GENERAL PRACTICE IN EUROPE***A JOURNEY IN COMPARISONS**

BY

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Since even before its introduction in 1948 our National Health Service has been subject to more criticism and comment (more unkind than kind) than any other of our national institutions. In all this the G.P. has come in for more than his share of abuse. It has been implied that standards in general practice have fallen, that many more patients are being referred to hospital, that practice premises are poor, and that many improvements are necessary.

As a practising family doctor in our N.H.S. I have never been convinced by these criticisms and for a long time I have wanted to go and see for myself how our methods of general medical care compared with others considered to be the best. The opportunity came with a World Health Organization Fellowship in October, 1960. I was able to spend a week each in Holland, Denmark, and Sweden, visiting family doctors and watching them at work; seeing what medical services were available for the ordinary man in the street and his family, and what preventive care was going on to keep them healthy; and observing the inter-relations between the general practitioners and the hospitals and the social services.

The Countries

The medical services of a country must always be related to social, economic and historical backgrounds. Holland, Denmark, and Sweden were chosen because it was considered that they had many points of similarity with Britain. All had a Western European outlook and culture. Economically there were close ties with Britain and the basic standards of living were very similar.

There were also natural differences. All were very much less densely populated. The population of Holland is nearly 11 million, that of Denmark is 4½ million, and that of Sweden 7½ million (compared with 50 million in U.K.). Compared with our area of 93,000 square miles, the area of Holland is 13,514 square miles, of Denmark it is 16,608 square miles, and Sweden is 173,436 square miles.

All are industrial and agricultural countries, but nowhere is there any industrialization as intense as in Britain. Apart from a marked absence of atmospheric pollution, the climate in all three is similar to ours.

Medical Services

Some form of medical insurance exists in all three countries. Only in Sweden is it compulsory to include the whole population. In Holland and Denmark only those earning less than (approximately) £750 join the medical insurance scheme. This covers more than 75% of the population. Those in the higher social scales usually take out private insurance cover for hospital care. Private practice still accounts for more than 25% of the work in general practice.

These insurance schemes are administered by "sick clubs" or "sick funds" along lines similar to those that existed here before the N.H.S.

The contributions from the patients depend on their incomes. As a rule the contributions work out at about 5% of the worker's salary (half the contribution being paid by the employer).

The benefits are comprehensive, but not so comprehensive as under the N.H.S.

General medical care is given by doctors with whom the patients register in Holland and Denmark. The doctors receive a capitation fee (of about 25s.-30s.). In Denmark this fee applies only to those aged 16 and over (in sparsely populated rural areas there is also a fee-for-service). In Sweden there is a fee-for-service scheme, the patient having to pay the doctor and then claiming 75% back from the sick club.

Hospital care is more or less free. In Sweden there is a small (5s.) daily contribution for in-patients, and in Holland patients are only allowed free care up to 70 days.

Consultants' fees are paid by the sick clubs, but the methods differ in the three countries.

Patients have to pay a good deal for drugs. In Holland and Denmark only a few "life-saving" drugs are free. Most other drugs have to be paid for by the patient. In Sweden the patient pays the first 5s. of the prescription's costs and 50% of the amount above this.

There are intriguing "extras" that have to be paid for by the patients. In Denmark all requests for visits have to be in by 9 a.m. For later requests the doctor claims a fee, which is doubled in the case of a night call or a week-end request. Requests for repeat prescriptions on the 'phone are charged about 3s. in Sweden.

The Medical Profession

There are approximately 7,000 doctors in Holland (1 for 1,500 of the population), 5,000 doctors in Denmark (1 for 900), and 6,500 in Sweden (1 per 1,200). (In Britain our rate is around 1 per 900.)

In Sweden there is an apparent shortage of doctors, a shortage that is serious outside the large towns. In the remote areas one district doctor may have to look after more than 10,000 people.

The profession is well organized in each country with active and powerful medico-political medical associations and other allied societies.

