the sub-regional hospitals when the state of health of the patient is very serious and exceeds the technical capacity of the sub-regional hospitals.

These hospitals must also guide the sub-regional hospitals existing in the regional area, and establish a liaison with the hospital at the top of the scale (the central hospital).

5. The central hospitals are the apex of the organization and deal not only with current specialist services, as is the case with regional hospitals, but also with rare specialist cases. Our aim is to make each zone technically autonomous and to supply each zone with all the working elements required for a fully comprehensive unit with the capacity to resolve all medical problems in its area.

6. The Portuguese system of hospital regionalization can only be efficient so long as each zone has committees capable of co-ordinating the hospital services under their jurisdiction, drawing up the plans for regional activity and controlling and supervising the execution of these plans. Hospital regionalization entails transferring responsibilities from a central office to the zone or regional hospital authorities and, needless to say, the setting up of an efficient service to supervise and control the actions of the latter.

7. In each head of a zone, there is a zone director who is the permanent delegate of the 'General Direction of Hospitals' to the hospitals in the area. In each of these regions there is also the equivalent of a British regional hospital board ('Comissao Inter-Hospitalar') formed by representatives of each type of

hospital in the area in question, whether general or specialist, central, regional or sub-regional.

8. Each 'Comissão Inter-Hospitalar' has a plenary council which sets the policy for the hospital activity and approves the major plans and an executive council which is entrusted with the execution of the decisions taken by the plenary council or of instructions from the General Direction of Hospitals.

9. The main characteristic of the Portuguese regionalization system lies precisely in the fact that the members of the 'Comissão Inter-Hospitalar' are elected by the actual hospitals and that their duties are limited to orientation and co-ordination and not to hospital management.

10. In actual fact the 'Comissão Inter-Hospitalar' in Portugal is formed not by civil servants but rather by representatives elected by the actual hospitals. On the other hand, it has no administrative duties, the latter being entirely in the hands of each individual hospital. The functions of the 'Comissão Inter-Hospitalar' are limited to co-ordination, orientation, encouragement and supervision. There can however be collective services for the transportation of patients, for purchases, statistics, etc.

11. At each of the regional hospitals there is a bed bureau to which the patients who cannot be treated by the sub-regional hospitals may apply to find out which hospital is more suited to their particular case. This bureau reserves the beds for these patients and notes why the sub-regional hospital was unable to treat them.

12. These bed bureaux are essential in the Portuguese regionalization system because patients are only transferred to other hospitals when it is proved that there are medical reasons for doing so. The bed bureau must be informed why the hospital was unable to treat the patient.

The bed bureaux work not only in liaison with the regional hospitals but also with the 'Comissãoes Inter-Hospitalares', the latter being the apex of the organization.

13. The regionalization movement is already in operation. More than half of the country has been brought under this

system and it is hoped that it will be in operation all over the country by the end of the first trimester of 1963.

7. OWNERSHIP AND ADMINISTRATION OF THE HOSPITALS IN PORTUGAL

1. As regards ownership, upkeep and administration, there are two types of hospitals in Portugal: public hospitals and private hospitals.

Public hospitals are founded, supported and administered exclusively by the State. The private hospitals are founded, supported and administered by the 'Santas Casas da Misericordia', or by other private institutions, although the State grants them considerable financial aid.

2. The 'Santas Casas da Misericordia' are private institutions which came into being in the fifteenth century as brotherhoods.

There are a total of 14,000 beds in the 'Misericordia's' hospitals, i.e., 60% of the general hospital beds.

3. Hospital activity is nowadays a public function to which no State can remain indifferent. It is one of the most pressing collective necessities and nationalization is therefore accordingly fully justified.

4. The problem, however, is to know whether special conditions existing in some countries might not make it advisable to permit the ownership and administration of hospitals to remain private but to subject them to State orientation and supervision.

In my country we are trying to maintain this alliance between the private character of the hospitals and State supervision.

5. As regards the general hospitals, the State owns and administers directly only the central hospitals and the teaching hospitals. The other general hospitals belong to the 'Santas Casas da Misericordia'. In Oporto, however, there is a central hospital belonging to the 'Santa Casa da Misericordia'.

6. But, no matter whether public or private, all hospitals are integrated in the same regionalization system on a national level, all come under the technical orientation of the Ministry

of Health and all are subject to the administrative tutelage of the State which approves their budgets and audits their reports.

7. The administration of the private hospitals belongs to a 'board' formed by citizens elected by the General Assembly of the 'Misericordia'. In the more progressive hospitals, however, there are qualified administrators responsible to the board for the management of the hospital.

8. THE FINANCING OF THE HOSPITALS

1. Funds for the financing of the hospitals are obtained from the following sources:

(*a*) The fees paid by the patients who can afford to do so;

(*b*) The municipal authorities who pay the fees for needy patients domiciled in their area;

(*c*) The Social Insurance Service which is responsible for its insured in the terms of the agreement already mentioned;

(*d*) The hospitals themselves from income from private property or from the exploitation of services operated through the hospitals;

(*e*) The State which makes up for any deficiency in the aforementioned sources.

2. The portion payable by the patients depends on their financial status and is assessed by a means test; there are accordingly patients who pay the full fees, whereas others pay only a part or nothing at all.

3. The municipal authorities pay a portion of the cost of the daily upkeep of the patient. This portion is variable depending on the category of the hospital.

4. The Social Insurance Service pays in the terms of the aforementioned agreement but, for the time being, this applies only to general surgical operations. Their responsibility is limited to 20 days stay in hospital.

5. The hospitals own property, sometimes exceedingly valuable, the income from which goes towards its running costs.

6. Lastly, the State, through the Ministry of Health and Public Assistance, grants subsidies to the hospitals, the rate being that which will assure their proper functioning and in accordance with the needs of the hospital.

9. THE CONSTRUCTION AND EQUIPPING OF THE HOSPITALS

1. The Committee for Hospital Constructions, under the Ministry for Public Works, is presided over by the Director General of the hospitals. This committee is responsible for the construction and remodelling of the public hospitals and, in the case of private hospitals, gives technical guidance.

2. A committee was also formed for the re-equipment of the hospitals and is annually granted funds from the State budget. These funds are used to carry out the plans drawn up by the 'Comissãoes Inter-Hospitalares' and passed by the Minister of Finance and the Minister of Health.

10. THE ADMINISTRATIVE STAFF OF THE HOSPITALS

1. A distinction must be made between the regimen applicable to public hospitals and the regimen for private or 'Misericordia' hospitals. A further distinction must be made between the managing staff and the purely executive staff.

2. In public hospitals the managing staff (administrators and heads of departments) are chosen from candidates holding a university degree and with administrative experience. A course for hospital administrators has not yet been started but will start under the National School for Public Health, the foundation of which depends on a new law pending for debate in the National Assembly.

3. The executive staff of the public hospitals all follow a common career in the services of the Ministry of Health. The members of the staff are admitted or promoted by means of an examination.

4. Both the managing staff and the executive staff of the public hospitals are civil servants.

5. The administrative staff of the 'Misericordia' hospitals have, up to now, been appointed freely by the board of directors without any special qualifications being required.

6. However, under a new regulation being gradually applied to regional hospitals, this freedom of appointment has been limited by the following conditions:

(*a*) The administrators and head clerks can only be chosen from candidates who have passed an examination set by the General Direction of Hospitals;

(*b*) The executive staff can only be chosen from candidates who have passed a similar type of examination and who hold academic qualifications on a high school level.

7. A course in hospital administration has already been held for head clerks and it is hoped to hold a similar course for administrators soon.

11. THE GENERAL DIRECTION OF HOSPITALS

1. The General Direction of Hospitals, formed under Decree 43,853 of 10th August 1961, comes under the Ministry of Health and Public Assistance and must guide, co-ordinate, supervise and control the activity of public and private hospitals.

2. The General Direction of Hospitals is being organized on an essentially technical basis and responsibility is being gradually delegated to the zone and regional hospital authorities.

3. Its central offices comprise the following departments: medicine, pharmacy, nursing, social services, management and regional organization, which are backed by a central department of archives, library, statistics and general information.

4. In the head city of each zone, there is a director who presides at the 'Comissão Inter-Hospitalar'. This director is the representative of the General Direction of Hospitals for the area and must see that the instructions from headquarters are carried out. He is also responsible for drawing up, and execution of, the hospital plan for the zone. In each region there is a regional delegate.

PORTUGUESE HOSPITAL SERVICES ON 31/12/60

Map I—Total Number of Hospitals and Beds

Classification	*Units*	*Beds*
General Hospitals	267	21,086
Mental Hospitals	11	6,441
Tuberculosis Hospitals	96	10,093
Maternity	15	1,082
Cancer	1	300
Cottage Hospitals	39	1,823
Nursing Homes	118	8,751
Total	547	49,576

Map II—Public and Private Hospitals

Classification	*Public Hospitals*		*Private Hospitals*	
	Units	*Beds*	*Units*	*Beds*
General Hospitals	8	5,809	259	15,277
Mental Hospitals	4	2,996	7	3,445
Tuberculosis Hospitals	23	5,154	73	4,939
Maternity	6	967	9	115
Cottage Hospitals	—	—	39	1,823
Nursing Homes	—	—	118	8,751
Total	41	14,926	505	34,350

Map III—General Hospitals

Classification	*Units*	*Beds*
Central Hospitals	14	7,544
Regional Hospitals	24	4,622
Sub-Regional Hospitals	229	8,920
Total	267	21,086

PORTUGAL

Area	91,618·81 Km²
Population	9,130,410 inhabitants
Doctors	7,797

SWEDEN

by

DR. ARTHUR ENGEL

Director General, National Board of Health

THE SWEDISH REGIONALIZED HOSPITAL SYSTEM

The rising costs of hospital care and shortage of medical personnel and especially doctors and nurses have focused the interest of the responsible medical and political bodies on rational hospital planning and organization. It is worth mentioning that the consumption (or production) of all kinds of health care has increased by 3·2% each year during the years 1945–58. During the same period of time the total labour force occupied within the health service has gone up by 4·3% annually while the total expenditure out of public funds for health rose by 8·2% each year. Those costs correspond to 3·3% of the gross national product of the country. In fact, we are looking forward to a similar development in years to come but the increase is expected to be less pronounced. The share of the gross national product spent on health thus is calculated for the years 1970 and 1980 to become roughly 5% and 6½% respectively. It should be observed that in Sweden there is only a small sector of private expenditure for health (22 U.S. $ per capita against 105 $ in the U.S.A.*) and that such social services as care for alcoholic addicts and the welfare of children and the aged are not included. Furthermore, neither investments nor running costs of water supply, sewage disposal or labour protection are included.

The health services in this country are well developed and hospital facilities especially well provided for. There are hospital beds (cottage hospitals and nursing homes not included) for somatic diseases corresponding to 6·6% of the population and hospital beds and nursing homes for mental diseases to 6·7% (mental deficiency included). Taking this into consideration the expected increase in expenditure for

* Facts on the major killing and crippling diseases. National Health Education Committee, Inc. 1961.

health at the first glance might appear as an exaggeration of the future need. I am, however, convinced that medical science and technology will continuously furnish practical medicine with new and certainly more expensive weapons against disease that will require more and more personnel for its operation. I also believe in an increasing public demand for health services of different kinds not least in prevention, health control and medical advice in many situations of life. In Sweden with its extremely low birthrate (13·85%) and long expectancy of life (for men 70·5 years and for women 73·4); the age distribution of the population is becoming an undesirable one from many points of view. One of them is the aspect of medical care. Recent studies of a royal commission on the future need of doctors, of which I was the chairman seem to reveal a very strong increase in consumption of medical care by high-age-groups. The following table demonstrates this relationship by means of an index calculated from the use of hospital facilities, other institutional care and medical consultations of all kinds.

Number of consumer units in different ages

Age	*General hospitals, TB and contagious diseases*	*Long term diseases*	*Mental diseases*	*Ambulatory care*	*Total*
0– 9	0·63	0·00	0·00	0·35	0·4
10–19	0·47	0·02	0·01	0·27	0·5
20–29	0·78	0·02	0·27	0·53	0·5
30–39	0·82	0·03	0·49	0·73	0·6
40–49	0·90	0·09	0·90	0·83	0·8
50–59	1·29	0·21	1·30	1·24	1·2
60–69	1·74	0·69	1·87	1·68	1·6
70–79	2·00	2·09	2·15	2·07	2·0
80–	1·37	6·85	3·01	2·30	2·4

The figures of the table show the percentage of medical care in the different age groups in relation to the percentage for the whole Swedish population according to each type of care. The last column shows those figures for all types of medical care together. A consumer unit is defined as one individual of the

age group representing the mean value for the use of health services of all age-groups. A person between 10 to 19 is only counted as half a unit, a person about 50 is one unit, etc.

