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SCANDINAVIAN HEALTH INSURANCE LEGISLATION

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INTRODUCTION

Professor R. H. Graveson of England has stated that "it is in the solution of modern social problems that I think we may see a most valuable function of comparative law."[1] This statement is particularly significant with respect to government health insurance in view of the number of nations which have adopted such insurance programs.

This article applies Professor Graveson's dictum to the solution of a critically significant "modern social problem" by a comparative study of health insurance systems in Denmark, Finland, Iceland, Norway, and Sweden.[1a] Because of their democratic institutions, their unsurpassed rate of literacy, and their high standards of living, these nations have long received attention and admiration from the American people. With the exception of Finland, they have had systems of health insurance in effect for several decades so that it is possible to assess the virtues and defects of their systems with a large degree of assurance. Yet, no article in English has appeared discussing their experience, although there is much literature about the system operating in England since 1948. The author believes that the United States may profit from the Scandinavian experience as well as from that of Great Britain.

In order to secure first hand information on Scandinavian health insurance, the author[1b] visited all five Scandinavian

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1. Graveson, *Philosophy and Function in Comparative Law*, 7 INT'L & COMP. L. Q. 649, 655 (1958).

1a. Because of frequent reference in the course of the article to Scandinavian currencies, the following recent approximate currency exchange values are listed:

1 Danish Krone (crown) = 15¢
100 Finnish Marks = 31¢
1 Icelandic Króna = 4¢
1 Norwegian Krone = 14½¢
1 Swedish Krone = 19¢
(There are 100 Øre in 1 Krone.)

1b. Three grandparents of the author immigrated to the United States from Norway, and one from Denmark. The author has long been interested in Scandinavian law, and published THE GROWTH OF SCANDINAVIAN LAW in 1953.

states commencing September 1, 1958, for almost three months. He spent one week in Iceland and one in Finland, and three weeks each in Denmark, Norway, and Sweden. The author acknowledges his indebtedness to the Social Science Research Council for a Grant-in-Aid of Research, and to the Scandinavian embassies in Washington, D. C., for extremely valuable assistance.[1c]

As of January 1, 1931, systems of compulsory health insurance existed in 22 countries: Austria (adopted in 1888), Bulgaria (1918), Chile (1924), Czechoslovakia (1920), Esthonia (1912), France (1928), Germany (1883), Great Britain (1911), Greece (1922), Hungary (1891), Ireland (1911), Japan (1922), Latvia (1912), Lithuania (1925), Luxemburg (1901), Netherlands (1913), Norway (1909), Poland (1920), Portugal (1919), Rumania (1912), The Soviet Union (1912), and Yugoslavia (1910). Systems of voluntary insurance existed in five countries: Belgium (1903), Denmark (1892), Iceland (1911), Sweden (1891), and Switzerland (1911). Thus a total of 27 countries had systems of health insurance.[2] By 1937, 32 countries had compulsory sickness insurance laws protecting more than 90 million persons. By 1949, 36 nations had compulsory health insurance, and by 1958, the number of countries with some form of health insurance had leaped to 59.[2a] In that year, 77 countries had systems of workmen's compensation; 58 had old-age, invalidism and survivor programs; 26 had unemployment insurance; and 38 had family allowances. Next to workmen's compensation, the most popular social security system was health insurance.[3]

1c. Acknowledgments to individuals in the Scandinavian countries are listed at the end of the article.

2. ARMSTRONG, INSURING THE ESSENTIALS 598-610 (1932).

2a. Countries which have adopted health insurance legislation in the last 18 years are: Venezuela in 1940, Costa Rica and Panama in 1941, Mexico and Spain in 1942, Italy and Paraguay in 1943, Australia in 1945, Colombia and Guatemala in 1946, Albania and the Dominican Republic in 1947, India in 1948, Bolivia, El Salvador and Iran in 1949, Nationalist China and Turkey in 1950, Communist China in 1951, Israel in 1953, Burma and the Philippines in 1954, Nicaragua in 1955, Iraq in 1956, and Canada, Honduras and Libya in 1957.

3. [The recent survey of the United States Department of Health, Education and Welfare was reported in the New York Times for January 13, 1959.] SOCIAL SEC. ADM'N, U. S. DEP'T OF HEALTH, EDUCATION AND WELFARE. SOCIAL SECURITY PROGRAMS THROUGHOUT THE WORLD, 32-59 (1959). The nations are: Albania, Argentina, Australia, Austria, Belgium, Bolivia, Brazil, Bulgaria, Burma, Canada, Chile, China (Nationalist), China (Communist), Colombia, Costa Rica, Cuba, Czechoslovakia, Denmark, Dominican Republic, Ecuador, El Salvador, France, Germany (West), Germany (East), Greece, Guatemala, Honduras, Hungary, Iceland, India, Iran, Iraq, Ireland, Israel, Italy, Japan, Libya,

In 1953 Australia established a system of tax-supported grants supplementing approved private health insurance schemes.[4] The grants provide direct subsidies for hospitals, contribution towards the cost of hospital and medical treatment and supply of medicines for insured persons, in addition to amounts recoverable from the insurer, and the whole costs of certain medicines and hospitalization.

In 1957 the Canadian Parliament passed a statute making provision for hospital care.[5] Under it the national government provides grants-in-aid to the provinces whose duty is to administer the system. Hospital benefits consist of meals, lodging, nursing, drugs, surgical supplies, use of operating room, x-ray and laboratory, and medical interpretation of diagnostic procedure. Prior to the statute, only half the Canadian people had hospital insurance. The law provided that when six of the nation's ten provinces with half its total population agreed to cooperate, the Minister of National Health and Welfare would contribute about one-half of the operating expenses of provincial hospital insurance plans. By 1959, seven provinces had agreed to do so: Alberta, British Columbia, Manitoba, Newfoundland, Nova Scotia, Ontario, and Saskatchewan. All Canadian residents except those covered by other government schemes are covered. Aliens are eligible if they intend to stay. Full out-patient services are offered in Newfoundland. Alberta and British Columbia have a $1-$2 a day "deterrent charge." In Alberta and Newfoundland, the provincial share of the cost is met out of general funds; in Manitoba, Ontario, and Saskatchewan it is met through premium payments of $20-$25 a year for single persons and $48-$50 for families; and in British Columbia and Nova Scotia through a sales tax. The whole field of medical and surgical treatment is still open for voluntary prepayment plans.

In the United States, four states have adopted nonoccupational temporary disability benefits.[6] Rhode Island, California,

Luxemburg, Mexico, Netherlands, New Zealand, Nicaragua, Norway, Panama, Paraguay, Peru, Philippines, Poland, Portugal, Rumania, Spain, Sweden, Switzerland, Turkey, Union of Soviet Socialist Republics, United Kingdom, United States of America (four state laws and national law for railway workers), Venezuela, and Yugoslavia.

4. AARON & MATTHEWS, THE EMPLOYMENT RELATION AND THE LAW 798-799 (1957).

5. Taylor, *National Hospital Insurance Act*, 12 U. TORONTO L. J. 300 (1958).

6. AARON & MATTHEWS, THE EMPLOYMENT RELATION AND THE LAW 362-373 (1957); Willcox, *Patterns of Social Legislation: Reflection on the Welfare State*, 6 J. PUB. L. 3, 21 (1957); Note, 60 YALE L. J. 647, 650 (1951).

and New Jersey have done this by amending their unemployment insurance laws, and New York by amending its workmen's compensation law. In 1946, Congress amended the Railroad Unemployment Insurance Act to include sickness benefits.

On May 8, 1958, the Delegates' Assembly of the National Association of Social Workers of the United States, representing 22,000 members, issued an official statement approving a comprehensive national health program, compulsory if necessary, to assure full health care to all through principles of group payment and tax support.

Social insurance has often been classified into five groups: workmen's compensation, old age insurance, survivor's insurance, unemployment insurance, and health insurance.[7] Between 1911 and 1948, all of the then 48 states and Alaska passed workmen's compensation laws. Unemployment insurance was provided for in 1936 in the Social Security Act, and all states passed laws to take advantage of the Act's tax credits.

The Act also provided old age insurance in 1936, and in 1939 it was amended, granting survivors' insurance on a like basis, with both programs on a national basis. Survivor benefits are payable to a widow or dependent widower who is 65 and has not remarried, dependent children under 18 and the mother of such children, and the dependent parents if they are 65 and no monthly benefits are payable to any of the survivors previously listed. The Social Security Act was amended in 1956 to provide disability insurance on a national basis for persons over fifty years of age. The one social insurance now lacking is health insurance.

I. HISTORY

Germany was the first nation to adopt health insurance legislation, which was, in fact, the first social insurance legislation enacted in that country. Health insurance legislation was adopted in 1883, workmen's compensation in 1884, and disability and old-age pensions in 1889.

The first social insurances to be organized under national legislation in the Scandinavian nations were health insurance

7. RIESENFELD & EDLUND, MODERN SOCIAL LEGISLATION 5 (1958) (Replacement Pamphlet); *See also* FREEDOM AND WELFARE 388 (1953), (sponsored by the Ministries of Social Affairs of Denmark, Finland, Iceland, Norway, and Sweden).

and workmen's compensation.[8] By 1911 all Scandinavian states had statutes on health insurance and by 1917 on workmen's compensation. Thus it is correct to say that health insurance preceded all social insurance in the Scandinavian countries. Sweden in 1891 and Denmark in 1892 enacted legislation which authorized support to reorganized health insurance societies. In Finland an 1897 statute regulated health insurance societies, but no public subsidies were given. In 1909 Norway established a compulsory system. In 1911 Iceland provided for registration of health insurance societies, and subsidies from the state. The American critics of health insurance who stress the great expense and administrative difficulties involved seem to have forgotten that in many states, including Germany and the Scandinavian countries, health insurance prceded all the other social insurances.