General Practice

Before I went I was not certain whether "general practice" as we know it existed on the Continent, and if it did how it compared with our own.

In Holland and Denmark it certainly exists. The doctor works independently from his own premises with the minimum of interference from anyone. He arranges his own routine of work and he has the closest relations with his patients. In Denmark, where there are no out-patient departments, the doctor is encouraged to investigate his patients very fully and to seek private consultant advice (for which the insurance scheme pays) before the patient is admitted to hospital.

In Sweden there is *no* general practice in our sense, and the Swedes acknowledge the fact. The Swedish system of medical care is based on the principles of free choice of any doctor by the patient at any time and on free access by the public to hospitals. The patient can be under the care of more than one doctor at the same time.

*The last of three articles on general practice in other countries. The others were published in the last two issues of the *Journal*.

In the large towns in Sweden most doctors are "specialists." To be a "specialist" it is necessary to do approximately five years' postgraduate work in a hospital and then one is automatically graded a specialist by the Royal Medical Board. The vast majority of these specialists have no access to any beds in hospitals.

Outside the large towns there is a great shortage of doctors in Sweden. Medical care is provided by district doctors who are responsible for between 6,000 and 10,000 patients. These district doctors are a mixture of an M.O.H. and a G.P. They organize all local preventive care and are also general practitioners. They are well paid, receiving a salary of £2,000 for being an M.O.H., and also collect fees for all G.P. work. Their premises are provided for them by the local communities, and they have nurses to work with, and it is only by using these nurses a great deal that the doctors can cope with the work.

Entry into Practice

Entry into general practice in Holland and Denmark is by buying and selling goodwill (in Copenhagen G.P.s are appointed to vacancies in order to control their numbers). The cost of a practice is around one and a half times its annual income. In Sweden there is no sale of goodwill. Specialists merely "put out their plates" and district doctors are appointed by the Crown.

There is no system of training for general practice, or any organized postgraduate education of practitioners. A doctor can buy his practice in Holland and Denmark as soon as he qualifies. There are no "assistants," trainee or otherwise, by means of which the young doctor can serve an apprenticeship. No teaching of general practice is given to medical students during their long 6-8 years' medical training.

Doctors work alone, single-handed, and there are no partnerships or group practices.

Premises

In Holland and Denmark the general practitioners work from their own homes in premises that have to be improvised for the job. Their problems are identical with our own in Britain. Waiting-rooms tend to be small, and some patients sometimes have to wait up to three hours. The consulting-rooms were of the usual type and there were no special examination rooms. In Sweden, where the premises are built and provided by the local committees, the facilities are lavish and extravagant. Waiting-rooms are still small, but there are two or even three examination rooms, a minor operating theatre, and a small x-ray unit, an E.C.G. machine, and a laboratory. There were also rooms for nurses and secretaries. The equipment used and the care provided was very similar to that in Britain. In Sweden the x-ray and E.C.G. machines were used only occasionally.

Secretary-nurses are employed by most of the doctors (6 out of 10 of the doctors visited had one). They are specially trained for their job and carry out book-keeping, records, diagnostic tests (they did all the investigations), dressings, and injections. In Sweden they are employed by the local authorities.

The Doctor's Day

Basically the day of the G.P. in Europe is the same as in Britain. He sees patients in his consulting-rooms and he also visits patients in their homes. The sessions,

however, are arranged differently. There is always a morning consulting session that tends to start early, usually about 8 a.m. (one Dutch rural practitioner starts seeing patients at 7.15 a.m.). This session goes on for anything from 2-4 hours, although the official period on the plate is 8-9 a.m. Patients wait their turn. There are no appointment systems. In many practices this is the only consulting session of the day, but in some practices in Holland and Denmark there are one or two afternoon and an occasional evening session during the week. Evening consultations are the exception. Visits are done after the morning sessions, but they tend to be much fewer than in Britain. The doctor usually finishes his work by 5 or 6 p.m., and in the large towns in Denmark and Sweden he is then free because the G.P.s do no night calls.