No doubt our ageing population will require a volume of medical care that is surprisingly high and which the health authorities should consider and plan for in time. The inequality of the demand for health services in different age groups has brought the Swedish National Board of Health to start operating with 'consumer units' instead of number of inhabitants in the planning for the future medical care.

Against the background here briefly outlined it is quite clear that the Swedish health policy must find ways and means to use its resources in a rational over-all health organization favouring preventive measures, domiciliary and out-patient services and trying to make intensive use of the hospital beds. Great concern has especially been taken in the planning for hospital care with the view of providing easy access for the population to specialized medical treatment. As Swedish hospitals to a large extent are offering ambulatory specialized care through their out-patient departments there is an extra demand from the public for a decentralization that has to compete with the necessity of a certain centralization to arrive at rational units.

It goes without saying that medical care of general character, however, does not need to be centralized as is the case of highly specialized services. Forty thousand inhabitants may constitute a reasonable population to set up hospital departments of internal medicine and surgery with X-ray departments and anaesthesiology (Swedish normal hospital) while the most advanced specialties (neurosurgery, thoracic surgery, etc.) should roughly have 1 million inhabitants to serve. Without a sufficient population basis you cannot organize hospital departments of an optimal size and effectivity. The specialist himself certainly demands a clientèle large enough to give him necessary experience and routine.

During the last 15 years the requirement of hospital beds was eagerly studied. Attempt has been made to estimate the number of beds in general and of different specialties in relation to

population, so-called *bed quotas* (bed/population rates). As has already been pointed out these figures are highly dependent on the composition of the population according to age groups. They must further vary with the prevalence of disease among the population in respect of the total pattern as well as of the frequency of the individual diseases. Many other factors are also involved, e.g., social and economical. Health insurance schemes thus can have an effect in either raising the demand for hospital beds as is the situation in Sweden with completely free hospital care and lesser benefits for ambulatory and domiciliary care, or bringing them down where consultations are favourably covered by the insurance. The housing situation in certain areas may influence the tendency to hospitalization as well as a strong family tradition (Israel) may be effective in the opposite way especially in the case of old people.

The value of minimum standard rates for hospital beds '*bed quotas*' is—that must be frankly underlined—a limited one. If the figures are related to age groups (consumer units) they are more reliable as a base for hospital planning but there is still much criticism left. However, if we take them with a pinch of salt they are in our experience indispensable in hospital planning as a crude guidance. I will here below present the Swedish figures as used for hospital planning inside the counties by the National Board of Health and the special Commission on Hospital Planning and Equipment. They are entirely based on the experiences from the last 15 years hospital planning and they have been revised from time to time. Prominent causes for revision have been the marked decrease of infectious diseases and increase of diseases related to old age.

Hospital beds in relation to population as recommended by the Swedish National Board of Health. (The most specialized services not included, cf. page 258.)

	Beds per 1,000 *population*
Somatic hospitals	
Non-specialized (residual small hospitals)	0·2
Surgery	1·3–1·4
Medicine	1·4–1·5

	Beds per 1,000 population
Gynaecology	0·3 – 0·4
Obstetrics	0·5
Otorhinolaryngology	0·15 – 0·19
Ophthalmology	0·12
Paediatrics	0·3
Orthopaedics	0·3 – 0·4
Long term care	0·25
(in nursing homes)	(3·75)
Lung diseases (decreasing)	0·4
Contagious diseases (decreasing)	0·2 – 0·3
Psychiatry (minor psychiatry)	0·3
Total	5·72 – 6·26

	Beds per 1,000 population
Mental hospitals and institutions for mental delinquency	
Mental hospitals	3·6
Mentally deficients with other handicaps, delinquents and low grade deficients (idiots)	0·3
Nursing homes for mentally diseased	1·0
Mentally deficients: nursing institutions (external schools excluded)	1·2
Total	6·1

The new hospital plan for England and Wales,* presented by the Minister of Health to Parliament, January 1962, presents the existing ratios of hospital beds and assesses the needs for 1975. The provision of beds which ought to be made by 1975 is in comparison with the Swedish estimates surprisingly low and lower or the same as the present available number.

* Her Majesty's Stationery Office, London, Cmnd. 1604.

	Per 1,000 *population*
Acute beds	3·3
Maternity beds	0·58
Geriatric beds	1·4
Beds for mental illness	1·8
Beds for mental subnormality	1·3

Similar studies are reported from Norway (personal communication by Dr. Evang), Czechoslovakia and U.S.S.R. (cf. WHO Techn. report series No. 215).

One hundred years ago there arose on the ground of the historical Swedish counties a new regional system of self-government, the county councils. This competent body is a small locally elected parliament meeting as a rule once a year and having the right to impose a specific duty on the inhabitants of the county. An executive committee carries out the resolutions taken by the county council in session. A county has on average a population of about 250,000. Their appropriate size together with a very well manifested interest in providing the best facilities for hospital care—their main responsibility according to the national law regulating their activity—have offered excellent capability of development. The high standard of hospital care in Sweden is thus to a great extent the merit of the county councils. It is a well established fact that a population of 200,000–250,000 is enough as a base for a modern well-specialized hospital. Our so called *central hospitals* (one for each county) have proved it. Those hospitals have up to 13 specialized departments and several laboratory and other technical services. The recommended pattern—realized in several counties—is:

Departments with wards

Internal medicine
General surgery
Paediatrics
Gynaecology and obstetrics (women's clinic)
Ear, nose and throat
Ophthalmology

*Neurology
*Dermatology
Orthopaedics
Minor psychiatry
Child psychiatry
Rehabilitation clinic
Long term diseases

Other services

Radiology
Anaesthesiology
Physiology
Biochemistry
Microbiology
Pathological anatomy
Dental clinic

Around the central hospital and its many specialized outpatient departments as the very core of the hospital system there are grouped so called *normal hospitals* with internal medicine, general surgery, radiology and anaesthesiology represented. In some places there are also departments of gynaecology and obstetrics as well as of paediatrics with much importance placed in their participation in the MCH-Welfare of the area. As already mentioned 40,000 individuals seem to be a reasonable population for such a normal hospital. Here I feel justified to state that the policy of the National Board of Health, supervising the whole field of medical care, is to eliminate the small hospitals or to transform them into normal hospitals. In very remote and sparsely populated areas only a one-doctor hospital or a cottage hospital may exceptionally be accepted. Good roads and every fifth Swede a motor-car owner seem to neutralize the local resistance our policy sometimes meets with.

The success of the county hospital scheme has convinced the public and reluctantly the medical profession of the advantage of having the county councils as responsible for all medical care including individual preventive measures. The county councils will therefore according to a parliamentary act of 1961 take over the district doctors and their stations (today serving a population of about 6,000 in a rural area). A better integration between

* In larger counties only.

medical care inside and outside the hospital will thereby be achieved. It is to be expected that the County Council will in a near future become responsible for the administration of the mental hospitals now run by the State—a process already developing on a voluntary basis. The state will thereafter be responsible—apart from its over-all planning, supervising and controlling functions—only for environmental sanitation and probably a few small branches of highly specialized institutional services (criminal psychopathics, the blind, the deaf and complicatedly disabled individuals). The responsibility for environmental hygiene, however, is divided between the smallest administrative units (the communes) and the state. The desirability of congruence between local communes and rural health districts has been claimed and from the public health point of view it has repeatedly been advised to have both not smaller than 8,000–10,000 inhabitants, and with two or three district doctors working at one station which under these conditions could be better staffed and equipped and acting as the local health centre.

I have tried to visualize the hospital organization inside the counties and to present the counties' newly acquired over-all responsibility for medical care including individual preventive medicine. Experience has shown that these self-governing territories have been capable of building up highly differentiated hospital facilities but otherwise it is full evidence that they are not large enough to support such specialties as neurosurgery, thoracic surgery, radiotherapeutic cancer clinics, virus laboratory, etc.

Also in our country as everywhere, new branches of medicine first emerge at the teaching hospitals. Exceptions, however, exist and there are a few examples of even world-famous clinics for new, highly specialized disciplines established at municipal non-teaching hospitals around a professional of high competence and strength of will. In 1956 I was appointed by the government as a one-man commission to study the need of resources for the most specialized hospital services and to advise on a suitable organization to provide this care on a nation-wide scale. Medical reasons are not the sole justification for a rational organization. Sound economy in the use of medical

personnel and of available funds interfere, too. Equipment and running costs are, as is well known, extremely high for those services indicating a concentration to units of a sufficient number of beds. Large units are furthermore indicated to secure a clientèle large enough for practical and scientific studies and for teaching purposes. Each large and highly specialized hospital should be regarded as a potential teaching hospital for education and training of doctors, not least the post-graduate training of specialists. It is an important task to balance the factors speaking in favour of high centralization against those indicating decentralization, based among other factors on an understandable wish of the public to have medical facilities within a convenient distance. In spite of excellent communications the last mentioned circumstance must be duly considered in a hospital plan of a country like Sweden so sparsely populated in its northern wide area. Strong local political forces will immediately remind the hospital planner should he forget to implement this basic psychological factor.

Elements necessary in hospital planning are:

The number of people you have to plan for;

Demographic character and distribution of this population;

Total needs of beds;

Optimal size of the different departments of the hospital;

A site of the hospital with a guarantee for best communication facilities for an optimal number of inhabitants.

I have above described the hospital organization of the Swedish county. The terms of reference of my commission now required a higher organizational level for let us call them superspecialties. Regionalized hospital systems of this kind exist in the United Kingdom since the introduction of the National Health Service. England and Wales thus have 15 hospital regions of 1,500,000 to 4,500,000 inhabitants and Scotland five with a population varying from 200,000 to 3,000,000. The guiding principle was independent and complete medical service inside each region. The system of France is a very logical one. The 'Centre hospitalier regional' is serving five or six 'départements' with a total population of 2,250,000 to

2,700,000. There is also a requirement that nobody should be living more than 120–150 kilometers from his regional hospital. There is one 'centre hospitalier' in each département (450,000 inhabitants on average) organized on the whole as a Swedish central hospital. As early as 1947 the master plan for hospitals and related facilities for Greater New York recommended one 'central hospital' with neurosurgery, plastic surgery, thoracic surgery and ophthalmology for each million of population of the city. Massachusetts calculated in 1954 for their 4,500,000 inhabitants four regional hospitals with every specialty.

I held a series of hearings with representatives of the most specialized branches of medicine demanding their opinion on the need of hospital beds for their different specialties, the optimal size of departments, etc. By means of an enquête to the hospitals the present activity within the following branches was analysed: neurosurgery, thoracic surgery, plastic surgery, radiotherapy, neurology, dermatology, urology and child surgery. Waiting lists were also required.

The estimated standard figures arrived at were the following:

	Beds per 100,000 *population*	*Unit size*
Plastic surgery	5·5	60 beds
Thoracic surgery	5·5	50–75 beds
Neurosurgery	4·1	40–45 beds
Radiotherapy (cancer clinics)	8	100–150 beds (at least $\frac{1}{3}$ for gynaecological cancer)
Neurology*	12–16	60 beds
Dermatology*	15 (rural areas) 30 (big cities)	50–60 beds
Urology	(undetermined)	60 beds ($\frac{2}{3}$ male patients)

* To be divided between regional hospitals and the largest central hospitals.

	Beds per 100,000 children *under* 15 *years of age*	
Child surgery	100 (densely populated areas) 20 (sparsely populated areas)	50 beds

The four first mentioned specialities seem to be leading for the size of the region because here a strong centralization is most indispensable. The majority of cases belonging to neurology, dermatology or urology can and should be taken care of in departments of internal medicine and general surgery of county central hospitals whereas the recommended regional unit should provide for treatment of the most complicated cases. As regards child surgery the requirement of beds is high in the large cities where all children with surgical diseases are expected to consult child surgery department. In other areas it has been found most practical to leave it to the general surgeon to take care of the majority of children, representing as a rule emergency cases. Only those cases which need the experience and the technical skill of the child surgeon have to be sent to him.

From the above mentioned calculations it was apparent that in accordance with experience from abroad about 1 million inhabitants would be necessary for setting up a hospital with the specialities we had in mind and with enough number of beds to constitute a desirable unit.

The next step of procedure was to nominate those among the large hospitals which seemed to become most suitable as *regional hospitals*. The five teaching hospitals (Caroline Hospital, Stockholm, University Hospital, Lund-Malmö, Sahlgrenska Hospital, Gothenburg, Academic Hospital, Uppsala, and Umeå Hospital at Umeå in the northern part of the country) are from the beginning predestinated. In order to draw up the borders of the regions required for Sweden's 7,500,000 inhabitants an expert in economical geography was summoned to study the problem from the point of demographic and economic development as well as a problem of transport. It

was from the beginning clear that if possible a county should not be divided between two regions and that we had to be prepared in the vast sparsely populated Umeå region a smaller number of inhabitants than the ideal 1 million.