The most widespread causes of destitution are sickness, unemployment, injuries arising out of employment, old age, and disablement. Sickness and unemployment involved short term risks, and the legislation in the Scandinavian states was preceded by mutual benefit societies voluntarily developed. The other causes of destitution involved long-term risks, and the legislation was not preceded by such societies. Social insurance, as distinguished from public assistance or poor relief, seems to be the natural solution in all these cases, since a great many cases of need are essentially similar to each other with respect to cause and effect. Within the past quarter of a century social insurance has become sufficiently widespread so as to reduce public assistance to second place. Social insurance as understood in the Scandinavian states consists of six branches: health insurance, unemployment insurance, old age pensions, disability pensions, survivors' benefits, and workmen's compensation.[9] Wide coverage has been traditional since self-employed persons were protected by health insurance, whereas they were ordinarily debarred from workmen's compensation. Coverage was not limited to industrial workers, but was available to poor and middle class persons generally. On the other hand there were some severe limitations. Membership was voluntary as in Denmark. Many failed to avail themselves of membership. Furthermore in some countries, such as Denmark and Finland, the applicant had to be in good health when applying for membership.

8. FREEDOM AND WELFARE, *supra* Note 7 at 383, 401.
9. *Id.* at 388.

The Scandinavian choice of time for establishing health insurance was excellent. Before they established health insurance, available medical care, hospitals and drugs left much to be desired. As James B. Conant, former President of Harvard University, has concluded: "Indeed, it is probable that only within this century have medical men and surgeons helped more people than they have injured — one might almost say, cured more persons than they have killed."[10] An American expert has stated: "I think it was about the year 1910 or 1912 when it became possible to say of the United States that a random patient with a random disease consulting a doctor chosen at random stood better than a fifty-fifty chance of benefiting from the encounter."[11] A noted American physician stated in 1953: "Seventy-five years ago poor patients were sent to hospitals to die, and the hazards of health were greater among those sent to hospitals than among those kept at home. By and large, hospitals were then regarded with horror."[12] As of 1860 most drugs in use were more harmful than helpful.[13] Over "80 percent of the prescriptions now written by doctors are for drugs which did not exist twenty years ago."[14]

A. *Denmark*

In Denmark the first social insurance to be set up on a state regulated and supported basis was health insurance, a statute being passed in 1892.[15] Before Denmark adopted its health insurance legislation Germany had in 1883 adopted compulsory health insurance for the entire working class. The paramount purpose of such legislation was to defeat revolutionary socialism. The Danes were greatly interested in the German legislation, and accepted the notion that the state should intervene. But there the resemblance ended. The Danish legislation was adopted largely through the efforts of the Left party which was made up mostly of middle class farmers and which had a broader basis than previous parties. The Danish folk school movement attached great importance to popular elements in the national life. The Danes did not like the idea of compulsion. Three fundamental principles were accepted by

10. CONANT, MODERN SCIENCE AND MODERN MAN 129 (1953).
11. L. J. Henderson, quoted in GREGG, CHALLENGES TO CONTEMPORARY MEDICINE 13 (1956).
12. MEANS, DOCTORS, PEOPLE, AND GOVERNMENT 41 (1953).
13. CALDER, MEDICINE AND MAN 13 (1958).
14. *Id.* at 36.
15. SOCIAL DENMARK 33 (1947).

the Danes. (1) All persons of moderate means have the right to insure regardless of occupation; the German system covered only the working class. (2) Membership in so-called "sick clubs" and "sick societies" is voluntary; the German system was compulsory. The concept of voluntariness continues today although passive membership is compulsory. Such membership costs only a few kroner a year and gives no right to health insurance benefits. (3) The administration is in the hands of autonomous, though State controlled, clubs and societies.

Sick clubs commenced in Danish towns in the sixteenth century through voluntary organizations of artisans, and were developed in rural districts during the past century. The clubs often admitted other persons of similar economic status. They were managed by members without remuneration. Many leaders of other segments of the population, such as ministers and attorneys, supported the movement. But the movement was financially weak. Unlike the German compulsory plan of 1883, the Danes preserved the existing voluntary plans, but regulated them and gave them financial support. There are four major acts on health insurance, those of 1892, 1915, 1921, and 1933. The 1892 Act gave state grants to sick clubs which in turn must submit to government inspection and give members certain benefits laid down by law. Only after some years did all clubs submit to regulation, and then for financial reasons. The Act of 1921 extended coverage to more well-to-do persons by establishing sickness insurance societies, called "continuation sick societies," but these societies received no grants from public funds. Sick club members who improved their financial status were transferred to the sick societies, and chronic invalids were admitted as members. The Act of 1921 introduced invalidity insurance which was compulsory for impecunious members of the sick clubs.

Although the nineteenth century in Europe was an age of *laissez faire*, the necessity of mutual aid and of government support for such programs was recognized a century ago.[16]

In 1861 the Danish parliament appointed its first commission on sick clubs. During the parliament debates in 1878 it was asserted that the sick clubs could not rely entirely on pri-

16. See a paper by P. Friis Olsen, *The Origin and Historical Development of Danish Sickness Insurance*, delivered as a lecture in 1956 in the training course at Copenhagen on mutual benefit societies sponsored by the International Labor Organization. These lectures were mimeographed, but not otherwise published.

vate persons and local communities, and that state subsidies were necessary. In 1880 the newly established Social Democratic party requested the lower house of parliament to pass legislation providing free medical treatment, hospitalization, and medicine for all; that such aid should not be regarded as poor relief, and that cash benefits should be paid to replace loss of earnings due to sickness. In 1887, a new commission (appointed in 1885) proposed, after studying conditions in Denmark and elsewhere, use of the existing clubs; and this proposal became the basis of the Act of 1892.

This statute which followed a year after the Swedish law accomplished far more substantial results than the Swedish law. It gave more liberal subsidies and required standardized benefits. The sickness societies had to have 50 members, whereas the Swedish required only 25. The Danish law provided not only cash benefits, but also medical and hospital care. In 1895 the government subsidies amounted to 42.3 percent of the membership contributions, and in 1913 to 46 percent. By 1907 Denmark had more members than Sweden though the population of Sweden was almost twice as great. By 1914, 36.5 percent of the Danish population were insured. No voluntary system was more successful in securing members than the Danish system. And no voluntary system was as successful in standardizing benefits. By 1928, 63 percent of the population was covered, and the government contributions amounted to 50.3 percent of the total contributions made by members. The average size of a sickness society grew from 736 members in 1918 to 890 in 1925. The Danish system required both medical care and daily cash benefits, whereas the Swedish gave only cash benefits. In 1915, 42 percent of Danish health insurance expenditures was for cash benefits and 58 percent for benefits in kind; in 1926-1929, corresponding figures were 16 percent and 84 percent. By 1925, 1559 out of 1647 sickness funds provided specialist treatment, 1018 provided drugs, and 1241 provided dental treatment. Several hundred funds furnished nurses for home nursing, and massage and hydrotherapy. Many funds provided maternity benefits. In 1925 expenditures, in order of amounts involved, were for medical care, hospitals, drugs, specialists, maternity, clinics, dentistry, tuberculosis, home nursing, and convalescent care. Only the first two were required benefits, yet the amounts spent for optional benefits constituted about 30 percent of all expenditures.

A 1921 statute provided that physically handicapped persons must be admitted to a club if they could contribute towards self-support. There were special subsidies from the state to cover expenses as to such persons. In turn, the consumers reimbursed the state for half of such subsidies. Another 1921 statute provided for maternity allowance: cash allowance for ten days after birth, and medical care during confinement.

The National Insurance Act of 1933 unified the legislation on sickness and invalidity insurance.[17] It made the right to an old age pension dependent on membership in a sick club or society even though old age pensions are noncontributory. All Danish subjects between 21 and 60 who were not already in sick clubs or societies and whose health made them eligible were required to apply for passive membership in the clubs and societies. Such members, however, receive no health insurance benefits. The individual remains free to decide whether or not he will be an active member, and thus entitled to benefits. The statute was passed to make persons not active members eligible for old age and invalidity pensions. Persons who fail to apply for passive membership must pay an annual fine of 13 kroner, the cost of passive membership, yet do not get the right to an old age pension.

Some of the factors which make Danish health insurance successful are good transportation, short distances to hospitals and physicians, density of population, homogeneity of the people racially, culturally, and religiously, and an excellent system of education. These factors have been suggested by the head of the Directorate of Sickness Insurance Services in the Danish Ministry of Social Affairs, Miss Alice Bruun. A Danish physician, Dr. Richard Friedberg, has pointed out that income is quite evenly distributed, there being few rich and few poor.

At the request of the sick clubs, the Danish government in 1954 appointed a commission to examine desirable reforms in the Danish system. Members of the Commission consist of representatives of the political parties, of the civil service, the

17. The present Danish law of health insurance is to be found in SOCIAL MINISTERIETS LOVBEKENTGØRELS NR 228 at 12 (September 1957). The Danish system is described in ARMSTRONG, THE HEALTH INSURANCE DOCTOR: HIS ROLE IN ENGLAND, DENMARK AND FRANCE 101-162 (1939). See also the papers at International Labor Organization, Training Course on Mutual Benefit Societies, Copenhagen, July 31 to August 25, 1956 (23 lectures).

medical associations, and the sick clubs. Among the questions the Commission is considering are the following: Should the system be made compulsory? Should the prerequisites as to good health, age, and qualifying period be eliminated or changed? Should the limitation to a total of 420 days benefit from the sick club in the course of three consecutive financial years be abolished? Should the daily cash benefits, which are very small, be increased? Should preventive medical treatment be provided for? Should more dental care be provided? Should the two classes of sick clubs and sick societies be continued? It is anticipated that the report will be completed in 1959 or 1960.