Night calls and week-end work in Copenhagen are carried out by an emergency call scheme that is approved by the profession and by the insurance scheme. The doctors who work in it are either young G.P.s or in junior hospital appointments. The scheme is operated with the approval of the Danish Medical Association, and the doctors are paid by the insurance authorities at about £1 per visit (the patient contributes about 5s. of this). This is considered as a good training for general practice.

In Stockholm a 24-hour emergency service is operated by the local authorities. Because there is no recognized general practice and no patient has his or her "own doctor," teams of young doctors in radio-cars are employed to deal with urgent requests for visits. There are 3-4 of these doctors for each of four daily shifts, and on an average each doctor deals with 15-20 visits per shift. The doctor is paid (about £1 per visit) by the patient, who then claims 75% back from the insurance scheme.

Outside the large towns there are no such schemes and it seems that night calls are much less frequent, on an average about one call every three or four weeks.

Volume of Work

How hard do our colleagues abroad work? When I visited these doctors I took particular note of the number of patients seen, and the Table shows the average figures.

Country	Size of Practice	Daily		Annual Attendance Rate per Patient	Annual Gross Income
		Consults.	Visits		
Holland ..	3,750	35	15	4.3	£5,000
Denmark ..	3,500	40	10	4.3	£4,500
Sweden ..	8,000	30	5	1.1	£6,000
Britain ..	3,000	35	10	4.4	£3,000

Although these are rough estimates they do show certain trends.

(1) The average size of the lists of the doctors whom I visited were much higher than those in Britain, yet the doctors were coping very easily—even in Sweden. In Sweden, as we shall see, much of the doctor's work was done by his nurses.

(2) The total numbers of visits and consultations were similar even though the numbers at risk were different.

(3) As a sign of local habits, and as an index of how hard the doctor worked, it is seen that in Holland and

Denmark the patients saw their doctor just over four times a year each, but in Sweden the rates were much less.

(4) The gross incomes of the doctors are a very rough estimate calculated from capitation fees and other sources of income.

Diagnostic Facilities

It must be accepted as a fact that the modern doctor cannot practise a high standard of medical care without access to diagnostic facilities. How do our colleagues in Europe fare, bearing in mind that not all G.P.s in Britain have this access?

In Holland, although there is theoretical access to hospital diagnostic departments, this does not exist in practice because the patient or G.P. has to pay for it. The G.P. does simple blood estimations in his practice and refers others who require more detailed pathological investigations and x-rays to a specialist in hospital, who then investigates them and takes over their supervision.

In Denmark a much more enlightened view exists. The G.P. is actively encouraged to investigate his own patients. He is given access to all diagnostic aids. This encouragement goes so far that there is no system of out-patient consultations in hospitals, and no patient is admitted to hospital until the G.P. has fully investigated his patient and obtained a consultant's opinion. This opinion is obtained at a private consultation for which the insurance scheme pays. X-ray investigations are carried out either at the hospital or by private radiologists (again, the sick clubs pay). Pathological investigations are done in hospitals or, in Copenhagen, at a special G.P.s' laboratory.

G.P.s' Laboratory

This G.P.s' laboratory in Copenhagen requires special comment. It was first established in 1922 to maintain the doctor's independence, and has now grown to a building covering eight floors and a staff of over 60 technicians. It is owned by a G.P.s' organization and it is financed by charging a scale of fees for each investigation. These fees are paid by the insurance scheme. Any doctor can refer cases for investigation. In 1959, 300 doctors referred 75,000 patients for 275,000 investigations. On an average, each G.P. in Copenhagen refers between 200 and 300 of his patients to the laboratory each year.

The investigations carried out are very comprehensive, and as well as any pathological investigations there are facilities for electrocardiograms (12 machines), electroencephalograms (3 machines), B.M.R. (six rooms for this test), audiometry, serum analyses, tonometry, and electromyography. The results are sent direct to the doctor.