The geographer, Dr. Godlund, has published his studies separately.* The reader interested in the details is referred to this paper. Here shall only be remarked that these potential regional hospital sites were earmarked by me and analysed by Dr. Godlund from his special points of view, taking into consideration the population and transport situation in the year 1955 (the last available figures when the study was made) and its probable development up to 1970. The result as it appeared in the report of the commission took the form of two alternative proposals.

1. Six regions immediately, with Linköping Central Hospital as regional hospital.

2. Seven regions with Orebro Central Hospital as the seventh regional hospital from 1970.

The counties were supposed to collaborate in the regionalization plan on a voluntary basis. The county in which the regional hospital is situated should run the regional hospital and the other counties should pay for the real costs of the treatment of their patients, i.e., for running as well as investment costs.

Additional recommendations were that the co-operation between the counties should start with the following clinical branches: neurosurgery, neuromedicine, thoracic surgery, plastic surgery, urology, child surgery, radiotherapy, dermatology and rheumatology† and special cardiology. Further on, 'jaw units' and units for renal diseases including artificial kidney treatment were recommended.

The following laboratory services were proposed: paediatric X-ray departments, virological, allergological and blood-coagulation laboratories, laboratories for hormone analysis, for cytology and for isotope diagnostics and therapy ('hot laboratories').

* Godlund: Population, regional hospitals, transport facilities, and regions. Royal University of Lund, Sweden, 1961.

† Against my recommendation.

As might be observed from the list, specialization in the surgical field has been largely embarked upon whereas great concern has been taken not to break up internal medicine too much. I always felt that specialization in medicine should mainly be based on technological grounds. This attitude seems to me to guarantee the integration of medical care of the individual in the best possible way. I therefore suggested that cardiology in principle should be kept under the department of internal medicine, but that a small technical unit of about 30 beds should be arranged for the advanced diagnostic procedures (catherization on the arterial side, etc.). This unit should closely co-operate with thoracic surgery, chest clinic and laboratory of clinical physiology. Endocrinology with its very close connections to metabolism will also remain inside internal medicine and here again the technical provisions will be offered by a special agency, the hormone laboratory.

Another matter of concern has been the independency of the new specialties. From the emerging young specialist there is a strong demand for separate departments for each specialty while the old clinicians are in favour of having them as subdivisions of departments of medicine and general surgery. My own attitude and my recommendations are on reasons already mentioned favouring independency of surgery branches and subordination of most of the new offsprings of internal medicine.

The plan was with slight modifications presented by the cabinet to Parliament in 1960. The main change, made in the cabinet bill, was that already from the start seven regions should be established. Parliament accepted the plan. Its application in practice has up to date gone very smoothly. The counties of each region have set up a joint agency of co-ordination advising the county councils with which the final decision lies.

Through this declaration of Parliament, Sweden has a regionalized hospital system with regional hospitals, county central hospitals and peripheral county hospitals called normal hospitals. The philosophy of the system seems to be very popular and a fruitful basis for further planning in the field of medical care. Thus, it has been recommended on the regional level to organize the following services.

1. In addition to the child psychiatry department, special homes for the treatment of mentally disturbed children.

2. Institutions for the treatment and education of children with cerebral palsy.

3. Highly qualified audiological laboratory.

4. Foniatric clinic.

5. Rehabilitation centre for neurologically disabled attached to the department of neuromedicine.

6. Departments of child neurology.

7. Clinical pharmacology departments.

No doubt there will be other activities added in the future.

ON EDUCATION AND TRAINING OF HOSPITAL ADMINISTRATORS IN SWEDEN

Leading administrative posts in Swedish hospitals

Hospitals in Sweden are owned and administered either by the state or by regional authorities—county councils or, on equal level, the largest cities (Stockholm, Gothenburg, Malmö).

As a rule, each hospital has a Board of Governors appointed by the owner. This board is responsible for the running of the hospital.

The chief executives of the hospitals are the director (large hospitals) or the managing doctor (small hospitals). The hospital directors are at present recruited by laymen but the post can legally be held also by a physician. In a hospital with a layman as director, one of the doctors is appointed as chief medical officer. In the case of a managing doctor as head of the hospital, he is assisted by a hospital secretary to assume responsibility for lay administration, especially in respect of finance, male staff, stores, equipment supplies, transport, etc.

In each hospital a matron is the chief of the nursing personnel aided by assistants.

Present training of hospital administrative personnel

No special requirements for holding any of the mentioned administrative posts are prescribed.

As a rule, the lay hospital directors have a training at university level (faculty of law or faculty of economics). Hospital secretaries sometimes have a diploma from a higher commercial school or college or from an institute of sociology (not on a Swedish university level), others have a very poor training. None of these educational lines gives a specialized training adapted to hospital administration.

Voluntary perfection courses of short duration have, however, been arranged for hospital executives, doctors as well as laymen.

For matrons only, there exists an acceptable voluntary training of eight months duration at the Swedish post-graduate school of nursing.

From the side of the hospital owners, the administrative personnel, and the medical authorities there is a strong demand for better training facilities for administrative personnel. Especially as it has been claimed that the large hospital as a big enterprise nowadays needs a rational running from the economical and medical point of view.

Training and education of the different groups of the administrative personnel should be brought up to such a high level that participation in applied research could be anticipated.

Proposed educational programme

A special commission appointed by the King has newly presented its report including a very far-reaching proposal on the education of hospital administrators.

This commission suggests a new educational agency coordinating training and research in the principal paramedical subjects of the proposed training programme, i.e., a special Institute of Hospital Administration connected to the medical faculty of a university. The studies should in the first place end up with an academic degree called Bachelor's Degree of

Hospital Administration. Advanced training up to a Doctor's Degree in Hospital Administration is foreseen.

Teaching in non-medical subjects will take place at the faculties of law, philosophy and science. The main topics are here propedeutic studies in law, statistics, sociology and enterprise economics. Before entering these studies the applicant should have a three months practical administrative training at a hospital. The whole training would take four years.

This programme is now under discussion. It has been criticized and that is the reason why I do not go into details. When we are meeting at the end of November I hope it will be feasible for me to summarize this criticism and present to the conference what probably will come out as a final result of the proposal.

SWEDEN

by

GILLIS ALBINSSON

1. *The hospital service, its organization and scope*

For a right understanding of the Swedish hospital service and its organization it is necessary to give a general survey of the major factors in the administrative organization of the Swedish democracy.

A. THE ROYAL GOVERNMENT

The Swedish Ministries have the ultimate political responsibility and are responsible for the general policy in all departments of the State. Their duties are mainly in the field of legislation and the compiling of annual estimates and the distribution of the grants to State institutions. The supervision and management of the State work and services is in the hands of administrative boards, which are responsible not to the Minister but to the King in Council (the Crown) and have a largely independent status.

The ministerial responsibility for the health services rests in the way mentioned above with the Ministry of the Interior (there are at present proposals that it will be taken over by the Ministry of Social Affairs). The Ministry is concerned with such matters as the preparation of legislation and the annual estimates for the State hospitals and laboratories. The King in Council (that means in practice the Minister of the Interior) also appoints senior physicians and other higher officers in the public health field.

The management of the governmental services and the supervision of the municipal and private services rest with the Royal Medical Board, which as said has a real independent status in relation to the Minister but is subordinated to the King in Council. The board's functions can be classified as advisory, supervisory and administrative. They advise government departments and other national boards and local authorities

on all matters requiring medical knowledge, watch over the state of the national health, supervise the medical management of the hospitals and other health services run by local authorities, and are themselves directly responsible for mental hospitals and certain other institutions. They authorize doctors, dentists, midwives and other medical workers to practise and make proposals to the Crown for new legislation.

B. THE COUNTY COMMUNITIES

The planning, organization and financing of the Swedish hospitals have, during most of the two hundred years we have had hospitals in a modern sense, been the duty of regional authorities in territories corresponding to the British counties. The primary communities—rural communities and smaller towns—corresponding to the British parishes have no tasks in the hospital field.

Up to 1864 the hospitals in the territories (provinces) were administrated by special committees with the Province Governor as chairman. From 1864 the management and responsibility for the planning and organization of the hospital services, their running and financing have been the duty of the County Councils which were instituted in 1862.

At first, a few words on the *County Council* and the *County Community*. These represent local self-government in the county. There are 25 counties. They have between 150,000 and 450,000 inhabitants. Only two are smaller than 100,000 inhabitants. There are great differences between their areas and populations. The county of Norrbotten in the upper north embraces 25% of the total area of Sweden but only 2½% of its population, but the county of Stockholm (the surroundings of the capital) has about 450,000 inhabitants in a relatively small area.

The four greatest towns do not belong to counties and they are themselves responsible for the same tasks as the county. They can be called county boroughs.

By law the counties are entitled to deal with matters concerning, *inter alia*, public health and sick care. In reality the major responsibility of public health and sick care rests on the

counties and these tasks take about 80–85% of their gross expenditures.

The power of decision in the county lies with the county council. The administrative and executive power belongs to the board of administration, the sick-care board and other committees. The members of the county councils are elected by general and direct elections every fourth year. The members of the boards are appointed by the council, mostly for four years. The county council meets once or twice a year, the board of administration once a month or more frequently. The county council has an office and secretariat managed by a county director and with a varying number of staff.

The county council has an unlimited power of taxation. The tax to the county is fixed on the same principles as the local income tax. On average for the country the tax to the counties takes about 5% of a person's income.

The county councils are to a high degree independent in relation to local as well as central state administration.

V. THE HOSPITAL SYSTEM

According to the Hospital Act, the counties and the county boroughs are responsible for the somatic hospitals. Each county forms legally a sick-care district and the county has to provide facilities of hospital care for everyone living in the county, both hospital beds and out-patient services.

The Act defines different types of hospitals. For somatic care there are generally *lasarett* (general hospitals) and *sjukstugor* (cottage hospitals). Furthermore there are some special hospitals for TB (sanatoria) but nowadays many of them are used for other purposes such as care of chronic sick. The reason is the diminishing incidence of TB in Sweden, which has made it possible to move the TB-care into special pulmonary clinics in the general hospitals. There also are special hospitals and nursing homes for chronic sick, for epidemics and for maternity care. In most general hospitals, however, there are maternity wards, special clinics for chronic sick and sometimes (in the central hospitals) also infectious clinics, which replace the special epidemic hospitals.

The State owns and runs the mental hospitals but according to a committee report some years ago it is expected that the counties will have to take them over in the next ten years. Owing to the deficiency of beds in the State mental hospitals and counties since about 1927 they have had nursing homes for mentally diseased and in the last ten years they have built psychiatric clinics in their general hospitals.

The State has three general hospitals, all of them university hospitals in Stockholm and Uppsala. The most well-known is perhaps the Karolinska Hospital. All other university hospitals are owned by counties or county boroughs.

The care and education of the mentally deficient patients rest with the counties with the exception of certain categories, such as the social and crippled, etc., who are treated in State hospitals.

The following table shows the distribution of beds by owner at the end of 1959.

Table 1. *Hospital beds by owner* 31.12.1959. (926 hospitals, nursing homes, etc.)

	The State	*Counties*	*County Boroughs*	*Local Auth.*	*Funds, etc.*	*Private*	*Total*
General hospitals and similar	4,033	28,199	9,072	7	1,162	1,354	43,827
Epidemic hospitals	—	1,865	1,151	—	—	—	3,016
Hospitals for TB of the lungs	—	4,673	1,076	—	254	—	6,003
Independent maternity hospitals	—	151	129	6	144	5	435
Nursing homes for the chronic sick	—	6,852	4,738	1,120	317	411	13,508
Mental hospitals	20,703	—	5,666	339	—	30	26,738
Nursing homes for ment. diseased	—	4,635	516	—	54	1,083	6,288
Total	24,736	46,375	22,348	1,472	1,931	2,953	99,815

This table does not include the establishments and schools for the mentally deficient.

The most striking feature which emerges from the table seems to be the low ratio of private beds and beds in hospitals run by funds. The beds run by primary communities are mostly linked together with homes for aged. Their number has diminished during the last ten years.

On the county level we have at least one *central hospital*, in which there is a range of general and specialist clinics such as surgery, medicine, obstetrics and gynaecology, ear-nose-throat, eye, paediatric, X-ray, psychiatric and generally also chronic/geriatric and infectious clinics. The central hospital is 'neighbour hospital' for a certain part of the county and specialized hospital for a greater part or all the county. Besides this there are what we in Sweden call '*normal hospitals*' with surgery, medicine and X-ray, sometimes also one or two other clinics such as ear-nose-throat, paediatric or gynaecology. Generally there is also a ward for the chronic sick. As 'neighbour hospital' we also have so-called *mixed hospitals* with mainly surgery and in the sparsely populated areas *cottage hospitals* where often the district medical officer is also the hospital doctor. Besides the clinics or wards for chronic sick in the general hospitals there are *nursing homes* for these patients in different places in the county and also nursing homes for the mentally diseased. There may also be a separate *TB-sanatorium* and an *epidemic hospital.*

As an illustration I will give a survey of the hospitals in the county of Halland on the west-coast, where I have my daily work.