B. *Finland*

The germ of social insurance, including health insurance, in Finland was the worker's benefit fund, represented by journeymen's "chests", the "boxes" maintained by carpenters and other craftsmen, the factory employees' benefit funds which some employers required all workers to join, and the general benefit funds created by the laborers' social movement which began in the 1870's. These funds paid out sickness and old age benefits. They functioned under no public control. Various legislative committees on sickness insurance published recommendations in 1892, 1911, 1921, and 1949, but no legislation was adopted to put the recommendations into effect.[18]

At the 1888 Finnish Diet, a committee to study the possibility of universal workers' insurance to be established and subsidized by the government was appointed, and on its recommendations a workmen's compensation law was adopted in 1895, and a decree was issued in 1897 regulating the operation of workers' benefit funds, including sickness funds. This decree was superseded by the Benefit Fund Act of June 19, 1942.[19] Benefit funds, the founding of which is entirely voluntary, grant to their members sickness, maternity, and burial benefits in return for membership contributions.

C. *Iceland*

The oldest sick club in Iceland was founded in 1897. One at Reykjavik, the capital, was established in 1909. Under a 1911 statute sick clubs, upon meeting certain conditions, could be

18. SALOMAA, SOCIAL LEGISLATION AND WORK IN FINLAND 85 (1953); ARMSTRONG, INSURING THE ESSENTIALS 345-346 (1932).
19. SALOMAA, *supra* note 18, at 92-93.

registered and thereby become entitled to financial support from the State.[20] The clubs were voluntary and each club fixed the annual premium paid by members. The required benefits for the insured member were medical care and hospital care for a period determined by the fund. There was to be a minimum daily cash benefit of half a króna, with a maximum of two thirds of earnings, for a period determined by the fund. No maternity benefit or benefits for dependents were required. There was an annual government subsidy per member of one króna in large towns and half a króna in rural areas. Conditions for receiving benefits were laid down in the rules of the funds. The Icelandic law was patterned on the Danish law. By 1935 there were only twelve clubs, with 5,000 members.

Voluntary insurance under the 1911 law had been poor in the scope of benefits and of population covered. The 1936 statute made health insurance compulsory but only in urban areas; elsewhere a public vote was required. Premiums were payable monthly or quarterly to the sickness benefit societies. The benefits also varied as the societies made their assessments on different bases.

A 1946 statute made health insurance compulsory for the whole country, but did not go into effect until the 1950-1960 decade.[21] In the meantime the Act of 1936, as amended in 1943, was in effect.[22] The health insurance was provided by the local societies which paid in full for maintenance, care and medicine during hospitalization. Out-patients received ordinary medical attendance free, but paid one fourth of the cost of specialized medical care. Urgent medicines were provided free, and less essential ones at a 50 to 75 per cent reduction.

In 1951 obligatory insurance for the whole country went into effect for all persons from 16 through 66 while older persons had the right to insure.[23] In 1956 insurance was made obligatory for all persons over 16 except those cared for through public assistance for the chronically ill and invalids.

20. ARMSTRONG, *supra* note 18, at 321, 609. Prior to this statute the social insurance legislation consisted of a very limited old age pension law of 1890 and workmen's compensation laws of 1903 and 1909 applying only to seamen.

21. The Social Security Act of 1946, which provides for health insurance may be found in a pamphlet, LABOR LEGISLATION AND SOCIAL SERVICE IN ICELAND 37-99 (1949).

22. *Id.* at 30.

23. SAMORDNAD NORDISK STATISTIK RÖRANDE SOCIALLAGSTIFTNINGEN [CO-ORDINATED STATISTICS OF SOCIAL WELFARE IN THE NORTHERN COUNTRIES] 48-49 (1957) (Hereinafter cited as SAMORDNAD).

The same year the system was largely decentralized; for example, daily cash benefits were to be henceforth paid by the local sickness societies. In the period just preceding 1956 daily cash benefits were paid by the Social Security Institution, the national organization. The daily cash benefits were the first portion of the 1946 Act to be placed into effect.

D. *Norway*

Norway was the fifth country in the world to adopt compulsory health insurance, having been preceded by Germany in 1883, Austria in 1888, Hungary in 1891, and Luxemburg in 1901. The Norwegian law was the first of the compulsory type to provide for a contribution from the government, with the government contributing one-fifth of the insurance cost. The Norwegian law gave protection to dependents before the German law which did not grant such coverage until 1930. Norway was also the first Scandinavian country to adopt the compulsory form of health insurance.

The first proposal for public health insurance came from the Labor Commission in 1885. The employee was to receive cash benefits amounting to half his earnings up to thirteen weeks of each six months during sickness, but no provision was made for medical care, hospitalization, or medicine. The Norwegians looked to Germany as a model. The Norwegian Labor Commission which was set up in 1885, two years after the German health insurance legislation was enacted, based its draft bill of 1892 on the German system, and recommended health insurance for employees. The health proposal was rejected, but in 1894 a workmen's compensation law was adopted, the first Norwegian social insurance legislation.

The first health insurance act was passed in 1909,[24] taking effect in 1911. It established the basic principle of compulsory health insurance for all wage earners below a certain income level. The law superseded and incorporated most of the earlier private insurance associations established by labor unions and lodges. Provision was made for Norwegian earners with small means to join the program voluntarily. The program was organized by communes so that local conditions could be taken account of. The statute defined the various forms of treatment to which the insured members and their dependents were entitled. A non-partisan and not a socialist measure, the law was passed with little political controversy and a genera-

24. ARMSTRONG, *supra* note 18, at 313-314.

tion before the Labor Party came to bear. It was adopted without resistance from the medical profession, and in this respect was quite unusual.

The original Norwegian law covered all industrial groups. It required medical care for the spouse of the insured person, and for children under fifteen living at home. It differed from the German law, which gave 50 per cent of the cash benefit paid to the insured to the dependents in all cases, in that a sliding scale adjusted to the number in the family was provided. Twenty per cent was given where there was only one dependent, 35 per cent where there were two, and 50 per cent where there were three or more. One public sickness society was organized in each commune. Each person subject to the act was considered a member until he proved that he had made satisfactory substitute arrangements. Private sickness societies were permitted to act as official substitute carriers on complying with strict regulations that they would provide the same service. They were entitled to the regular state and employer's contribution and subjected to the same control as the public societies. The Norwegian law required contributions from the employer. It differed from the law of other states having compulsory insurance in that it required a contribution from the state equal to one-fifth of the cost of the insurance. England later followed the lead of Norway in this respect. While other compulsory systems provided drugs and appliances, the Norwegian law provided for appliances but not for drugs. All Norwegian parties accepted the present 1956 law, and no existing political party rejects the health insurance principle. Whatever differences exist between the parties are as to the means of achieving the goal.

E. *Sweden*

Health insurance societies were established as early as a century ago in Sweden on a voluntary basis by local groups. In 1891 the Swedish Parliament passed a law authorizing state support to recognized health insurance societies; and there was an important decree on the subject in 1931. A statute of 1946 called for compulsory health insurance for the entire population to enter into force in 1950. But the reform was repeatedly postponed for financial reasons. In May 1953 Parliament passed a revised proposal retaining many of the basic provisions of the 1946 Act to go into force in January 1955.

Sweden was the first country in the world to adopt voluntary subsidized health insurance, the Danish following the next year.[25] The Swedish voluntary system was suggested by the report of the Swedish Workmen's Insurance Committee, a public investigating body appointed in 1884.[26] By a law of 1891, sick benefit societies having at least 25 members were permitted to have small subsidies from the Swedish Treasury on subjecting their books to public audit. The subsidies were based on the number of members. In 1892 the subsidies amounted to 3.2 percent of the benefits. The subsidies were substantially increased in 1898. In 1910 a law was passed doubling the contribution of the state. In the fifteen years from 1895 to 1910, when subsidies constituted from 5 to 7 percent of the receipts of the societies, there was a growth in membership from 24,735 to nearly 600,000. With the 1910 increase to 14 percent of the receipts, membership grew to only 650,000 by 1913. This constituted about nine percent of the population. The scope of health insurance benefits was small. Most of the societies concentrated on cash benefits. The weekly cash benefits in most funds ranged from 3.50 to 10.50 kroner for a period up to thirteen weeks. About one-fourth of the funds granted benefits for a longer period. Only about two percent of the total expenditures was for medical care and drugs. No benefits for dependents were required.

Following the end of the World War in 1918 there was a tendency for many countries with voluntary systems to shift to compulsory, but this trend was weakest in Sweden.[27] The Swedish Minister of Social Affairs conceded that compulsory insurance was more efficient and more desirable, but reform proposals did not suggest compulsion largely on account of the greater cost. In 1929 a committee of three experts appointed by the government recommended an increase in government subsidies by almost one-half to make possible a requirement of both medical and cash benefits and special maternity benefits, but medical benefits were not to be compulsory until 1936. In 1928 only 15 percent of the population was covered by health insurance, compared with 45 percent in Denmark. The government's contribution in that year was 17.8 percent of the total expenditures. The size of the

25. *Id.* at 316-317.
26. EEK, SOCIALRÄTT 21-22 (1954).
27. ARMSTRONG, *supra* note 18, at 330-337.

societies was expanding: in 1918 the average membership was 542, in 1924 it was 661, and in 1925 it was 695. In 1922 an order standardized the minimum contribution to be charged, thus making the system safer. The Swedish law required either medical care and drugs or hospital care on the one hand, or a fixed daily cash benefit of not less than 0.90 krona. Thus there was a choice between medical service and cash benefits. In 1915 cash benefits were 98 percent of all expenditures and medical care only 2 percent, but in 1926-1929 corresponding figures were 92.9 percent and 7.1 percent. As late as 1932 the great majority of Swedish funds had taken no steps to organize other medical or hospital treatment for their members, although a few funds had arranged for reduced rates for their members at hospitals and public clinics.