Figures for September, 1960, showed that 6,573 were seen and 24,322 investigations carried out. Amongst these 40% were for routine blood tests, 8% serum analyses, 20% urine tests, 2% gastric analyses, 5% examination of faeces, 6% E.C.G., 3% B.M.R., and 2% E.E.G.

A laboratory such as this works very well in Copenhagen, a town of over 1 million inhabitants, but obviously it would be more difficult economically to organize such a laboratory in a smaller place.

In Sweden the district doctors have laboratories and small x-ray machines provided for them, and their nurses

are trained to carry out simple tests. Anything more elaborate has to be referred to hospital.

Hospital Services

There are more hospital beds available on the Continent (approximately 15 per 1,000) than in Britain (12 per 1,000), and waiting-lists are shorter. The relations between the G.P. and the hospital vary. There are no G.P. beds and the G.P. has no appointment in the hospital service.

Outside the large cities admission to hospital is arranged directly between the G.P. and the hospital staff, as in Britain. In the larger towns of Holland and Denmark there are certain departments that control and supervise all hospital admissions in that particular town. This saves the individual hospitals much work.

In Amsterdam, for example, before a patient is placed on the waiting-list, or admitted as an emergency, a "control doctor" employed by the local authority has to see the patient to decide whether admission is necessary.

In Copenhagen there is a similar system. The admission has to be vetted by a doctor called the "visitator."

In Sweden admissions are arranged by the patient approaching the hospital directly and no introduction from an outside doctor is necessary.

Out-patient Care

The arrangements for out-patient care are quite different. The nearest approach to our own system is in Holland, where specialists on the hospital staff see patients referred there by the G.P.s, but these specialists are all paid a fee for this either by the insurance scheme or by the patient (if they are not covered).

In Denmark there are no out-patient departments as we know them. If a G.P. wants a specialist's opinion he refers the patient direct to the specialist's own consulting-rooms and an agreed fee is paid by the insurance scheme. The ideas behind this are admirable: (a) the hospitals do not take over long-term care of the patient; (b) hospitals do not carry out any routine care; (c) the patient is seen by the specialist himself; and (d) better personal contact and relations develop between G.P. and specialist.

In Sweden the system is quite the opposite. There are large polyclinics at hospitals which provide out-patient and G.P. care. Patients can go direct to the hospital without any doctor's letter, etc. They can select the specialist they want to see. The polyclinic carries out the whole care and supervision of the illness for which the patient attends.

This system has overloaded the hospitals. On a visit to a very large (1,700 beds) hospital in the E.N.T. polyclinic I saw three specialists seeing 200 patients during a morning session. At the same hospital I saw one surgeon working alone seeing 100 patients in a morning. Many of these (more than 70%) cases were minor conditions such as sprains, sore throats, and even wax in the ears. It seemed that there was a need for a G.P. to help.

Preventive Services

The countries visited have the lowest infant mortality rates in the world, and I was interested to see whether this could be the result of any special system of preventive care that they were using.

It was clear, however, that the good health of the people did not depend on any one system, because different methods were used in the three countries.

In Holland infant welfare and maternity care were carried out at clinics by clinic doctors in the cities and by G.P.s on their own patients in the smaller towns and villages.

In Denmark the G.P. carried out the preventive medical care. He was responsible for seeing and examining all infants in his practice at nine set periods from birth till school. For this he received a fee of 15s. for each examination. He also saw his expectant mothers in co-operation with the midwife.