The county is about 90 miles from north to south and from nine to 30 miles from west to east. It has 172,000 inhabitants.

We have a central hospital with 500 beds in the biggest town (40,000 inhabitants) which serve about 87,000 inhabitants as 'neighbour hospital' and all the county as specialized hospital. In the second town (15,000 inhabitants) we have a 'normal hospital' with 160 beds serving about 54,000 inhabitants and in the third town (11,000 inhabitants) a mixed hospital with 93 beds serving about 29,000 inhabitants. Furthermore we have two cottage hospitals, one with 30 beds in a small town and partly serving 20,000 inhabitants together with the normal hospital mentioned above. Two doctors are fully employed in this cottage hospital and its out-patient service. The second cottage hospital is in another little town and has a district medical officer as part-time doctor. It is a secondary hospital to the central hospital and serves a part of its district.

For TB we have a TB-sanatorium with 145 beds of which only about 50 are occupied by TB-patients and two wards are used for chronic sick. This sanatorium will be closed in the next three years and the patients transferred to a new pulmonary clinic at the central hospital.

At the central hospital we have a clinic for chronic sick and linked together with the normal hospital, the mixed hospital and the cottage hospitals we have nursing homes for such patients. Besides these we also have one independent nursing home. In all, the county has from next year 405 beds for this category.

Our epidemic hospital closed in 1961 and since then we have had an infectious clinic built at our central hospital.

For mentally diseased we have two nursing homes with a total of 150 beds and for mentally deficient two schools and two nursing homes.

Besides these institutions we have also a number of institutions and health workers outside the hospitals but as our theme is the hospital service I will not enter deeply into this subject.

The above gives the hospital and institutional provision of the hospital service in a county of 172,000 inhabitants. Such a county is not large enough to provide the highly specialized hospital care such as neuro-surgery, thorax-surgery, neurology, special cardiology, plastic-surgery, etc. For these specialties the counties and county boroughs have now introduced a system (based on a governmental survey and report in 1958) whereby the university hospitals and two other hospitals have been enlarged in order to serve larger regions with about 1 million inhabitants, in these specialties. The system is based on free negotiations between the counties.

Table 2 shows the number of beds in hospitals for somatic diseases and the distribution of special departments or special hospitals for the most frequent specialties.

It is necessary to lay stress upon the fact that in Sweden about 99% of the births take place in hospitals. Formerly there were a large number of small independent maternity homes but as communications have improved especially by the motorizing

of the rural districts many of these homes have been closed and the general hospitals and the cottage hospitals have taken nearly all births in their maternity departments.

Table 2. Hospital beds for somatic diseases 1959

	Beds	*Beds per* 10,000 *inhabitants*
Non-specialized departments	3,778	5·1
Medicine	8,817	11·8
Paediatrics	2,318	3·1
Dermato-venereology	637	0·8
Neurology	300	0·4
TB	6,366	8·5
Surgery	9,848	13·2
Obstetrics	2,207	3·0
Gynaecology	1,765	2·4
Ophthalmology	873	1·2
Oto-rhino-laryngology	1,429	1·9
Maternity wards without specialist	1,367	1·8
For chronic sick	16,023	21·4
Beds at epidemic hospitals	3,601	4·8
Non-specified specialties	7,473	10·0
Total	66,799	89·4

In Sweden much stress is laid upon the out-patient work of the hospitals, especially in the general hospitals and the cottage hospitals. Every clinic or special department has its own out-patient department. In 1959 the number of visits at out-patients departments in general hospitals was about 4·7 million and the number of visits per out-patient was 2·4. In the State mental hospitals there is very little out-patient work and in some types of special hospitals, such as nursing homes for chronic sick and epidemic hospitals, there is no out-patient work at all.

D. THE HOSPITAL PERSONNEL

The personnel in hospitals for somatic diseases is shown in table 3:

From the table one can see that the number of personnel per 100 beds is 110·5 in general hospitals. In cottage hospitals it is 71·2 and in epidemic hospitals 61. Attention may be drawn to the relatively low ratio of nurses and midwives. In Swedish

hospitals there are many special groups of nurses' aids and semi-trained nursing personnel (auxiliary nursing personnel). The training of nurses in Sweden is given in schools run by the county councils and county boroughs and a few private schools. The training lasts three years. We seek to give all nurses' aids a special training, now including seven weeks of theoretical educa-

Table 3. Personnel in hospitals for somatic diseases 1959

Personnel	*Number*	*Per 100 beds in general hospitals*
Physicians	3,603	7·52
Nurses	10,440	22·54
Midwives	656	58·73
Physiotherapists	507	
Occupational therapists	188	
Social workers	203	
Doctors' secretaries	1,462	
Auxiliary nursing personnel	28,884	
Administrative staff	1,295	2·98
Domestic staff	10,951	18·73
Total	58,469	110·50
The number in general hospitals	41,653	

tion and 16 weeks of practical training. After this training and two years of work in hospital the girl can attend a further course of eight weeks of theory and 24 weeks of practical training in order to get a higher position as semi-trained nursing personnel.

The following table shows the personnel at establishments for mental diseases:

Table 4. Personnel at establishments for mental diseases 1959

Personnel	*Number*	*Per 100 beds in State mental hospitals*	*Per 100 beds in Mental hosp. of the three largest cities*
Physicians	474	0·9	1·6
Nursing personnel	11,154	36·1	42·2
Administrative staff	395		
Domestic staff	2,642		
Total	14,665		

E. FINANCES, CHARGES AND COSTS

The charges a hospital may make for treatment are stated by the owner; for somatic hospitals usually the county council (or

county borough council). By tradition they have become fixed considerably below the real cost of maintaining and treating a patient. Before 1955 about 60% of the population were members of the State controlled sickness insurance which paid for them during hospital stay, and from 1955 the National Sickness Insurance pays for all hospitals patients by the local sickness fund. According to recommendations from the Federation of Swedish County Councils and the Federation of Swedish Towns all counties and county boroughs have fixed the same charge for their hospitals, about 7s. a day (5 sw.cr.). In the State hospitals the same charge is made. That low charge throws the major part of the expenses on the hospital owner. The counties and county boroughs have only small subsidies from the central government and have to cover their costs mainly by taxation. They also have to subsidise the State somatic hospitals by paying practically all costs for patients from their counties and boroughs who are treated in these hospitals.

The running cost per bed-day was in 1959 in general hospitals about 65 swedish crowns (£4 10s.), in cottage hospitals 41 sw. crowns (£3) and in homes for the chronic sick 27 sw. crowns (£2). In the State mental hospitals the average running cost per bed-day was 22 sw. crowns (£1 11s.) and in the mental hospitals of the three largest county boroughs 30 sw. crowns (£2 3s.).

The total net expenses (operation and capital development) of all types of hospitals in 1959 amounted to about 1,470 million swedish crowns (approximately £100 million) of which the share for mental hospitals was approximately 367 million crowns and 1,105 million crowns was the costs of all other hospitals. The expenses of the State for mental hospitals were about 281 million crowns and for other hospitals (including subsidies to hospitals run by local authorities) 88 million crowns. The expenses of the counties were 805 million crowns and the county boroughs paid approximately 298 million crowns. The capital costs for hospitals were approximately 290 million crowns or £20 million.

The average length of stay in general hospitals was in 1959 13·6 days and the costs per admission were 890 sw. crowns (£61 8s.).

The increase of the hospital costs in Sweden are attributed mainly to a rising level of salaries and wages. More than 70% of all costs of general hospitals are wage and salary expenditures.

2. *The way in which the hospitals are staffed administratively*

So far I have made no mention of the hospital administration. I will therefore first give some information about the Sick-care Board and the Hospital Boards.

It has been said before that every County Council has to elect a sick-care board with special duties in the administration of the county's hospitals. The board co-ordinates the activities of different hospitals, plans the continuous development of the hospitals and other forms of public health; and it has also to appoint all assistant doctors and hospital secretaries. The head-physicians are appointed by the King in Council after recommendation by the sick-care board of the respective counties, which has to choose among four applicants put on a ranking list by the National Health Board. Many county councils have entrusted the duties of the sick-care board to the board of administration, which has the central administrative, executive and economic power of the county between the council's meetings.

The direct administrative power of the hospitals is given to the hospital boards, one for each hospital or for a group of hospitals. The hospital board controls the grants from the county council, it prepares the estimates which later are scrutinized in the board of administration; the hospital board also appoints all hospital staff besides the doctors and the hospital secretary.

The daily administrative job rests upon the medical director. He is normally a clinician responsible for patients. There are no fully employed directors without clinical responsibility. The economic responsibility rests upon the hospital secretary. In the Hospital Act the medical director and the hospital secretary together are called the Hospital Guidance. According to the latest Hospital Act (of 1959) the county council can decide to lay the full guidance of the hospital in the hands of a hospital manager. Hitherto ten Swedish hospitals have adopted this form of administration (eight county hospitals and two State

mental hospitals). The eight hospital managers at county hospitals are two lawyers with administrative training, one is M.A., two are graduates from the Stockholm School of Social Work and Public Administration, two are graduates from commercial colleges and one has long practical experience in hospital work. There are no obstacles to a doctor becoming hospital manager, but there has been very little interest among doctors for these jobs.

The hospital manager administers the executive power on behalf of the hospital board. So does the medical director in co-operation with the hospital secretary. But the hospital boards have given more power and more independence to the hospital managers.

The ratio of administrative and secretarial staff in Swedish hospitals is rather low in comparison with many other counties. I have had information from Professor Chester showing them to be only half the ratio of England or about 4% of the total hospital staff while the ratio in England is said to be about 8%. Professor Chester has said that the only explanation attempted at this stage is that in Sweden administrative functions may well be performed in the offices of the County Councils; and I think he is right.

3. *How the administrators are selected and trained*

Hitherto the administrators in Swedish hospitals have been recruited from persons with commercial training and to some extent also from persons with general administrative training, especially graduates from schools of social work and public administration (three such schools are now working in Sweden giving training for social work and in providing special courses also for public administration with special regard to municipal administration). The administrator has entered the hospital work in a lower position as clerk, cashier or assistant secretary and then worked up to a position as hospital secretary. He will have been given special training in a three or four month course at a school of social work and public administration with special regard to hospital administration for people working in that field. The hospitals have had some difficulty in competing with the general municipal administration for the trained

and graduate personnel. The medical directors have had no special training apart from some weekly courses arranged by the Federation of Swedish County Councils, which has arranged similar courses for administrators as well.

A governmental committee has a few weeks ago presented a report on this subject. Their proposals are, shortly, as follows:

A special training shall be given to students who intend to enter hospital administration. That training shall be given in a special institution at the University of Uppsala during four years of theoretical and practical studies. It is meant to embrace law, statistics, sociology, economics and hospital administration.

Besides this training there are proposed special ten-weeks courses for doctors intending to seek positions as medical directors, and refresher courses for administrators. Special courses of 15 weeks will, according to the report, be arranged for administrators who have not taken the university training.

I think the proposals will be met with some doubts from many people and institutions involved in hospital administration and perhaps the training of hospital administrators will be given, in some respects, a form and a programme which differ from the proposals.

SWITZERLAND

by

DR. FRANCOIS KOHLER

Director of the Inselspital, Berne

1. THE GENERAL SITUATION

Swiss hospitals and their organization can only be understood in the light of the political and also the geographical structure of the country. I shall therefore begin with a few remarks of a general nature:

1. The Swiss Confederation is a federative state consisting of 25 independent cantons and half-cantons. Each of these cantons has its government, its parliament (in three small cantons it is called 'Landsgemeinde') elected by the people and also its own laws. More than in other states the commune is the cradle of political life, in which the work is carried out by a communal council also elected by the people. Furthermore, in larger communes there is a communal parliament while in smaller communes the electors gather together at a communal assembly.

It should be emphasized here that Switzerland is the *land of direct democracy* in which the electors not only vote in the parliament (and in the communes and cantons the executive body) but are also often called to vote on amendments to the constitution and on the approval of laws and even on decisions concerning large expenditure. For hospitals this means that—for example in the canton of Berne—a law governing cantonal subsidies to district hospitals has to be accepted by the people and the same happens with the decision to rebuild the university hospital for S.Fr. 70 millions.