In 1931 the Swedish sickness societies were welded into a national system of "recognized" central and local sick benefit funds.[28] Each society was to have a defined territorial jurisdiction. To be recognized, a society was required to open its membership to all persons within its territorial jurisdiction. Sick funds of trade unions and special funds created for specific industries and factories could also become recognized. The societies remained in form private voluntary organizations subject to extensive government control and supervision. The recognized societies were granted subsidies equal to about one third of their total benefits.

II. SCOPE: COVERAGE AND CLASSIFICATIONS OF INSURED PERSONS

A. *Denmark*

The steadily increasing coverage of the population in Denmark with respect to health insurance is shown by the following figures as to the percentage of Danes over fifteen who are active members of sickness clubs and societies: from 7.9 in 1892 to 88.6 in 1957.[29] Denmark maintained the highest percentage of coverage of any Scandinavian country until the decade between 1950 and 1960.

In the period prior to 1914 the Danish system was by far the most successful of the voluntary systems in obtaining full

28. EEK, *supra* note 26, at 156 (1954).

29. Backer, *The Health System and the Medical Profession in Denmark*, 5 Danish Medi. Bull. 185, 191 (No. 6, Aug. 1956); SOCIAL DENMARK, *supra* note 15, at 37.

In England and Wales the coverage is about 95 percent. TITMUSS, ESSAYS ON THE WELFARE STATE 136 (1959).

coverage of the population, 36 percent being covered in comparison with 10 percent in Switzerland, 9 in Sweden, 6 in France and 5 in Belgium. That the system of voluntary, self-administering associations worked to the satisfaction of the Danish people is shown by the fact that in 1907, 15 years after the legislation on health insurance, a similar system was established for unemployment insurance. As in the case of health insurance a rather full coverage was obtained; furthermore employee's contributions to unemployment insurance were kept very low.

As of January 1, 1955, 78 percent of the population were active members of sick clubs and 11 percent of the continuation funds. Thus about 89 percent of the people are active members although active membership is voluntary. Nine percent of the population are merely passive members who receive no benefits. Two percent of the population are neither active nor passive members.

About nine percent of the Danish population are passive members. The Social Reform Act of 1933 made it a duty for Danish subjects between 21 and 60 to apply for passive membership in a club or society. To be admitted one must fulfill the same health requirements as active members. This group, like active members, is insured against invalidity and are eligible to an old age pension. But members are not insured against illness, and receive no benefits so long as they are merely passive members. If in the financial class for sick club members, they may transfer to active membership in a sick club, subject to a six months qualifying period. If one, not an active member though he might have been one, receives treatment paid for by public funds, he will get such aid as poor relief, and thus forfeit certain civil rights. Also included as passive members are those in arrears as to contributions, who then receive aid as poor relief, and members who have exhausted their benefits. Passive members make annual contributions of 2.4 kroner, in addition to 8.4 kroner for invalidity insurance. If a passive member fails to pay his contribution, it may be recovered as taxes would be. If a member is in arrears for five years and over 40 years old, he is struck off and cannot be readmitted.

The main purpose of the statutory provision for obligatory passive membership was to induce people who meet the conditions for active membership to join as such. This purpose

has largely been attained. Another purpose was to make possible a decision when the person is young whether or not he meets the health requirements. Thus fewer persons will be precluded from membership because of subsequent ill health.

There are three main categories outside the health insurance system. First, there are those not eligible because of their health. However, such persons receive an old age pension, and if nonpropertied they are entitled to sickness benefits and invalidity pensions from the commune. Second, there are some of those who were insured as active or passive members, but were finally struck off for arrears. They receive sickness benefits as poor relief. Third, there are those outside for political or religious reasons, and antisocial persons who do not wish to comply with the statute. Until they reach forty, they must pay an annual fine for not fulfilling their duty to join the insurance.

All but one-eighth of the Danish people are active members of the sick clubs or societies. What is the status of this one-eighth? Those who argue for the continuation of the present system point out that some of them are covered by private health insurance policies.[30] Others do not have a need or desire for health insurance because they are so well situated financially that they can bear the economic consequences of sickness. Others wish to live more or less withdrawn from the community. Others by virtue of their position or status are assured of help during sickness; many could take out sick club membership if they desired. Others do not meet the necessary health requirements. Others may be in arrears as to contributions.

On the other hand, it may be pointed out that there can be no great hardship in adopting a compulsory system in view of the overwhelming proportion of the people who have taken out active membership. Moreover, a system of voluntary active membership and compulsory passive membership is difficult to administer. Compulsory membership would solve administrative problems as to payments of contribution and loss of the right to membership. Compulsory membership would mean the possibility of eliminating the prerequisites for active membership such as conditions of age and health, qualifying period, etc. In the cases of invalidity insurance and workmen's compensation the compulsory system is used in

30. *En Frivillig Sikring*, HELSE, No. 6 at 156 (Dec. 1958).

Denmark; the only two systems in which it is used. In many respects the voluntary system may be said in effect to be compulsory. Employers insist that their employees join sick clubs. The contributions are small and the benefits great. Insurance with a private insurance company is much more expensive, as no state grants nor reductions in hospital rates are given to such a company. One who is not covered is excluded from disability and old age pensions. Thus, the theory of voluntariness is largely a fiction.

Children under 15 are covered by their parents' insurance in Denmark as to the sick clubs. But members of the continuation societies for those with higher income must pay an extra amount for coverage of their children. In contrast, children are not members of the Finnish sick clubs, but some clubs provide health insurance for members' children under 15. Children under 16 are covered by their parents' insurance in Iceland. Under the Norwegian law prior to 1956 children under 16 were covered by their parents' insurance; since 1956 children under 18 are covered. Under the Swedish law prior to 1955 children under 15 were covered by their parents' insurance; since 1955 children under 16 are covered.

Any person residing permanently in Denmark, even though not Danish, may become a member in a club of the place of his residence. But an alien is not admitted thereby to an invalidity or old age pension unless a treaty so provides. Husband and wife are members independently of each other. That is to say, the wife is not covered unless she takes out membership. Children, step children, adopted children and foster children under 15 are members, regardless of health, by virtue of their parents' membership, and no separate contributions are paid for them. The qualifying period for admission is six weeks. When a member transfers to another commune, he becomes a club member there by transfer, regardless of age or health, and there is no waiting period.

There are age limits as to membership. One must have attained the age of 14, but must be under 40. In certain cases an upper limit of 60 years applies as when a Dane who has lived abroad returns to Denmark when he is over 40, or when a foreigner becomes a naturalized Dane when he is over 40. Persons between 21 and 40 who do not apply for at least passive membership are liable to a fine of 13 kroner annually, and lose their right to an old age pension even though the

fine is collected and amounts to the same as the premium for passive membership.

Admission to membership depends on the state of health. The person must not be suffering from any temporary illness or from any temporary aggravation of a chronic disease, and must be "capable of working". The term "capable of working" means that a person must be able to be employed and earn a certain wage by working for others, but not necessarily the full, normal wage. He must have this ability at the moment of admission and within the nearest future. Persons in mental hospitals for longer periods cannot become members. But not excluded are blind, deaf and dumb, and persons suffering from chronic diseases in a quiescent state as long as they can earn a small amount. Although the Danish clubs must accept persons who are often not very healthy, this is offset by the fact that they receive a higher state subsidy for members who have a chronic disease when admitted. Old age and invalidity pensioners may remain in the health insurance clubs and societies.

There are income and property limitations on sick club membership. If the income increases the member is automatically transferred to a society regardless of age or health. In 1944 about 92 percent of the Danish people had incomes low enough to permit them to be members of sick clubs; in Copenhagen the percentage was 89, in the rural communes 92, and in the provincial towns 94. Thus the statutory word "impecunious" is not synonymous with "poor". The Danish Medical Association favors the continuance of the two classes, and a reduction of the income limit so that fewer persons will be included in the sick clubs and more in the sick societies. In 1943, 60 percent of those whose incomes were too high for sick club membership belonged to sick societies.

In special circumstances the capital and income limits may be exceeded. The capital limit may be exceeded if the capital is invested in property difficult to realize or bearing a low rate of interest, or if the income consists largely of old age pension or disability pension or of interest on capital and the person's capacity for work is decreasing because of sickness or old age, or if a surviving spouse has lost the former supporter. The income limit may be exceeded if sickness, death, or old age have essentially aggravated the member's economic situation. A special local committee of three members, consisting of a representative of the sick club, a local physician,

and a representative of the municipal council inquire into the financial circumstances at regular intervals fixed by law. The local decision is sent to the Directorate of Health Insurance Services for approval.

Every third year a nominee of the Danish Parliament revises the limits. In the other two years the revision is by the Directorate for Sick Clubs. The figure for income is taken at the nearest 100 kroner, the figure for children at the nearest 25 kroner, and the figure for property at the nearest 1,000 kroner. The taxable income is the figure looked at, plus supplements for children.

In November 1958 the Danish Ministry of Social Affairs announced new higher income and property limits for membership in the sick clubs. For Copenhagen the limit was 15,200 kroner, the previous limit being 14,600 kroner. In a number of cities and communities having over 1,500 inhabitants the limit was 13,000 kroner, the previous limit being 12,400 kroner. In the remainder of the country the limit was 12,700 kroner, the previous limit being 12,200 kroner. As to children under fifteen one might have an additional income per child of 1,075 kroner, whereas previously the figure was 1,025 kroner. With respect to the whole nation the property limit for individual persons was raised to 38,000 kroner from 36,000 kroner. The property limit for persons with families was raised to 52,000 kroner from 50,000 kroner.

The medical members of the Danish Commission on Health Insurance would like to reduce the income figure at which a person may become a member of a sick club, thus excluding the more prosperous, while the representatives of the sick clubs would like to retain the present figure so that more persons may continue to be sick club members. The Commission is divided as to whether the present limit for sickness club membership should be made greater or less or remain unchanged.