In Sweden there is yet a very different system. All infants are seen at clinics. These clinics are in three grades. Grade I is a clinic staffed by a paediatrician (a paediatrician in Sweden is not one with a hospital appointment but one who sees only children)—there are 161 of these; grade II clinics are run by district doctors with a specially trained nurse—there are 53 of these; grade III are those run by a district doctor with no specially trained nurse—there are 562 of these. By this system 95% of children are seen and supervised in their first year of life, 85% in the second year, and 30% between two and seven years. More than 50% of children are seen by a paediatrician at some time in their first year. The type of maternity care does not seem to be related to the low infant mortality rate. In Holland only 40% of women are delivered in hospitals. In Denmark the figure is about 70%, and in Sweden 99%. Yet the results are good in all.

Clinical Problems

The main clinical problems encountered in all these countries were more social than medical and were related to the care of elderly, the chronic sick, and the mentally ill.

A successful experiment in Sweden in keeping these patients out of hospital has been to pay relatives up to £4 a week to look after these patients at home, and also to provide a wide range of home-helps and rehabilitation units at hospitals.

Alcoholism is a much greater problem than here. For instance, special clinics for alcoholics treat 5,000 patients (nearly 8 per 1,000 of the adult population) in Stockholm each year.

The abortion clinics in Sweden have achieved a good deal of publicity, and in 1959 there were 1,300 legal abortions carried out in Stockholm compared with 10,000 births.

Use of Nurses

A striking impression on the visitor to Sweden is the way in which nurses are given much greater responsibilities.

Without the help of nurses the district doctors caring for up to 10,000 patients could not cope. As it is each doctor has between three and five nurses working with him. These nurses have their own offices in their homes as well as rooms in the doctor's premises, and they are well paid—up to £1,000 a year. They carry out almost all the routine preventive care, visit infants and mothers, and carry out inoculations, etc. They also visit patients on behalf of the doctor and treat many cases on their own.

Anaesthetics in hospitals in Sweden are given by trained nurses and this includes intubation and muscle relaxants. There are no radiographers in Sweden. Nurses specialize in this branch and they also take up physiotherapy.

Discussion

What can we learn from all this, and in what ways can we be of help to our colleagues abroad?

In the field of general practice we can teach our colleagues much about the training of future practitioners and postgraduate education of G.P.s. The strides that have been made here in encouraging research in general practice have no parallel abroad except in Holland, where the young College of General Practitioners is beginning to organize field studies. The absence of a College of General Practitioners in Denmark and Sweden was evident in a lack of academic stimuli.

The development of group practice has aroused much interest on the Continent, and in Stockholm there are plans for building a series of medical centres in an attempt to halt the flow of patients to hospitals.

There are many good things that have been developed abroad that we should examine to see if they could be introduced here.

The example of co-operation between nurses and district doctors in Sweden has shown what can be done. By means of this co-operation the team is able to care most efficiently for up to 10,000 patients. What couldn't we do if our health visitors and district nurses worked with our family doctors?

In the field of preventive care we can learn from Denmark and Sweden how the G.P. is able to undertake the routine care of infants. We might see whether an experiment on these lines could be carried out in an area here.

The successful ways in which G.P.s are encouraged to investigate their own cases is most refreshing, and the G.P.s' laboratory in Copenhagen should be visited by some of our planners.

Two opposite lessons on the use of out-patient departments. In Denmark all goes well without any out-patient services (apart from follow-up clinics), whilst in Sweden much unnecessary work is done at the polyclinics.

Of interest to general practitioners are the absence of any evening consulting sessions, penalties for patients with late requests for visits, the universal use of the emergency-call systems in large towns for night calls, the sale of goodwill, and the training of nurse-secretaries for general practice.

In the social field, could we not encourage relatives to care for their elderly relatives by paying a money grant, as in Sweden?

Conclusions

The great stimulus given by visiting and talking to fellow doctors abroad cannot adequately be described. My sincere thanks are due to all who have made this visit possible—especially to the World Health Organization, who awarded me the Fellowship.

I left England in a mood of apprehension and inferiority, but I returned stimulated in the knowledge that our N.H.S. is in no way lagging behind others. We may have old buildings, but we seem to have ideas that are in many ways ahead of others.