2. The autonomy of the canton mentioned above is particularly pronounced in the domain of health and hospital services, as the Confederation has no legislative power over hospitals and does not participate in any financial aid for construction and running of hospitals. There are two exceptions,

one based on a federal law of 1928, for tuberculosis-sanatoria, the other—since the new law of 1960 governing the federal invalid-insurance—for the construction and completion of public and private but non-lucrative establishments, dealing especially with rehabilitation. In both cases the federal state gives subventions for building and running costs without actually either building or running these establishments itself. It only runs establishments on a modest scale for military purposes, while the Swiss Accidents Insurance, which assumes the compulsory accident-insurance for employers and workers in all factories, transport and building concerns, runs a spa and a school for rehabilitation for the limbless.

But the autonomy of the communes is also of great importance in the domain of hospital service as the majority of the district and municipal hospitals is planned, built and run by the commune or—as is more often the case—by several communes which associate for this purpose in the legal form of an association or a co-operative.

II. HOSPITAL PLANNING

I feel that—without deviating from the subject—it is necessary to say something about hospital planning on a regional scale as this influences the number, size and situation of hospitals.

It should be mentioned that—because the federal state has little to do with hospitals—there is no regional planning for the whole area of the Confederation which covers 41,000 km² and counts 5,429,000 inhabitants.

Each canton therefore establishes its own planning principles, whereby even some of the larger cantons do little or nothing in this respect. Again it must be emphasized that the conditions differ entirely from canton to canton. For example, one is a typical urban canton (Basel-Stadt) with 6,081 inhabitants to the square kilometre, while the other is a typical mountain area with only 21 inhabitants to the km². Yet another canton has to base its planning on an area of 1,729 km² with nearly 1 million inhabitants, a further one plans for 274 km² with 22,188 inhabitants.

Thus each canton has its own planning principles and hospital problems. But it can be said that at present there are some generally used basic figures establishing the coefficient bed/population, which vary noticeably according to the way of life and the 'hospital habits'.

The figures which I am going to give you can be considered more or less representative for Switzerland:

General hospitals	*per* 10,000 *inhabitants*
Beds for general medicine and related fields	16
Beds for general surgery and related fields	20
Beds for children (medicine and surgery)	7
Beds for infectious diseases	3
Beds for maternity (without babies'-beds)	7
Total regional beds	53
Supra-regional beds for highly specialized treatments	10
Total beds in general hospitals and maternity (without babies)	63
Mental hospitals of which 4 for acute cases	34
Hospitals for the chronic sick of all ages (urban districts)	30–33

To conclude this chapter it should be noted that the lack of general planning in hospital service has not yet proved disadvantageous. On the contrary the autonomy of the communes and cantons has a stimulating effect. There is no red tape and bureaucracy. We have at our disposal a close network of generally speaking well-equipped hospitals, a situation which we owe above all—and this we should always remember—to the peaceful development of the country throughout generations.

III. THE DIFFERENT TYPES OF HOSPITALS

1. As a rule each canton has a *central hospital* built and run as a specialized or super-specialized establishment. The mental

hospitals are also generally cantonal establishments. *Five* cantonal hospitals are at the same time *university-hospitals.*

Besides, depending on the size and density of the population, there are one or many district hospitals with a capacity of under 50 beds (but this is rather an exception) to 380 beds. In the large canton of Berne (about 900,000 inhabitants) there are, for instance, 33 district hospitals, 24 of which have less than 150 beds.

The geographical distribution, even there where no planning exists, is not unsatisfactory, as the hospitals are generally built in the normal centre of attraction of a region, the cantonal hospitals usually in the cantonal capital with good communications.

2. Contrary to Germany, for instance, public hospitals run by private bodies only play a secondary role. The vast majority of beds for general and mental cases belong to the cantons and communes. On the other hand, the hospitalization of the chronic sick and the mental defectives is still often the work of benevolent institutions which can reckon with the substantial aid of the population and the public authorities.

In the big cities (as for instance in Lausanne, Zürich and Berne) the private nursing homes play a part of considerable importance. They either belong to religious communities of all denominations or are purely business concerns in which the doctors are often financially involved.

3. For us in Switzerland the question of the *optimum size of the hospitals* is of less importance than in certain other countries for the simple reason that because of the intense decentralization of hospital services and of the communal autonomy, Switzerland is the land of small and medium-sized hospitals. Only in the university-hospitals does the number of beds exceed a thousand, which is due to the teaching requirements. It can be rightly said that we have too many small hospitals. This might be true from the viewpoint of economics and of concentration of means. People cling to their district hospitals and wish if possible to be cared for in the vicinity of their homes. Furthermore, the highly important contact

between the hospital and the general practitioner, which is apt to be underestimated, is thus guaranteed.

The newest trend in the *hospitalization of the chronic sick of all age-groups* is to abandon the idea of the hospital for chronic sick. The chronic department is incorporated in the general hospital, a procedure which has been practised with success in various hospitals for several decades. We are thus approaching the famous idea of the 'balanced hospital community' conceived by Prof. McKeown of Birmingham, all the more as in the large hospitals—although still on a limited scale—beds are being made available for psychiatric cases.

The tendency to decentralize also affects the *old people's homes* so that the inmates don't lose contact with their former surroundings. Fortunately, the old idea of building these homes in far away places is being gradually abandoned.

4. Many of our district hospitals are so called *two-man hospitals*, i.e., with a physician and a surgeon, the latter dealing also with gynaecology and obstetrics. There is a noticeable trend to the three-man hospital which means that there is more and more tendency to appoint an independent surgeon for gynaecology and obstetrics.

According to Dr. Büchel, cantonal physician of Zürich, the number of beds for these types of hospitals are as follows:

Two-man hospital	
Medicine	70
Surgery, obstetrics and gynaecology	100
Three-man hospital	
Medicine	90
Surgery	100
Gynaecology and obstetrics (not including beds for babies)	50

The next step before the real 'health centre' is what is known as a 'Vollkrankenhaus' (complete unity) with the following departments:

Internal medicine	100
Surgery	120
Gynaecology and obstetrics	60

Paediatrics	30
ENT and ophthalmology together	30

I would like however to stress the highly theoretical nature of these figures.

IV. THE ORGANIZATION OF HOSPITALS

1. In order to understand the organization of the hospital services in the cantons, it is necessary to say a word or two about the *financing of construction and running costs.* As we have seen, the Confederation contributes nothing apart from very few exceptions. The canton pays the total building costs and assumes the entire running deficit in the case of a cantonal establishment. Communal and intercommunal hospitals are principally financed by the commune or communes for construction and exploitation. As, however, this financial burden is constantly increasing and exceeding the possibilities of the communes, it has become a rule that the cantons help with *subsidies* for both construction and running costs. The amount varies from canton to canton. In the canton of Zürich it varies between 10% and 50% for construction and goes up to 90% for the exploitation deficit.

In a word, the public hospitals cannot cover their expenses with their receipts as the fees—except for amenity wards—do not cover the real costs. The difference is paid by the cantons and communes by means of subsidies.

2. In all the cantons, hospitals are subordinated to the cantonal ministry of health. For cantonal hospitals it is a direct subordination, for the others it is more a sort of supervision and control. Here, too, the solutions differ according to the cantons. Still, it is possible to establish the following principles:

(*a*) *Cantonal Hospitals*

They are subordinated directly to the ministry of health, usually by intercalating a hospital-board which sometimes has only supervisory and advisory powers and sometimes also is competent to make important decisions. Should this not be the case, the hospital administration is directly responsible to the

Ministry of Health or to the whole Government (e.g., the cantonal University Hospital of Lausanne). The election of these boards is done by the cantonal government, the Minister of Health being *ex officio* member or even chairman of the board. The remaining members come from all professions and all classes and exercise their activity in an honorary capacity. This system is also valid for hospitals belonging to an urban commune (for instance, Zürich).

(*b*) *District Hospitals* (*intercommunal*)

The communes delegate their representatives to a hospital board in which there are also members designated by the cantonal government. These usually large boards, whose members are also honorary, often nominate a management committee which carries out the administrative work and to whom the medical superintendent and administrator are responsible.

3. We come now to the problem of the actual *administrative structure* of the hospital. Neither here is there a generalized Swiss solution, but here, too, one can discern some basic principles to which I add my personal views:

(*a*) In the case of an establishment with a single type of patients (mental hospital, TB-sanatorium, children's hospital) the following type of administration is justified:

Hospital board
(or management committee)
|
medical superintendent—director
|
administrator

In this case, the administration is subordinated to the medical superintendent. There are also hospitals of this type in which the medical superintendent and the administrator are on the same footing. If you were to ask me my opinion, I would cite as many examples in both cases where difficulties have arisen between these two gentlemen. We must bear in mind that especially in the hospital field all organization and ruling is useless if people do not get on together.

(*b*) It still happens today in Switzerland that smaller hospitals (the limit being about 30,000 days of sickness) *do not have a full-time administrator.* I consider this solution as absolutely feasible, so long as two conditions are fulfilled: The chairman of the board must really look after his hospital. The medical superintendent and the matrons should be capable organizers and should have experience in hospital exploitation. In this case the school-teacher or the communal clerk will act as a secretary-treasurer of the hospital and the board can rely on an active women's committee which deals with the purchase of linen and household goods. I consider this a very happy and truly democratic form of organization.

(*c*) In smaller hospitals with several departments, one of the hospital physicians is nominated as responsible medical officer to the board. The administrator is then generally directly subordinated to the hospital authorities. In medium-sized hospitals (which means for Switzerland about 200 beds), the chief medical officers usually form a college and elect one of their number as chairman and spokesman to the board. In this case the administrator is *always* subordinated directly to the hospital authorities.

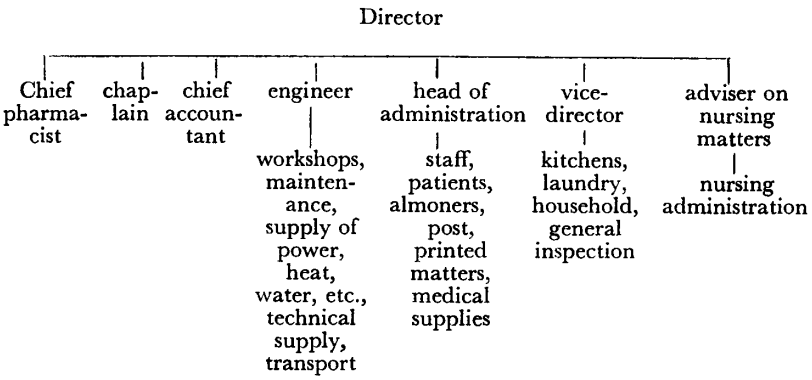
(*d*) In *big hospitals* the tendency in Switzerland is to follow the French system, in which the management is entrusted to a lay-man alone. For my hospital we thus have the following organization:

Board of governors
|
management committee
|
director

The medical superintendents form a college, the chairman of which is present at all the sessions of the board and the committee with an advisory vote. He is not—as in Germany—the medical director of the hospital but spokesman for his colleagues and adviser to the director on medical matters concerning the entire hospital. It corresponds however to the individualism of the Swiss medical corps—this may also be true for other countries—that the director should first discuss

with each senior medical officer problems concerning his own particular department.

(*e*) Let us now look at the administrative structure of our particular hospital, always remembering that each hospital is at liberty to choose its own type of organization. The following example of the Inselspital, a university hospital of a thousand beds, is thus by no means generally applicable. Our present schema is roughly as follows:



To this I should like to make a fundamental remark: Except in smaller hospitals and establishments we in Switzerland have been aware for a long time that the matron is responsible for the nursing administration and not for the kitchens, laundry and household even if she would like to be. We are not warmly disposed towards those all-powerful ladies who rule the whole hospital including the doctors and the administrator. The above mentioned vice-director of the Inselspital has under him seven particularly well trained and qualified *house governesses* who have full responsibility for household, kitchens and laundry and are given wide catering competences.

V. SELECTION AND TRAINING OF ADMINISTRATORS

If the organizers and participants of this meeting hoped to learn something new and even revolutionary concerning the training of a hospital administrator, they will be disappointed by Switzerland's contribution to this problem. I must confess

here that this question has not yet been solved in Switzerland and there seems to be no solution in sight. I will content myself with a description of the present situation and with my personal opinion:

1. Some years ago the University Hospital of Basel founded a school of administrators with the help of the Swiss Hospital Association. The training of a *mainly* practical nature lasted—if I am not mistaken—two years. The number of candidates was modest and the quality rather poor. *One* candidate managed to finish the course and then the school ceased to exist; the experiment had failed. The reasons for this failure are manifold. Owing to the language problem in our country (we have three national languages) and due also to the exiguity of Switzerland, the number of candidates will always be small. Moreover, the financial questions were not solved, as the candidates were paid little or nothing even though they had had previous professional training. Furthermore, the overworked collaborators of a big hospital do not form the ideal teaching staff for such a school.