B. *Finland*

In 1943 there were 359 sick and burial benefit funds with a membership of 200,081;[31] the corresponding figures were 320 funds and 149,795 members in 1945; 277 funds and 168,753 members in 1947; 284 funds and 183,645 members in 1949; 294 funds and 187,666 members in 1951; and 289 funds and 198,576 members in 1956.

31. SALOMAA, *supra* note 18, at 93.

In 1954, 86,081 men and 47,374 women were members of sickness club funds,[32] together constituting 133,455 persons, or 4.6 percent of the adult population.[33] Children are not included as members though some clubs give sickness aid to them. At the end of 1956, there were 255 sick club funds and 44 burial funds in Finland.[34] In 215 of the sick club funds, membership was compulsory and in the other 40 clubs voluntary; two burial funds had compulsory membership. The employer contributed to 187 sick club funds, and to one burial fund. The 253 active sick club funds consisted of 93,117 men and 50,231 women, or 143,348 in all, an increase of 3.7 percent over 1955. The 44 burial funds consisted of 40,057 men and 15,171 women, or 55,228 in all, a decrease of 2.6 percent from 1955. A serious limitation on membership in sick clubs is the requirement that the applicant be in good health when applying for membership. Furthermore in most cases the insurance does not cover dependents. Less than ten percent of expenditures are made for dependents.

C. *Iceland*

In 1954, 93 percent of the adult population was insured in Iceland, 90 percent in Norway, about 89 percent in Denmark, 57.4 percent in Sweden and 4.6 percent in Finland.[35] At the present time coverage in Iceland is practically 100 percent as it is now in Norway and Sweden.

Membership in an Icelandic sick club is now compulsory for all from 16 upwards except for invalids and persons suffering from certain chronic, active sicknesses who are cared for by public assistance.[36] Children under 16 who are cared for by sick club members are insured as dependent persons. Persons not required to insure may insure voluntarily. All persons receiving old age pensions are insured by the National Insurance Institution at its expense. There are no income or property limitations, or health prerequisites for membership in a sick club except as to certain chronic sicknesses. A married woman's contribution is included in her husband's provided he is liable to pay; if not, she contributes as if she were single.

32. SAMORDNAD, *supra* note 23, at 45.
33. In FREEDOM AND WELFARE, *supra* note 7, at 392, it is stated that "in Finland only 10 percent of the population are covered." That figure seems too high.
34. STATISTIK ÖVER FINLANDS UNDERSTODSKASSUR FÖR ÅR 1956 (1958).
35. SAMORDNAD, *supra* note 23, at 45, 47.
36. *Id.* at 48.

D. *Norway*

When health insurance became operative in Norway in 1911 under the statute of 1909, compulsory insurance included only wage earners in the lowest income class. Consequently only 34 percent of the population was covered in 1911. By 1930, 45 percent were covered, by 1950, 83 percent and by 1954, 90 percent. As of 1954 almost a third of the members were voluntary members. Under the 1956 Act coverage is practically universal.

Norway is the most thinly populated country of continental Europe, although Iceland is even more thinly populated. The experience of Norway appears to show that health insurance is possible over a large area containing many thinly settled districts. The contention of some American opponents of health insurance that it is workable only in thickly populated areas seems open to serious challenge when account is taken of the experience in Iceland, Norway and Sweden, all of which have less dense populations than the United States.

Under the Norwegian 1953 statute health insurance was compulsory for all wage-earners regardless of age, income size, or health. Foreigners working in Norway, except employees of a foreign government or employees insured at home, were covered. The wife, children under 16, and parents supported by the insured were covered without any additional premium; as were children over 16 if they were so handicapped as to be unable to earn a living. The employer paid a part of the premium.

In 1953 there were 440,000 voluntary members of the Norwegian health insurance system. Anyone in normal health not covered by the compulsory system could join. If he was over 60, he paid an extra year's premium on joining and thereafter only the normal premiums. There was a waiting period of six weeks before benefits could be given. There were no income or property limitations on membership. Most of those not covered by voluntary insurance were farmers and self-employed in small businesses. The voluntary insured with incomes over 15,000 kroner paid the entire premium themselves; those with lower income, such as the compulsory insured, received contributions from the state and the communes.

Prior to the 1956 Norwegian law, those not covered by health insurance consisted of two groups. The first group were persons who were qualified for voluntary insurance

under the prior law, but who did not take out membership because of economic grounds, ignorance of the law, or lack of initiative. The other group consisted of persons who because of poor health could not take out voluntary insurance. These two groups embraced self-employed persons, persons without income from labor, pensioners, and persons who neglected to take out voluntary insurance on reaching 16, persons who became ill before taking out insurance, and persons whose sickness benefits had been exhausted.

The Norwegian Minister of Social Affairs, Gudmund Harlem, pointed out in 1955 that those not covered by health insurance needed it and in large part needed it more than those who were covered. Moreover, health insurance "must be regarded as the foundation stone in a comprehensive system for social security."[37]

The Norwegian system covers not only Norwegians who live in Norway, but all who establish residence in Norway, those who work for Norwegian employers even outside of Norway, such as sailors on Norwegian ships, and many citizens of Norway who for various reasons are away from Norway, as persons in the diplomatic service. In general all are insured who live in Norway, either as a member or a family member.[38] Insured as members are persons 18 or over. A spouse is insured by the insurance of the supporting spouse without additional premium. But a spouse not supported by the other spouse or who has a yearly income of 1,000 kroner in the service of another or in self-employment must be a member. Persons under 18 who earn an income of more than 1,000 kroner are members. Insured as family members are the spouse supported by a member and children under 18 if they do not have an annual income over 1,000 kroner. A supported spouse is insured at the health insurance office of the other spouse. Children under 18 insured as family members are insured at the office of the parent's membership. If both parents are insured, the child is insured where the father is insured. Children without parents or foster parents are insured where they live.

37. OT. PRP. No. 52 (1955) p. 2.

38. For the Norwegian health insurance act, see International Labor Office, Legislative Series 1956 — Norway 1, Sickness Insurance, in English. For the [act in the] Norwegian text [language] see NORSK LOVTIDEND, March 26, 1956, No. 10, p. 156.

Much data about the Norwegian system is to be found in SOSIAL TRYGD, the monthly periodical on health insurance and workmen's compensation.

Members are classified into five groups. The first group consists of employed persons who work in Norway in the service of another for a wage or other remuneration consisting wholly or partly of a cash payment. But such persons are not covered where the employment relation is such that it cannot last at least six days; whose earned income is less than 1,000 kroner a year; or who are employed part-time in the service of another but whose principal source of income is self-employment. Employed persons are insured at the place of employment. The second group consists of fishermen, whalers, and sealers whose names are entered in the register of fishermen under the Act on workmen's compensation for fishermen. They are members of the insurance fund in the district covered by the register. The third group consists of seamen in foreign trade and public officials serving abroad. They are members of a special fund at Oslo. The fourth group consists of military personnel. They are insured according to special rules if their service lasts for at least 28 days. Ordinary soldiers continue as members of the fund in which they were insured before they entered military service. Other personnel have membership in a special fund. The fifth class consists of non-employed persons. They are persons not coming within any of the four previously mentioned classes. This group consists largely of persons engaging in occupations and work on their own, pensioners, and students. They are insured at their place of residence. Students and school children may, while attending school or university, elect to be insured with the insurance fund in the location where they are staying.

Under Section 175, the Act insured persons who were ill at the commencement of the Act or subsequently suffered a recurrence of a disease that developed before the commencement of the Act. But under section 70, a person becoming insured after the commencement of the Act receives no benefit as to a disease that developed while he was not insured unless no symptoms of the disease have appeared for at least one year; the National Insurance Institution could, however, make exceptions where reasonable.

Under section 11 of the Norwegian act, an unemployed person is covered by health insurance while he is receiving unemployment insurance benefits and during the waiting period preceding receipt of unemployment insurance benefits. He is regarded as insured as an employed person with the in-

surance fund in which he was last liable to unemployment insurance. Section 13 (2) provides, in general, that when the employment relationship terminates, the person ceases to be insured unless insurance is continued by means of contributions paid through the unemployment insurance scheme.

E. *Sweden*

A person becomes a member of the Swedish health insurance system following his sixteenth birthday. This applies to all Swedish subjects who reside in Sweden, and to aliens who are resident and registered for census purposes in Sweden. Thus, there is coverage of the entire population as in Norway and Iceland.

During the first 90 days after an accident the injured person comes under the health insurance law and thereafter under the workmen's compensation law.

Prior to 1955 membership in the voluntary sickness societies in Sweden consisted of persons from age 15 to 55, who were in good health and without deformities.[39] Underage children of members received medical care. Most members were insured for both medical care and daily cash benefits. Married women working at home could insure themselves only for medical care. Persons who in another connection were insured for medical care could also insure for daily cash benefits. Daily cash benefits ranged from one krona to fourteen kroner a day, depending on the contributions paid by the insured. The daily cash benefit stood in no direct proportion to the insured's income as long as he paid the premium required.

In 1954, just before the present Swedish statute, only 57.4 percent of the population over 15 were covered by health insurance.[40] Sweden had lagged behind both Denmark and Norway in coverage during the preceding decades. Denmark was the only Scandinavian country in which voluntary insurance had been successful in securing high coverage.

The 1955 Swedish statute reached various groups who previously were not covered. It helped those who could not afford the private rates, and those who were disqualified for membership because of poor health. Furthermore the benefits given are more extensive in scope. Under the former law only 25 percent of pensioners had been enrolled.

39. FREEDOM AND WELFARE, *supra* note 7, at 404; SAMORDNAD, *supra* note 23, at 50-51.
40. SAMORDNAD, *supra* note 23, at 45.