Be this as it may, no one today mentions this school and in Switzerland an administrator does not acquire his professional knowledge either in a specialized school or at a university. It is the same old story, namely that one is nominated administrator or director of a hospital by destiny, chance, promotion, vocation or sometimes by favourable political circumstances. It should be recognized that progress has been made in the timely training of a successor within the hospital and that generally the administrator receives an adequate salary. I know that the salaries of directors of big hospitals are noticeably higher here in Switzerland than for instance in France, Germany and Holland.

2. When a small or medium-sized hospital with a board, a senior medical officer and a matron dealing directly with the problems of daily administration looks for a full-time administrator, it will choose primarily a man with commercial or administrative experience. The candidate with previous hospital experience will be at an advantage. It should be noted with gratitude and satisfaction that our hospital authorities are being swayed by the point of view that administrators

who have gleaned their knowledge in small hospitals should be nominated to more responsible jobs. This shows the greatly desired possibility of a hospital career, one which goes even further than the still rather sealed frontiers of our cantons.

In larger hospitals (I am referring here to the not very numerous general hospitals of 400 beds and over) the commercial training is not always a decisive factor as generally there is a qualified staff of collaborators to hand. When I consider the six big hospitals of my country (five university hospitals and a cantonal hospital) I note that three of the directors are lawyers, one an economist, one a mathematician and the other a man of commercial experience. In this connection it should be mentioned that the conception of the doctor as director in the sense of administrator has died out in Switzerland, the last example having been up to 1954 in my hospital.

3. From the foregoing it appears that the hospital administrator in Switzerland either learns his profession by gathering his experience in a subordinate position in the hospital and is then promoted or nominated to a leading post in another establishment. Or he will be elected without any hospital experience (which is still possible in the case of certain political elections) and has to learn his profession while already holding down a responsible job. I shall come back to this aspect of the problem.

The hospital administrator is not without any training possibilities: The Swiss Hospital Association holds annual training courses and there are also in Zürich and St. Gallen institutes of economics which organize regular sessions for hospital and home administrators. In some cantons and larger towns the administrators organize regular meetings and visits. Many hospital authorities encourage participation in foreign congresses and specialized exhibitions. The Swiss and German or French hospital press is read and studied nearly everywhere. The five directors of the university hospitals meet several times a year to deal with professional problems and our most important collaborators gather annually for a two-day working session. All this is facilitated by the small distances and the excellent communications of our country.

4. In conclusion I should like to answer briefly the question whether it is unfortunate, that we in Switzerland have no actual course for training administrators, no clearly defined administrator's career.

The longer I work in a big hospital which is in the throes of a tremendous scheme of extension, and the more often I have the opportunity to study the structure of other hospitals in our country, the more I am convinced that the question of whether the administrator or director is fitted for his job is not really dependent on his specialized knowledge or on his skill in 'technique hospitalière'. In Switzerland, as in your countries, the hospital is what we call in German a real 'wasps'-nest' with many very intricate problems concerning human relations. Moreover, a large hospital has also become big business and an especially complicated enterprise. Whoever has to direct it or to assist in its direction must first be a *leader* and secondly an *organizer.* If these conditions are not fulfilled, all the technical knowledge is of no avail. This knowledge is acquired very rapidly—I could mention many examples—if the profession is exercised with enthusiasm, even with fervour. Two years ago during a conference I gave in Holland I made a list of what I feel to be the principle qualities of a hospital administrator. In conclusion may I repeat them:

a good education;
great tact and no exaggerated personal ambitions;
a sense of team-work;
a talent for organization;
good understanding for problems of public health and welfare;
a good sense of humour, broad shoulders and an ability to remain even-tempered.

Under these conditions I feel it is possible to get on well with a large number of professors of medicine and a regiment of nurses.

UNITED KINGDOM

THE NATIONAL HEALTH SERVICE (1948–1971)
ASSESSMENT AND FORECAST

by

PROFESSOR T. E. CHESTER

University of Manchester
Department of Social Administration

The British National Health Service celebrated its 14th birthday on the 5th July 1962. In the same year the Government published a Ten-Year Plan for the rebuilding of about half of our existing hospitals. Both these events—the coming of age of 'one of the great social experiments of the Twentieth Century' as the Editor of the *Times* recently called it, and the launching of this imaginative blue-print for its vigorous development over the next decade—seem a suitable point in time to take stock of what has already been achieved, analyse unresolved difficulties and attempt a forecast of the potential for healthy growth.

To do so now, in particular in an article going to press abroad, may also assist in setting into the proper perspective some recent criticism by British authors. This—sometimes taken out of context—has been eagerly taken up and given wide publicity in some countries by political opponents of publically provided health care. One would also hope that in this small way a contribution is being made to further the comparative study of social administration as a newly emergent discipline with great scope of urgent public interest but as yet disposing of little valid material.

Finally, a clarification for foreign readers who may not be aware that in practice the National Health Service in Great Britain is organized in an English (including Welsh) Service and a Scottish one. Both are controlled by separate Ministries, administered by different staffs, financed by separate budgets and provide their own reports and statistics. To avoid confusion and to limit the complexity of the presentation this article is restricted to the English and Welsh Health Service which

comprise in resources and services about seven-eighths of all health care publically available in Great Britain. Although there are some significant differences in the organizational framework—particularly concerning the teaching hospitals—the broad picture is essentially the same on both sides of the border.

Was a National Health Service necessary?

The golden age—as human failing will it—is either to be found in the good old days of the past or in a Utopian future, but never in the present. Before receding memories distort the facts it may perhaps be worthwhile to restate briefly why a National Health Service was introduced and what it set out to remedy in the previous system of health care provision. It is also sometimes forgotten that when the National Health Service was launched in 1948 it had been preceded by prolonged public debates and by many legislative measures, backed by all political parties and sponsored by many and varied social reformers. There was disagreement about many points of detail but nearly everybody was agreed that in particular since the end of the First World War health care in this country suffered from at least three far reaching defects.

1. No co-ordinated organizational framework was in existence with a result that one could not speak of a system of health services but merely of a patch-work of haphazard growth, widely divergent standards with overlap and duplication by no means the exception. In short the provision of health care was nobody's responsibility. The Ministry of Health, established in 1919, had only broad regulatory powers over any services provided by local government. The thousand or so voluntary hospitals—practically the sole providers for the care of the acutely ill—were by their legal nature independent from public supervision.

2. The costs of hospital care had risen steeply since the 1920's at a pace with which neither voluntary donations nor local taxation could keep up. Voluntary contributiory schemes on the lines of the American Blue Cross were hardly developed and compulsory state insurance introduced since 1912 covered only manual workers and lower paid office staff without benefits

for their dependents and restricted to domiciliary care by general practitioners. In this situation it was unavoidable for the Government to step in and take on large financial commitments when the need for substantial hospital services became a major public issue with the coming of the Second World War.

3. The researches by teams of investigators, among them outstanding clinicians and medical administrators, revealed at that time a maldistribution of available resources, especially of the scarcest and most important, i.e. the high grade medical consultant and specialist. Owing to the lack of other financial provisions they had of necessity to congregate where the majority of fee-paying patients were concentrated, i.e. in the metropolitan area of London and the six major conurbations. On the other hand the rest of the country, and more than half its population, often had to be satisfied with the medical skills applied by general practitioners, however well intentioned these wanted to be.

Even the fiercest critics today are prepared to admit that the situation in all these respects has radically changed since 1948. Indeed no responsible party politician inside or outside Parliament has in the last 14 years questioned the necessity of continuing with the National Health Service.

Freedom from Fear

The provisions of finance were radically altered in 1948 and now 70% of all funds come from general taxation, 20% from compulsory health insurance, 5% from local taxation and the remaining 5% from various charges levied on patients largely for prescription of drugs, dental care, spectacles, etc. (Approximately 1% of all available hospital beds are designated 'pay beds' largely in the main teaching hospitals and only about 2% of all in-patients in 1962 were in fact fully fee-paying patients.)

There is general agreement that in this reform can be found the greatest achievement of the National Health Service so far.

(*a*) By ignoring the ability to pay and making medical need the sole criterion for access to health care need it has in the real sense of the word 'freed' the ordinary citizen, in particular the middle classes, from the fear that sudden serious or prolonged

illness not only brings personal distress but spells financial disaster.

(*b*) As the overwhelming sources of finance have been made general taxation, of which direct progressive taxes are approximately 55%—it can be said with considerable truth that the broadest shoulders carry the heaviest burden. In short the British now pay for their health services not when they are ill and their capacity to earn is at their lowest, but when they are well. Moreover by spreading the net over the whole community we have to use a phrase coined by Sir Winston Churchill—brought 'the magic of averages to the aid of millions'. All risks for the dependent and active population alike can be covered without difficulty and the chronic sick, the unemployed and particularly the increasing proportion of the aged, can be catered for.

(*c*) Finally, in comparing the administrative costs of securing health care finance it seems that the British method of finance, approximately three-quarters from taxation, is by far the cheapest. The costs of collecting this revenue are estimated as substantially below 2% of all monies collected, whereas there is evidence that in other countries the costs of financing health care through voluntary insurance systems may reach up to 10% and under private profit-making insurance companies a cost ratio of 20% to 30% is by no means an exception.

The New Administrative Framework

By taking over both voluntary and local authority hospitals—with the exception of some usually smallish religious foundations—the Minister of Health and his department were given statutory authority for the provision of a comprehensive health service, comprehensive in both senses, i.e., extended all over the country and including all branches of health care. This authority is, of course, matched by an equally comprehensive public accountability to Parliament which has made good use of exercising criticism and pressure in debates and questions.

Central control and finance have, however, been balanced with an attempt to decentralize substantially through regional and local newly created hospital authorities. It is the 15

regional hospitals boards who have the general oversight of financial allocation, the designation of existing hospitals and even more important the planning authority. Some 400 hospital management committees are in charge of the actual running of the 2,500 hospitals conveniently grouped so as to provide for their communities comprehensive clinical services. The teaching hispitals again under separate boards of governors are charged with the task of offering a complete range of clinical facilities to the 12 metropolitan and 10 provincial medical schools, with another 14 hospital authorities for specialized training. To avoid the charges of bureaucracy the National Health Service also incorporated the unique feature of entrusting administration of these various hospital authorities to voluntary members serving in a part-time and unpaid capacity.

The advantages of this administrative re-organization have already been significant.

(*a*) It enabled the better deployment of consultant and other senior medical staff over whole regions so that now in all parts of the country high grade medical skill has become available to all.

(*b*) Many hospitals whose use in their original capacity has become unnecessary or obsolete have been switched to other uses. For example, regionalization facilitated the retention of a much smaller reserve of infectious diseases hospitals than the various hundreds of independent local authorities could afford. These, as well as many tuberculosis sanatoria whose occupancy has dropped with the decrease of the virulence of this disease, have now been handed over to the care of geriatric cases without the need to provide costly and additional facilities.

(*c*) But perhaps the best proof of current achievements can be seen in the vastly improved use of beds, the most expensive asset of any hospital service. In 1948 the National Health Service took over in England and Wales some 2,700 hospitals with approximately 448,000 staffed beds. In 1961 this number had increased by only 5% to 469,000. Nevertheless it was possible to increase the number of new in-patients from less than 3 million in the first year of the service to more than $4\frac{1}{4}$ million in 1962; that is by $1\frac{1}{3}$ million or 30%.

This substantial increase reflects, of course, also the continuous reduction in the length of stay brought about by improved treatment methods such as more efficient diagnostic facilities, more potent drugs and early ambulation. Thus the Ministry of Health is able to report that the average length of stay of patients treated in the departments of general medicine of our non-teaching hospitals had declined between 1954 (the earliest year for which equivalent data are available) and 1961 from 23 to 19 days, that is by 20%, with a corresponding increase in the turnover rate of beds from 14 to 17 patients per annum.

It would, however, be quite misleading to pretend that all problems of administering this vast service have been solved. The organizational structure has by now, in particular since its far reaching review by a committee of enquiry in 1956, become acceptable. In other words the anatomy of the service is considered to be about right. The balance of authority and responsibility allowed to the various levels—what one might call metabolism—is still very much a matter of controversy. There are those who blame the Ministry of Health for too much interference whilst others attack it for not doing enough especially by not providing the new hospital authorities with more effective information and guidance. Since some drastic changes took place in 1960 on the political as well as on the civil service side of the Ministry there has been blowing a 'strong wind of change'. This—one hopes—might lead to both more centralization and more decentralization. Thus, for example, improved systems of budgeting, costing, operations research and statistics may give the Minister a better control of overall needs and performance whilst simultaneously permitting greater freedom of action within the national policy to the individual regions and hospital groups. These are being strengthened by better recruitment, training and promotion of senior administrative staffs including university graduates.

Among the other great remaining question marks it must suffice here to mention the future role of voluntary members in hospital administration appointed as they are by higher authorities and not allocated like local government councils. And the even more controversial place of local authorities and

general practitioner services, both of which are so far only junior partners in particular in the allocation of finance.

Does the service cost too much?

One of the recurrent charges against publicly provided health care all over the world is that it leads to abuse by patients and vastly increased costs. Is there any evidence to corroborate these views from the British experiment?

(*a*) Abuse would surely be reflected as far as hospital care is concerned by steeply rising admission figures quite out of line with those in other countries where similar facilities are not available. It will have become clear from the in-patient totals already quoted that more patients are now annually admitted to British hospitals than ever before. Even though the overall admission rate per thousand of the population has increased (taking account of changes in the population) from 67 in 1949 to 93 in 1960 these rates are substantially below those of other countries with an equivalent standard of living, and only about two-thirds of the figures available from the United States. Moreover the causality for this increase is very complex and depends on many factors, i.e. changing age structure of the population, increasing health education, new advances in medicine, an analysis of which would go beyond the scope of this article but indicates clearly that the increasing rate of admissions can by no means be attributed to the fact that we now have a publicly provided service.

(*b*) In calculating the costs of the National Health Service it is true that there has been a great jump in costs in absolute figures and at current money values from some £400 million in 1949 to over £800 million in 1960. Again it is well known that increasing medical costs are a widespread phenomenon. In addition two considerations may yield a better insight.

(i) The Gross National Product in Great Britain which was £11,750 million in 1949 has now increased to £23,700 million. Reckoned as a percentage of these totals health service expenditure remained completely stable at 3·4%.

(ii) If we take account that the value of the pound over the same period has, owing to inflation, decreased by approximately 40% and consider simultaneously the increasing output of our hospital services by treating 30% more patients, one is bound to arrive at the conclusion that there was by no means any extravagant spending and that any additional costs are evenly matched by additional work and by additional staff to perform it, as the following table shows.

Staffing of Hospitals in England and Wales (Part-time staff are counted in their whole time equivalent)

	1949	1961	% *increase*
Medical and Dental (all grades) . . .	11,940	17,050	43
Professional and Technical (including students)	16,669	27,053	60
Nurses and Midwives (all grades) . .	137,282	187,780	36
Admin. and Clerical	25,117	35,967	43
Ancillary (all grades)	156,586	185,525	18
	347,594	453,375	30

It will be appreciated that salaries and wages absorb, as is the case in most countries, more than 60% of total revenue expenditure.

Too few doctors and nurses

Since the inception of the service there has been persistent criticism that shortage of staff, in particular of doctors and nurses, has been due to unsatisfactory pay rates and conditions and that as a consequence some of the best young British doctors emigrate; that there is an enormous wastage among trained nurses; that we have to rely more and more on immigrants from the Commonwealth to run our hospitals, etc. How can these accusations be squared with the fact that over the same period, as the above figures have shown, there have been substantial increases of staffs, particularly so among doctors and nurses.

It must be admitted that the service has so far not been very fortunate in its attempts at forecasting staffing requirements. Thus in the early years there was an over-estimation of the number of senior medical staffs required. As a consequence a

substantial number of young doctors underwent specialist training, at the end of it only to be faced by the fact that no permanent places were available for them as consultants. Many of these so called 'frustrated registrars' (as the training grade for specialists is called) emigrated in the early 1950's taking with them—not unnaturally—a feeling of bitterness against the service. Moreover the remedy to prevent a recurrence of such miscalculations proved equally fallacious. A committee charged with the task of advising on long range medical needs recommended a 10% cut of the intake of medical schools. This was proved by subsequent events, in particular by a higher natural growth rate of our home population, to be a wrong step and the decision had to be rescinded by the Government in 1961.

It would, however, be equally misleading to accept at their face value the accusations of the critics in all respects. Thus, for example, the emigration figures of British doctors are of doubtful value and seemingly highly exaggerated owing to the defects of British migration statistics and they have been vigorously renounced in and out of Parliament by the present Minister of Health. It is, however, good to know that the Nuffield Provincial Hospitals Trust, one of our major voluntary research foundations, has sponsored a detailed controlled enquiry into the fate of British medical graduates produced by British medical schools over the last decades. (The critics also conveniently fail to point out that whatever migration there was has not been a one-sided affair. During the last few years—in 1961 nearly 200—dentists immigrated from the Commonwealth, obviously preferring conditions under the National Health Service to those in their homeland.) Since the recommendations of a Royal Commission on Pay and Conditions of Service of Medical Staffs were accepted in 1960 by both the Government and the medical profession, little has been heard of open criticism about current salaries, with the exception of general practitioners and dentists. An outside observer cannot help feeling that the real cause of a lot of the continuing dissatisfaction is the belief, in particular among junior medical hospital staffs, that the staffing structure needs drastic overhaul. This at present provides only one permanent grade, the top grade of consultant and specialist, apart from the various temporary

training posts. Clearly no government can contemplate a vast and uncontrolled expansion of top consultancy posts. On the other hand various suggestions of reform by introducing some junior consultancy grades have broken in the past on the resistance of medical associations, but are again now under active consideration.

There is equally little doubt that in spite of the increase in absolute figures there is a relative shortage of nurses brought about by the increased admission and more intensive treatment of patients. This applies particularly in the case of qualified and full-time nursing staffs. It is a fact that in view of the considerable difficulties to find these grades, about 20,000 beds annually cannot be staffed and wards have to be closed. There have been numerous enquiries into the causes but two fundamental factors become fairly obvious in any serious investigation, i.e.,

(i) The changing incidence of marriage, and

(ii) The long range impact of full employment.

Between the two world wars, in particular owing to the fearful manpower losses at the Western front in the First World War British hospitals could count on a substantial number of spinsters for whom devotion to social tasks was a compulsory substitute for the impossibility of married life. Today young women face a substantial majority of eligible bachelors and the average age of marriage has dropped considerably year by year since 1950. By the time the young nurse has completed her training she is usually married and after only a few years of active working life she normally withdraws to have children. In addition hospital work, with its strict routine, the necessity to be on duty at all hours including weekends, make it—unless there is a strong sense of vocation—a much less attractive job for the young girl than is offered by offices or factories, and this in spite of the fact that there has been an official reduction in the nurses' working week and a considerable increase in their emoluments. The answer to this staffing problem in the long run is recognition of these long range factors and an acceptance of the fact that present establishments may never be filled again and thus a willingness to reconsider the organization of our

hospitals, the structure of wards and in particular the possibility of introducing more automation.

The way forward to the 1970's

Many students of the British National Health Service became convinced that the real causes of the lingering malaise among doctors and public were not so much those openly manifest but the lack of any new hospital buildings over the last 20 years. The *Lancet* expressed this deep-seated feeling concisely when it wrote:

> 'We have all felt envious of the hospitals we have seen abroad, where, though there may be less sense of what really matters, there is more concrete evidence that medicine is on the move. If only for the same reason as women occasionally need new hats, doctors occasionally need new hospitals; and the lack of them here has been depressing. Even more important, to profession and public alike, is the fact that obsolescence so often means inefficiency and waste.'

It is common knowledge that nearly half of all British hospitals are over 70 years old, that one-fifth were built before the Crimean War (1860) and that the building spurt in the 1930's following the reorganization of our poor law was cut short by the Second World War which also prevented even ordinary maintenance for ten years. From 1948 to 1961 nearly £200 million were spent on capital schemes for hospitals. Many improvements in existing hospitals were accomplished, new operating theatres, X-ray equipment, etc. But so far no new hospital has been built under the National Health Service.* Priority in resources was given to housing, school building, and in particular industrial investments.

This is the background against which one must assess the publication by the Ministry of Health in 1962 of the new hospital plan. It specifies 90 new and 134 substantially remodelled hospitals to be started by 1970–71, apart from 356 other schemes (each costing over £100,000), to be completed by 1975 at a total cost of over £700 million. This plan is the cul-

*Since this was written a complete new hospital, The Queen Elizabeth II Hospital has been opened at Welwyn-Hatfield to the north-west of London.

mination of much preparatory work by the Ministry of Health and the hospital authorities. It is intended as a flexible, forward-moving plan which will be reviewed annually to take account of changes in the incidence of illness and the availability of medical care. The core of the plan can be summarised under two headings:

(i) It sets out—on the basis of current researches—standards of hospital provision in terms of number of beds per thousand of the population for 5 broad categories of patients with the following result:

Type of Patient	*Present Ratio*	*Planned Ratio*
Acute	3·9	3·4
Geriatric	1·3	1·3
Maternity	0·45	0·55
Mental illness	3·3	1·9
Mentally sub-normal	1·3	1·3
	10·25	8·45

(ii) It clarifies the general pattern of the future location and arrangements of hospital services, and introduces the concept of the comprehensive general hospital as the central feature of the new pattern of hospital services. Normally district general hospitals will be of 600–800 beds and will serve a population of 100,000–150,000. Some hospitals may be larger, especially those providing special forms of treatment such as radiotherapy, neuro-surgery, plastic surgery and thoracic surgery, others may be smaller, though rarely of less than 300 beds. Hospitals in this size are necessary to give patients the benefit of the full range of present medical and surgical techniques. These will eventually supersede many of the present smaller hospitals, though some comparatively small local hospitals will be needed for long-stay geriatric patients and for a proportion of maternity cases, and may provide peripheral out-patient clinics or diagnostic centres.

The 'Plan' has been debated in Parliament, it has been discussed in the press, and naturally a number of criticisms have been made. Nevertheless, and in spite of these criticisms all professional groups, all political parties and all citizens in Britain accept the Plan as the first realistic and comprehensive attempt which may lead to a future where the service will provide twentieth century hospitals for the practice of twentieth century medicine. As the *Lancet* put it:

> 'It is a proposal that all concerned should accept certain rational (if sometimes controversial and inconvenient) conclusions, and apply them to useful ends. But though its appeal is to the head rather than the heart, we believe it will prove none the less heart-warming.'

In this new climate, which one may hope will eventually arise, the day must surely come—to quote the Editor of *The Times*—when doctors' pay, staff shortages, the bill for drugs and all the rest of what has become the stage army of medical news sink into the background, and the service can concentrate on some of the fundamental problems at issue, i.e., the quality of care which a public and free National Health Service can and should provide.

UNITED KINGDOM

TRAINING FOR HOSPITAL ADMINISTRATION

by

R. A. MICKELWRIGHT

Principal, Hospital Administrative Staff College

As indicated earlier in this book, sufficient time was not available at the conference for full coverage of the training facilities in the United Kingdom. The following brief summary is given for purposes of reference:

Development of training for hospital administration and of refresher and specialized courses has been considerable. In 1956 the Ministry of Health inaugurated a national training course under a Selective Recruitment and Training Scheme. This provided a comprehensive training in hospital administration over a period of three years (now reduced to two and a half years) and was open to candidates possessing a degree of a British university; to those holding certain approved professional qualifications and to officers employed for not less than three years in an administrative department in the hospital service and who had passed the intermediate examination of an approved qualification. These conditions still remain. The annual intake has varied from sixteen to twenty-four and the training has been provided by the University of Manchester and the King's Fund Hospital Administrative Staff College, each of whom has accepted half the trainees.

In 1962 the Ministry of Health further inaugurated a regional training scheme, providing a course of two and a half years' duration, the responsibility for which is that of regional staff advisory committees and their training officers. The theoretical content of this course is provided by the Universities of Leeds and Manchester and by the Hospital Administrative Staff College, the basic difference between this course and the national training course being the shorter period of theoretical instruction which is about half.

The students ('trainees') are picked by a National Selection Committee which is appointed by the Minister of Health and the Secretary of State for Scotland from nominees of the training institutions and representative hospital organizations. Scottish trainees are normally selected by a Scottish panel of the Committee.

There are other courses provided by the regional staff advisory committees such as those for new entrants to administrative departments of the hospital service and for officers in the middle ranges of administration. Some regions are developing supervisory courses for departmental heads and some provide other refresher courses and 'summer schools'.

Many courses in hospital administration are also provided by independent training institutions as mentioned hereunder.

University of Edinburgh

In 1959 the University of Edinburgh instituted a diploma course in medical services administration providing a full academic year of intensive study at academic level.

The course is open to persons of experience in health services in the United Kingdom or overseas, who are in possession of a medical or other university degree or are of approved educational status. The majority of those admitted to the course in its first four years have been administrators of considerable experience aged from about 35–45 years.

Each intake is limited to twelve students forming a group of both medical and non-medical membership. More than half the members of each group have been drawn from other countries and, in this, the course is distinguished from the other courses in Britain.

The diploma is awarded after passing an examination, written and oral, and the presentation of a dissertation on a subject chosen by the candidate.

University of Leeds

From July 1958 to March 1961, the University of Leeds provided residential courses for hospital administrators as part

of a 'pilot scheme' financed by the Nuffield Provincial Hospitals Trust. In 1960 the Ministry of Health and the University of Leeds agreed that courses should be continued on a permanent basis.