III. BENEFITS

A. *Denmark*

There are two types of benefits in the Danish sick clubs. First, there are the obligatory benefits fixed by law. Second, there are the voluntary benefits which clubs may incorporate in the rules with the approval of the director of sick clubs. The obligatory benefits to members of sick clubs are free medical attendance, free hospital treatment and care, cash benefits, vital medical preparations, maternity benefits, and funeral assistance.

In 1954, 58.2 percent of expenditures of sick clubs went for compulsory benefits and 41.8 for voluntary benefits. The percentage for ordinary medical attention was 30.4, for hospital treatment 13.4, for daily cash benefits 4.4, for vital medical preparations 1.6, for maternity benefits 3.5, and for funeral benefits 4.9. All these were compulsory benefits. With respect to voluntary benefits, the percentage for specialist treatment was 6, for dental treatment 6.1, for maintenance in convalescent homes .7, for medicine 8.3, for home nursing 1.4, for medicinal baths and massage 1.3, and for surgical appliances and eye glasses 2.2. The percentage for administration was 11.2.

A Dane who is absent from Denmark receives no help from the Danish health insurance. In practice, however, passive membership may usually be maintained up to three years.

Health insurance aid in Denmark is given only during actual sickness, except for maternity benefits and funeral aid. Thus, it does not cover preventive measures nor rehabilitation invalidity insurance, or workmen's compensation.

In Denmark about 70 percent of all mentally ill patients are treated at State expense, while most of the other 30 percent are paid for under the health insurance system.[41]

There is a qualifying period before one may receive benefits. In the case of first admission, the period is six weeks. When, however, a member is transferred from the passive to the active list, it is six months. Thus, there is pressure to become an active member at once, and not to wait until sickness seems to be approaching. For maternity benefits, the period is ten months. If a member has an accident during the qualifying period, help will be given at once.

41. FREEDOM AND WELFARE, *supra* note 7, at 372.

When a member other than a child has received sickness benefits for a total of 420 days within three successive years, he loses his right to further benefits from the sick club and is transferred to passive membership. If the sickness continues, the member then receives a continued benefit by way of special relief. This special relief may not exceed what the sick club has paid him in the current and two preceding years. When this latter benefit has been exhausted and he is able to produce a medical certificate showing ability to work, he can re-enter the sick club as an active member. There is no duty to repay such special relief and no legal disabilities are suffered. Thus, the Danish system gives longer benefits than most European systems. This combination, however, of sick club benefit and public assistance seems unnatural.

1. Medical Care.

A member of a Danish sick club gets free medical care. There is attendance by general practioners based on agreements which are terminable on notice between clubs and medical organizations. The agreements must be approved by the Minister of Social Affairs. The agreements fix the doctors' remuneration and define the services to be rendered. Agreements can be made only with doctors who are members of the Danish Medical Association. The sick clubs do not pay for treatment by chiropractors, Christian Science Healers, and homeopaths. A dispute between a club and a doctor is settled by a specially appointed board of arbitrators.

A statute of 1915 established a council of arbitration consisting of three representatives of the Central Federation of Danish Sickness Insurance Funds and three of the Danish Medical Association with a Chairman chosen by these six members or, if they could not agree, by the Ministry of Social Affairs. A decision of the Council interpreting agreements in force and in cases where the parties have agreed to refer disputes to the Council is binding on both parties. The assistance of the Council has been sought as to renewal of agreements. In 1921, under the auspices of the Council, it was decided that all agreements with sick clubs should provide remuneration in accordance with the cost-of-living index published by the state twice a year. This stipulation is still in force. The main agreements are made with general practitioners. Separate agreements are made with specialists. The practitioner may select his own place of practice, but he may have patients only

within ten kilometers of his residence. Thus, a patient may usually choose between two or more practitioners.

Arrangements between clubs and physicians regarding fees are invalid unless they are approved by the Minister of Social Affairs. If the average outlay for active members on medical attention exceeds the average in other clubs of a corresponding group by 25 percent or more, the Director of Sick Clubs must bring the matter to the notice of the club and remind it that, if the outlay is not reduced, the club may lose the right to grant free medical attention.

Physicians are paid in two ways in Denmark. Under one method, the physician gets a fixed annual sum per member who has registered with him and further extra payment for certain services. Under the other method, the physician is paid by the visit or consultation. The former method is used in cities and densely populated areas and applies to about two-thirds of the sick club members; the latter method is used in the rural areas. Under the former method, a family chooses a general practitioner for a year; under the latter method, a member may choose his doctor for each consultation so long as the doctor chosen does not live more than six miles away. Physicians are remunerated directly by the sick clubs. The physician, therefore, has no financial dealings with the patient, and need not worry about fee collection. Under the Danish system, it is possible to have family doctor service, as all members of the family usually have the same doctor for a long period. The general practitioner, in effect, is an advisor in all cases of sickness. He may refer a member to a specialist, under an agreement with the club, or to a hospital as an in- or out-patient, and may prescribe the services of a visiting nurse or homemaker.

The Danes have encouraged the distribution of doctors into rural and small city areas by limiting the percentage of doctors in Copenhagen who can serve on panels to about 70 percent. In other places all may serve on the panel.

Doctors working on a panel basis are given fair treatment by payment to them of a rate of 50 percent higher than the normal rate for patients with chronic diseases and 35 percent more for patients over forty. Special provision is also made for Sunday and holiday calls. Specialists are paid on a fee basis.

The fee-for-services method may have a number of disadvantages. It invites the doctor to increase his income by de-

creasing the time spent with each patient, by accepting too many patients, and by giving unnecessary treatment. Such a system is more costly than other systems, and it is much more difficult to estimate the costs in advance. The patient is reluctant to go to the doctor as often as he should and when he may really be ill. The system does not encourage preventive medicine and, additionally, requires the keeping of more elaborate and time-consuming records.

Payment on a per capita or panel basis may encourage perfunctory care so long as doctors do not have to compete for patients, but it may unduly encourage patients to go to the doctor. On the other hand, it does not encourage the doctor to give unnecessary services. The costs of such a system are not as great and are more predictable. By laying down a maximum number to be allowed on a panel, good care can be assured. Likewise, the right of the patient to choose another doctor acts as a brake on neglect. The doctor is assured of a stable income irrespective of the number of services rendered.

The sick clubs prefer the per capita fee or panel system to the fee-for-service system, whereas the medical association prefers the latter. The arguments which they make for the per capita system are as follows. Expenditures for medical care can be kept at a reasonable figure. Over-treatment is avoided, as is unfair competition between doctors to win patients. Administration is simpler. The doctors prefer the fee-for-service system because it will raise their income. Patients will be benefited because more and better care will be given. Some doctors go even further and assert that the doctors should fix their own rates and receive payments from the patients, who might then be reimbursed by their sick clubs, as is the case in the continuation funds involving high paid persons. This, however, would be a hardship as to ordinary and poorly paid workers. The workers could not advance the payments and would therefore have to do without care or apply for poor relief. That was the attitude of the German sick clubs. That is also the English attitude. Less administration is called for. An economic barrier between patient and treatment is avoided. The high professional and moral standing of Danish doctors, and the expectations of Danish patients, and Danish public opinion generally would not tolerate poor treatment by doctors paid on a per capita basis. The contention of doctors that patients under the per capita system often waste

the doctor's time with trivial complaints is not in keeping with the stress doctors place on seeking medical aid seasonably.

The practitioner must have fixed consultation hours on all week days. In towns of more than 15,000 it may be required that once a week the doctor may be consulted after 5 p.m., so that members may consult the doctor without losing wages. If the conditions of health permit, the patient must consult the doctor during the fixed consultation hours. Appointments for visits in the home must be made before 9 a.m. if they are wanted on the same day; otherwise the visit may occur the next day except in emergency cases. Danish patients receive as prompt medical care as do American patients. Danish physicians do not feel that they are under too great pressure of numerous patients so that they cannot give adequate care.

A sick club member who applies for medical aid must inform the doctor that he is a member of a sick club and show his membership book.

While medical attention is free in Denmark some charges not mentioned in the statutes have grown up. In areas where the panel system of payment is used a small fee is charged for visits on Sundays and holidays or in the night. In areas where payment is for actual services rendered, application must first have been made to the sick club and a voucher issued on payment of a small fee ranging from one-fourth of a krone to two kroner. These fees cover only about four or five percent of the club's expenditures for medical treatment. A provision of the statute which has never been applied provides that the Director of Health Insurance Services may deprive the club of the right to pay in full for medical care if the club has much higher payments for medical care than other clubs of a corresponding group.

When a member misuses his rights, the doctor is bound to notify the sick club. If the member refuses hospitalization ordered by the doctor, the doctor must inform the sick club, and the member loses his right to treatment. If the member fails to follow the doctor's orders, the doctor may terminate his treatment and notify the sick club. Members must pay for unnecessary medical attendance outside the usual hours.

There are safeguards against misuse by the doctor. If the doctor visits the patient without being called and without the visit having been previously agreed upon, and unnecessary expense is incurred, the sick club need not pay. In case of re-

currence the doctor may be excluded from working for the sick club.

The agreements carefully regulate complaints from members or doctors. If the sick club federation and regional medical association cannot agree, the matter goes to the arbitration court, and its decision is final.

2. Workmen's Compensation.

Danish workmen's compensation does not provide medical treatment, but leaves this to the health insurance. But special treatment, such as treatment by a specialist, at an orthopedic hospital, when not covered by the health insurance must be given by the workmen's compensation. Regardless of sick club membership the workmen's compensation must provide the worker with surgical appliances, artificial limbs, and other aids necessary for treatment. There is no daily cash benefit from the workmen's compensation for the first thirteen weeks as health insurance usually covers this. But when the health insurance is exhausted, the workmen's compensation pays daily benefits thereafter.