The courses were initially provided for hospital administrators of different seniority and professional interests. Since 1961 the Centre has expanded its scope to include courses on planning and the study of communication processes in a large organization. Since 1962 the work of the Centre has also included introductory, review and theoretical courses for the Ministry of Health regional training scheme.

London School of Hygiene and Tropical Medicine

In 1958 this post-graduate school decided to hold three or four three-month courses in medical administration with a view to the possible establishment of a two-year course in the future.

The courses so far held have been attended by medically qualified administrators from regional hospital boards and other branches of the National Health Service and from overseas, and by a small number of non-medical administrators of suitable educational status. Each intake is limited to a group of about twelve to fifteen students.

University of Manchester

In 1956 the University of Manchester undertook to accept half the annual intake of trainees in hospital administration under the Ministry of Health selective recruitment and training scheme. Most of the trainees have degrees in subjects which are unrelated to the social services. The University therefore considers it necessary that the trainees should have an opportunity to reflect upon the general principles underlying their experiences during their first year and, at the same time, to become familiar with current theory about administrative practice. The course of studies for the Diploma in Social Administration has been designed with this end in view. The Diploma is awarded, with or without a mark of distinction, to students who pass a written examination in six papers.

The University considers that it is essential for the potential senior administrator to have a detailed grounding in professional expertise, and the students are expected to work for the final examinations of the Institute of Hospital Administrators after completing the diploma course.

The University also provides introductory, review and a twelve-week theoretical course for trainees under the Ministry of Health regional training scheme.

King's Fund Hospital Administrative Staff College

In 1951 the King's Fund established its Hospital Administrative Staff College following the termination of a bursary scheme through which some fifty men and women had been trained in the practice of hospital administration.

The four main functions of the College remain, as at the start:

(1) to provide refresher courses for the most senior administrative officers in the hospital service;
(2) to provide training courses for those who, with further experience after training, might be likely to reach senior administrative posts;
(3) to undertake studies in hospital administration;
(4) to provide a meeting place for those interested in or associated with the National Health Service.

A large number of refresher courses of up to four weeks' duration have been held. Initially, in addition to the refresher courses, an experimental two-year training course in administration and a number of three-month courses were held until the establishment of the national training scheme in 1956 when it was agreed with the Ministry of Health to accept half the trainees under the selective recruitment and training scheme. As is the case at the University of Manchester, the trainees are expected to work for the examination of the Institute of Hospital Administrators.

The Staff College also provides introductory, review and twelve-week theoretical courses for trainees under the Ministry of Health regional training scheme.

In all, the Staff College has held over 135 separate refresher and training courses including specialized courses on building planning, personnel management and management efficiency. They include also sixteen-week courses for the training of work study officers and one-week courses in work study appreciation for those responsible for the use of work study techniques in the hospital service, this part of the College's activity having been established in 1960.

Guest night dinners and receptions designed to bring together, with members of the courses, those interested in, or associated with, the National Health Service, are a special feature of the life of the Staff College.

UNITED KINGDOM

THE INSTITUTE OF HOSPITAL ADMINISTRATORS

A note on its Work as a Professional Society and Examining Body

by

S. R. SPELLER

Secretary and Director of Education

1. The Institute, which was founded in 1902 and incorporated in 1910 as an association of hospital administrators, was in the 1920's first in the field in recognizing that hospital administration was something for which special training was desirable and in which it would be appropriate to establish a qualification obtained by examination.

2. At that time the chief administrative officers of all the major voluntary hospitals were members of the Institute and, except in the mental and isolation hospital field, the voluntary hospitals constituted by far the major section of the hospital service, including all the teaching hospitals (i.e. hospitals with medical schools). Junior officers desirous of making progress in the hospital service were encouraged by their chiefs to study for the Institute examinations and also to widen their experience by seeking promotion not in the same hospital but in another. Next emerged, by the 1930's, the idea of 'on the job' training, a number of the more foresighted senior officers giving selected members of their staff, especially those studying for the Institute examinations, special opportunities for widening their practical knowledge and experience, actively encouraging them to move on to different posts in other parts of the country at the appropriate time.

3. In 1942, when the local authority hospitals had developed from the embryonic stage of poor law infirmaries, which they had mostly been some 15 or 20 years earlier, and when, under stress of war, all types of hospital—including voluntary hospitals —were reliant on public funds and subject to a measure of

public control, the Institute, under an agreement for fusion, accepted into membership administrative officers of local authority mental hospitals who had formerly been members of a sectional professional society with similar objectives, and also interested itself in the qualifications of other local authority hospital administrative officers.

4. Then, in 1943, following an exploratory conference under the chairmanship of Mr. William Goodenough, a committee was set up on the initiative of the Council of the Institute including representatives of all types of hospital authority and of the Government departments concerned, as well as of the Joint University Council for Social Studies together with representatives of the Institute and of certain other staff interests. The Committee* was under the Chairmanship of Mr. D. N. Chester, now Warden of Nuffield College.

5. The most important recommendation of the committee—which was immediately accepted by the Council of the Institute—was that the Education Committee of the Institute, which is responsible for its examinations, should be reconstituted to include—as it now does—representatives of substantially the same range of Government departments and hospital authorities as had been represented on the Committee making the recommendations, together with representatives of staff interests, a committee on which the Institute representatives are just outnumbered by the others. The report of the Chester Committee continued:

15.(2) 'Whilst we appreciate that so large a committee as this may be inconvenient for day to day administration of the examination scheme recommended in this Report, we feel that in no other way could all interests be adequately represented. We therefore further recommend that whilst the Education Committee should itself decide all questions of major policy, it should be empowered to delegate the actual conduct of the examinations and other routine matters to a smaller

*Joint Committee on the Training and Qualification of Hospital Administrators.

Examinations Committee appointed by and responsible to it, receiving regular reports of the work of that Committee.'

16. 'The Education Committee and, subject to its direction, the Examinations Committee would be responsible for holding the examinations in hospital administration, appointing examiners, deciding standards, and prescribing the regulations and syllabus, etc. Subject to that the Committee would operate within the framework of the Institute, using the Institute's offices; and the senior administrative officer of the Institute, who was expressly appointed for the purpose of directing its educational work, would be responsible for arranging the examinations and carrying out the instructions of the Committee. The cost of conducting the examinations would be met out of the examination fees charged, but should this not be sufficient for normal purposes, the Institute accepts financial responsibility.'

17. 'An Education Committee so composed, with full control over the examinations in an important field of the public service yet at the same time working within the framework of a professional institute, appears to us to be an important development and worthy of every support. The employing authorities should have extra confidence in appointing and promoting persons who have passed an examination with the control of which they, the employers, will have been concerned, whilst on their part, the members of the Institute of Hospital Administrators will feel reinforced in their work of raising the standard of their profession.'

20. 'The object of our recommendations is the establishment of a standard qualification in hospital administration to provide employing authorities with a generally recognized criterion of professional achievement which, if his practical experience and personal qualifications were also taken into account, would afford a satisfactory measure of the suitability of any

candidate for a particular hospital administrative post. It is not intended, however, that the discretion of employing authorities in making appointments should be fettered in any way.'

21. 'Even if it were desirable it would be manifestly impossible for a very long time to come to insist that *all* candidates for senior hospital administrative posts should possess the new examination qualification. It is confidently hoped, however, that hospital authorities will give due weight to a qualification established as a result of decisions in which their representatives have shared and controlled by a committee upon which they will be represented, and that they will in all appropriate cases require that candidates for senior hospital administrative posts shall hold the new diploma unless already in the hospital administrative service before the new arrangements become operative.'

6. It is in accordance with the above recommendations that the work of the Education Committee has since developed. It may here be mentioned that, only recently, the Committee, in light of experience over the last 15 years, has very substantially revised the examination syllabus.

Training of Candidates

7. Of practical training the Chester Committee in its report said:

22. 'In this report we have concentrated mainly on the solution of the problem of establishing a recognized written examination qualification. We have not made any detailed suggestions as regards the recommendations of the Conference that hospital administration called for special training, except in so far as we have suggested a syllabus for an examination which could generally be passed only by a candidate with suitable practical experience. We have worked on these lines because we felt that thus general agreement might be

reached on certain broader issues and co-operation in the first stage, viz., the establishment of a standard examination, achieved. If this first step is taken—as we hope it will be—we suggest that the Education Committee should in due time explore the possibility of special training of candidates, a matter largely dependent on the policy and the good will of employing authorities, and one in which little progress could be expected under war conditions.'

8. But training proved to be a matter in which, in the circumstances surrounding the unification of the hospital service, and because of the lack of financial resources, it was impracticable for action to be initiated through the Education Committee. Also from 1945 to 1948 the old hospital authorities were all too conscious of their own impending dissolution, whilst for some time after 1948 the new authorities were too busy grappling with what they regarded as more urgent problems, with very limited resources both of money and of man-power, to do much about it either.

9. The first major move came from King Edward's Hospital Fund for London which, having funds available, first provided a limited number of administrative bursaries and, next, established the Administrative Staff College, of the work of which Mr. Mickelwright, the Principal, will in his paper be telling you. And I am happy to say that right from the start there has been the closest consultation and the most cordial relations between the College and the Institute, the Principal of the College also being a valued member of the Education Committee of the Institute.

10. After the establishment of the College, the next major development was the issue in 1956 of the Ministry memorandum on recruitment and training,* which provided for the establishment of the National Training Scheme, the training responsibilities being shared by the King's Fund Administrative Staff College and the Social Science Department of Manchester University under Professor T. E. Chester. The Institute was

*Ministry circular H.M.(56)32.

very fully consulted by the Ministry before the Ministry memorandum was issued and, save for the reservation that it did not go far enough, welcomed its issue. Also, an Institute nominee, one of its Past-Presidents, Mr. S. C. Merivale, has served from the start on the National Selection Committee which chooses the national trainees. Co-operation between the training institutions (i.e. the College and Manchester University) and the Institute is close and national trainees, although not obliged to do so, are strongly encouraged by the training institutions to take the Institute examinations. Almost without exception they do so.

11. Recently the Ministry of Health—and the corresponding Scottish Department—have taken further steps both to encourage hospital authorities to provide practical training and to encourage officers to study for their professional examinations—again in consultation both with the national training institutions and the Institute as well as with the employing authorities. What has now been done is to provide for the appointment of a training officer in each hospital region who, in collaboration with the national training institutions,* will be concerned with the training of a new class of regional administrative trainees in the selection of whom the National Selection Committee plays an important part. In addition, the Ministry has given hospital boards and committees authority to allow not only regional trainees but also other approved officers not more than a day a week free of other official duties in order to attend lectures in preparation for the Institute examinations.

12. But in one special field of training the Institute—because no one else was in a position to do so—has had to play a special part, for, since 1950, it has been placing overseas Commonwealth students for training in hospital administration, most of these students coming from Ghana, Nigeria and British Guiana. These students also sit for the Institute examinations. In addition the Staff College has provided a few special courses for very selective groups of more senior overseas administrators.

*The expression here includes in addition to the King's Fund Hospital Administrative Staff College and the Department of Social Studies of Manchester University also the Nuffield Centre for Hospital and Health Service Studies at Leeds University.

13. However, both the College and the Institute are of opinion that somewhat different provision is needed and, as a result of consultations with the City of Westminster College and with the training officers, it is hoped that there will be established a two-year course leading to an examination of appropriate standard, most likely to be under control of the Institute Education Committee. The Institute has also undertaken the placing of hospital administrators from other countries for shorter periods of higher level experience, rather than training, these coming from all parts of the world.

14. Certain other activities of the Institute designed to assist the training of younger officers, and the keeping up to date of the more senior, which may be mentioned, are the Annual Conference (with a hospital exhibition every second year); an Annual Summer School; and week-end and day 'schools' in most of the regions. There must also be mentioned the Institute publications, the most important of which are its monthly magazine, 'The Hospital', and 'The Hospitals Year Book'. It should also be said that it is a function of the Institute to answer enquiries by its members on any aspect of hospital administration—either giving an answer or indicating where it can be found or obtained.

15. It will be appreciated that as this paper has been written with the sole intention of explaining the part played by the Institute in the field of professional education and training, I have not dealt in any detail with its other activities as a professional society. Nor have I been so impertinent as to presume to explain the work of the three training institutions, the Hospital Administrative Staff College, Professor Chester's Department at Manchester and the Nuffield Centre for Hospital and Health Service Studies at Leeds University under Mr. John Griffith. But I ought not to conclude without a reference to the year's post-graduate diploma course in Medical Administration established at Edinburgh University under Professor Brotherston, a course attended by students from overseas as well as from Great Britain. At Professor Brotherston's invitation I represent the Institute on the Board of Studies. For the sake of completeness I should also say that at the London School of Hygiene and Tropical Medicine in the

University of London a short post-graduate course in medical administration is offered under Professor Walton, the course being aimed mainly at trainee and assistant senior administrative medical officers of regional hospital boards.

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