To be entitled to a disability pension one must be covered by health insurance. But not all covered by health insurance can be admitted to disability insurance. The health prerequisites for disability insurance are stricter. A disabled person who is covered by health insurance receives medical treatment first under his health insurance, but when his health insurance is exhausted as it will be in disability cases, the disability insurance intervenes. Contributions for both health insurance and disability insurance are collected by the health insurance offices.

In 1948 there were in Denmark 4,200 doctors or one per 997 people; there were also 1,168 dentists or one per 3,587 people, 793 midwives or one per 1,343 people, and 346 apothecaries or one per 12,109 people. The doctors are rather evenly distributed. No patient need travel more than six or seven miles to see a doctor. Of the 4,200 doctors 2,725 were in private practice, 1,678 on hospital staffs, and 1,065 were specialists. By 1954 there were 4,907 doctors or one per 898 persons.[42] The proportion of doctors has been increasing, in contrast to the United States. Of the 4,907 doctors, 2,064 were on hospital staffs, 67 were in other salaried positions, and 2,776 were in private practice; there were 1,300 specialists. In 1954,

42. SAMORDNAD, *supra* note 23, at 51.

there were 1,870 dentists or one for each 2,350 persons; of these about 240 worked in the schools. The proportion of dentists to population has increased in recent years. In 1954 there was one nurse for each 326 inhabitants in Denmark, for each 356 in Norway, for each 468 in Sweden, for each 587 in Finland, and for each 838 in Iceland. There are now about 14,000 trained nurses, 750 midwives, and 1,200 pharmacists in Denmark.

In 1949, 58.1 percent of all doctors in the country were in private practice in Denmark, 50.7 in Norway, 46.7 in Iceland, 39.8 in Finland and 38.1 in Sweden.[43] With respect to public health, there were 33 percent in Finland, 31.1 in Iceland, 15.5 in Sweden, 14.1 in Norway, and 1.5 in Denmark. With respect to hospitals, there were 46.4 percent in Sweden, 40.4 in Denmark, 35.2 in Norway, 27.2 in Finland, and 22.2 in Iceland.

The Danish system operates fairly to the physician. For a period of more than 20 years no physician was excluded from continuing his health insurance practice. From 1917 to 1936 not a single complaint of neglect of a patient was made to the official complaint tribunal, and only seven disputes as to overcharge or improper charges.[44]

The average gross income of the general practitioner from insurance practice is between 40,000 and 60,000 kroner. In addition there is income from those who do not belong to any sick club, from preventive or prophylactic care, and from appointments and positions of various sorts. Operating costs are about one-third of the gross income. This income is as high as that received by the higher civil service employees. There can be little doubt that a Danish physician has an economic and social status in relation to the rest of the Danish population comparable to the status enjoyed by the American physician.

Under the auspices of the Danish Medical Association, a collective old age and disability pension scheme for the entire medical profession was established in 1946. The Danish Medical Association and the Danish Sick Clubs together publish six times a year a magazine "Health" (*Helse*).

3. Hospital Care.

A member of a Danish sick club gets free treatment and care, including special services necessary, in local hospitals,

43. FREEDOM AND WELFARE, *supra* note 7, at 332.
44. ARMSTRONG, *supra* note 17, at 155.

central hospitals, medical centers, mental hospitals, tuberculosis hospitals, and sanataria. The sick club pays for treatment in a general ward. If the member wants a special ward, he must pay the difference. The clubs pay not only for treatment of ordinary medical and surgical conditions but also for treatment of chronic and congenital conditions. If a member wishes treatment in a private hospital or in a public hospital out of the area, the club pays only what it would pay for treatment in the local hospital. One-seventh of the patients in mental hospitals are paid for by the sick clubs.

The Danish government recognized its responsibility for hospitals more than two centuries ago. In 1757 it established the first large general hospital, King Frederick's Hospital, now know as "Rigshospitalet". The older of the two Danish medical schools is attached to it. Local authorities began to build hospitals a century later. Today there are so many hospitals that there is one within ten miles of anyone's home. The regional hospital system is made up of three elements: (1) two medical centers, (2) 26 central hospitals, and (3) 107 district hospitals. There are thus 135 public hospitals. There are 17 private hospitals, chiefly Catholic. There are several hospitals for special diseases. There are 44,502 beds, or 10.62 beds per thousand people. The two medical centers combine training, medical research, and expert diagnosis of complicated cases from the whole country. The 26 central hospitals are numerous enough so that there is at least one in each county. They are all new and have modern equipment. They serve the whole county. They admit patients from smaller district hospitals for study and treatment, and serve as district hospitals for the town in which they are located. All have departments for major surgery, internal medicine, and ears-nose-throat diseases, and diseases of the eye. They are important centers for intern and nurse training. As to the 107 district hospitals, some have specialized departments like the central hospitals; the smallest consist of one mixed surgical-medicine department.

An American expert who visited Denmark recently states: "Danish hospital buildings are noted for their functional design and they are thoughtfully and efficiently planned in advance of construction. The equipment is of excellent quality. Spaciousness and harmonious furnishings are distinguishing characteristics of the building exteriors. The pristine cleanliness that is maintained is a source of pride and is rep-

resentative of national standards of sanitation . . . . Modern hospital buildings, highly qualified medical staff, and related personnel has earned for Denmark a world renown and well deserved reputation in the fields of medical service and institutional administration."[45]

All Danish hospitals have permanent staffs of physicians, surgeons, and other specialists, who receive salaries as public servants. When a patient goes to a hospital, his own doctor surrenders him to the hospital for care. On discharge he is then restored to his own doctor who receives information as to the hospital diagnosis, treatment given, and advice as to further treatment.

In Denmark about one-half of the doctors work full time in hospitals as civil servants on salary. This practice has gone on for more than a century. The adjective "socialized" has never been applied, the practice having commenced under a conservative government. The medical profession accepts it as it insures good standard treatment throughout the country. This more than offsets the difficulties of lack of personal relation between doctor and patient. Great care is employed in the selection of senior physicians and surgeons, a professional committee being consulted. They receive salaries of 40,000 to 50,000 kroner together with fees for private consultations, while the junior officers receive salaries of 20,000 to 30,000 kroner.

The cost of running a hospital in Denmark ranges from 35 to 50 kroner per day per patient. Ordinary patients not covered by health insurance pay less than one-fourth of such amount. The sick clubs have a further 50 percent reduction. They thus pay only 10 percent of the costs. The hospitals are supported by the communes which receive state grants in proportion to their population. The expenditures of the communes are covered by taxes on real estate and by direct assessments on the towns. About half of the expenditures for health is for hospitals. The notion of having hospital costs paid in part by sick clubs and in much larger part by taxation is that the financial risk of sickness should be spread over as many people as possible. It would be asking too much of the individual that he pay all the actual hospital costs involved in his case.

45. *Professor Mary K. Boetjes, Ph.D., Reports on Study Days in Denmark,* 8 Scan. (No. 2) at 3 (Feb. 1959).

Does the fact that the sick club pays so low a rate for hospital costs mean that too many persons are sent to the hospitals? Not at all. Virtually the whole population is covered by health insurance, so that there is no real problem as in America of giving preference to insured persons. Moreover, the Danish system gives all the necessary types of medical care; hence there is no reason to go to a hospital unnecessarily. Furthermore the physicians exercise such close control over the sick that only those who actually need hospital care are sent to the hospital. In 1931, 56 patients per thousand inhabitants were hospitalized in Denmark; by 1942 the number had risen to 92. But during the same time the average period of stay in the hospital declined from 33 to 23 days.

4. Medicine.

Under the rules of the Danish Minister of Social Affairs there are three groups of medicines: (1) essential medicines, (2) less important medicines, and (3) medicines sold over the counter. The sick clubs may not pay for medicines sold over the counter; they may not pay more than three-fourths of the costs of essential medicines, and, as to less important medicines, they may not exceed two-thirds of the shares which the club pays toward essential medicines. About 1050 or two-thirds of the clubs pay for medicines and drugs. Members of Danish sick clubs receive three-fourths of the costs of insulin, liver preparations, and other vital medical preparations. The State reimburses the sick clubs as to these. The Minister of Social Affairs determines whether a preparation is vital for a certain disease.

The amount spent in Denmark for medicines has been increasing in recent years and has given some concern not only because of the money spent on it but also because of the danger involved in a possible abuse of medical preparations. Efforts are made in Denmark to keep the prices of medicine reasonable. The Danish Health Directorate has proposed to the Minister of Interior that commencing in 1959 prices on factory prepared medicine, especially as to the more costly medicines, be reduced. New medicines and preparations should not be sold at unreasonable prices. It is not costly for druggists to sell factory prepared medicines. Perhaps a price reduction of ten percent can be anticipated.

5. Maternity Benefits.

The sick club gives free mid-wife assistance. It pays the

fee of the mid-wife and for the necessary help for mother and child. The fees of the mid-wife are fixed by agreement between the principal organization of the sick clubs and that of the mid-wives. If the mid-wife regards the service of a physician as necessary, the sick club pays for such services. Medical assistance is increasing. In 1942 the sick clubs paid for such assistance in 55 percent of the cases. If the physician regards the case as complicated, the mother may be sent to a hospital. The qualifying period for maternity aid is ten months after joining the sick club.

With respect to ordinary women the sick club pays a daily allowance of the same size as the woman has secured for herself in case of sickness, for a period of 14 days after confinement. For female members coming under the Maternity Rest Act, the daily allowance is extended to four weeks after confinement. If the mother remains away from work to suckle the child, the allowance is given for six weeks. Factory workers receive the daily allowance for a period up to eight weeks before confinement if the doctor certifies that work would be detrimental to mother or child. The daily allowance corresponds to less then half the daily earnings for women. Women not in sick clubs are entitled to assistance from the commune, but the assistance given is less comprehensive than that given by the sick clubs.

Danish law does not insure regular medical examinations for expectant mothers without means. The sick clubs are bound to help only in cases of sickness. But many sick clubs provide for the necessary prophylactic examinations by the panel doctor. The Rigshospitalet in Copenhagen provides free examinations in the hospital.

6. Funeral Benefits.

When a member dies, the sick club pays the amount of funeral benefits for which the member is insured. The usual amount is 550 kroner. The funeral insurance is reinsured with an organization established by the federation of sick clubs. By statute of May 30, 1940, funeral assistance is a compulsory benefit.

7. Cash Benefits.

Cash benefit insurance is obligatory for Danish men over eighteen. For illness lasting only three days no cash benefits are paid, but if the illness lasts four days or more a benefit will be paid for the first three days as well, provided the

patient has notified the doctor. Except during hospitalization the doctor must certify once a week that the member is fully incapacitated. Partial incapacity is not recognized so that a half benefit would not be paid to one well enough to work a half day.

The demand for sickness cash benefits must be made within nine days after the commencement of the sickness. If the demand is late the sick person may lose a part of his support, as it is recovered from the date of the personal demand. It is too late to make the demand after one has recovered.

Under the statute the right to receive cash benefits extends over a period of at least 26 weeks within 12 consecutive months. But in practice this minimum period is used as the maximum limit. Old age and invalidity pensioners get a cash allowance for only 13 weeks in 12 months.

Daily cash benefits in Denmark are very small, having remained unchanged since 1921. The sick clubs must give their members an opportunity to insure themselves for daily cash benefits of at least 40 øre and at most six kroner. Men must insure for at least 40 øre. The cash benefits may not exceed four-fifths of the lost earnings. If the worker still receives his regular pay, he may not receive a cash benefit. The top benefit of six kroner is only one-fifth of the daily earnings of male workers with the lowest incomes. Thus cash benefits have not been brought up to date. They are much smaller than cash benefits paid by way of workmen's compensation and unemployment insurance. The Danish theory favors benefits in kind over benefits in cash. There is less incentive to cheat when cash benefits are small. But many Danes feel that there should be adequate compensation for loss of earnings during sickness. The problem is being considered by the Commission on Health Insurance. But if financial reasons make both benefits in kind and in cash impossible, the former should be preferred.

An active member under forty may insure himself for a higher daily benefit than when he was admitted, provided that he submits a doctor's certificate that he suffers from no illness, acute or chronic at the time of application. If there is a doubt the question may be submitted to the Directorate of Health Insurance Services.

Although members may insure for up to six kroner, few do. In Copenhagen, they usually insure for three kroner and in the rest of the country for a krone and a half. The reasons seem

to be lack of foresight and the feeling that the premium is too high. Yet higher premiums are paid for unemployment cash benefits. But many workers regard unemployment as a greater risk than sickness. In 1942 the average cash benefit paid out per sick day in the home was 1.31 kroner and the hospital .31 kroner.

Usually cash benefits are reduced when the member is in a hospital as he gets free board and lodging. Cash benefits are not paid to old age or invalidity pensioners as they have no loss of income; but they may get one krone a day for 13 weeks within a year in case of acute sickness or a temporary aggravation of a permanent disease. Cash benefits are not paid to children of covered members. Persons suffering from a chronic disease cannot get more than three kroner a day. The clubs may reduce the cash benefits to women members and to male members under 18.

By agreement between the workers' and the employers' organizations both contribute to a fund from which the workers receive a cash benefit during illness equivalent to unemployment insurance. This arrangement is administered by the sick clubs but not financed by them. This agreement does not cover all workers. But many of those not covered are civil servants who have a right to full salary during illness.

Under recent regulations in Denmark persons still working who are receiving an old age pension or invalidity pension are no longer to be paid sickness cash benefits. Previously where such cash benefits were paid the pensions were correspondingly reduced by the communities, so that the cash benefits operated to the advantage of the community rather than to that of the sick person.

The victim of an industrial accident who is incapable of working for more than seven days after the accident is entitled to a daily cash benefit from the workmen's compensation office. Before that time he may receive a daily benefit from the health insurance office. The daily cash benefit under workmen's compensation is 16 kroner compared with 6 kroner for health insurance. As to expenses for medical treatment, the workmen's compensation pays only such expenses as cannot be paid by the health insurance under its rules. Workmen's compensation supplements health insurance if necessary for obtaining the maximum recovery.

The Danish sick clubs are allowed to include in their rules provisions for voluntary benefits. Such benefits are dental

treatment, medicines, massage, stays in convalescent homes, and home nursing. The sick clubs do not pay the whole amount as to all voluntary benefits. Fifteen years ago the voluntary benefits amounted to about one-third of the total expenditures for sickness assistance.

8. Specialists.

Nearly all club rules provide for specialist treatment. In Copenhagen the clubs provide specialist treatment for diseases of the eye, ear, nose, throat, surgical cases, nervous diseases, female diseases, alimentary trouble, skin diseases, venereal diseases, chest, heart, kidney, lung diseases, and infantile diseases. The Copenhagen agreement covers X-ray examination, mechanotherapy, and orthopaedy. While in England specialist treatment must take place at a hospital's outpatient clinic, in Denmark the preference is for treatment at the specialist's private office.

9. Dental Care.

As early as 1936 all urban and most rural clubs provided a dental benefit towards specified dental care. In Copenhagen this covered all but gold fillings and artificial dentures. One-third of the clubs outside of Copenhagen offered similar benefits; two-thirds paid only for extraction. In the urban clubs the insured paid the charge directly to the dentist of from 20 to 50 percent of the costs, except for extractions, while the dentist collected the balance from the clubs. Dental charges are regulated by agreements with the dental association.

Practically all sick clubs, 1500 out of 1588, provide for some dental treatment, involving extraction of diseased teeth or also preventive treatment. About 700 clubs representing about 500,000 members pay only for extraction. No payment can be made for supplying, repairing, or renewing artificial teeth, as for bridge work or jacket crowns. The dental benefits are not required under the Danish statute, but are voluntary benefits, and only 6 percent of sick club expenditures is devoted to it. Benefits are paid on the basis of agreement between the sick clubs and dental associations. By means of arrangements with the dental organizations some clubs have made it possible for their members to obtain dentures at low prices.

As of 15 years ago the communes provided for free dental care for about one-fifth of all Danish school children. In Copenhagen children can obtain systematic dental inspection and treatment twice a year throughout their school years, and

may come to the clinic at any time they need immediate attention; 95 percent of the children made use of the system. In 1954 about 572 communes provided for dental care for children.

10. Other Benefits.

In Denmark it is quite common for sick clubs to pay for spectacles, and some clubs have their own opticians. There were 1425 clubs in 1944 which paid part of the cost of spectacles. The individual would himself pay for the bows.

In Copenhagen the sick clubs provide massage, either at the three clinics which they own, where there is specialist supervision and where light and heat treatment are available, or by private practicing specialists. Similar treatment at sick club clinics is provided by 24 other clubs outside of Copenhagen. About 900 clubs grant help toward paying for massage prescribed by a physician and performed by authorized professionals at previously arranged charges. About 820 clubs provide help towards medicinal baths.

Up to four weeks' stay in a convalescent home may be paid for. About 80 percent of all clubs have rules on the subject.

Home nursing may be provided. This is nursing in the home by a registered nurse. The purpose is to relieve the physician, and shorten or avoid a stay in the hospital. About half the clubs provide for home nursing.

Many sick clubs, especially those in the towns, undertake the administration of the duty imposed on local authorities, to make homemakers available when the housewife is ill.

Nearly all the sick clubs, about 1500, help towards procuring bandages, surgical appliances and artificial limbs.

Most of the Danish sick clubs have a help fund from which they can give assistance in cases of need that are not covered by the regular benefits supplied by the sick club. But sometimes these funds are rather limited.

Members of sickness societies or continuation clubs for those with high incomes are entitled to the following benefits. They are entitled to medical attendance or care, by general practitioners and specialists. The society reimburses the member four-fifths of the maximum amounts fixed in the rules of health insurance. These maximum amounts are equal to the minimum fees fixed by the Danish Medical Association. The member may be attended by any Danish physician so long

as the physician belongs to the Danish Medical Association. The society pays ordinary charges fixed for ward care in the local, or central, medical center, and in tubercular and mental hospitals. The maternity benefit is paid with a cash amount laid down in the rules of the society. But few societies pay for medicines and drugs. Like the clubs, the societies pay cash benefits not over six kroner per day to members who wish to insure for and have paid for such benefits.

In 1954 the percentage breakdown of expenditures of sick societies or continuation funds, covering the higher paid employees was as follows: for medical treatment 51.5, for hospital treatment 22.8, for medicinal baths and massage 5.3, for daily cash benefits 2.3, for medicine 2.3, for maternity benefits 1.2, for funeral benefits 2.2, and for administration 9.

The commune must provide free conveyance for certain members. This comprises the conveyance of members to and from his physician or hospital, and also of a midwife or physician to and from a member's home. If the commune believes that the right is being abused it may require the member to pay a control charge not exceeding a fourth of the costs of conveyance and not exceeding two kroner a time.

General relief is given to those who are not active members of the sick clubs or associations or to former active members who have exhausted their claims for health insurance. Those who have not fulfilled the conditions for membership consist largely of those handicapped from their youth. There will always be some persons not covered, since active membership is voluntary, and since, also, there are health conditions of membership, restrictions on the amount of benefits (420 days within 3 consecutive years), and preventive hygiene is not included. General relief would be greatly diminished if the statutes were to be amended so as to provide for compulsory or automatic active memberships, eliminate health and age conditions, eliminate restrictions on treatments and benefits, and pay higher daily cash benefits. Perhaps, too, the sick clubs should be given control over individual preventive hygiene, home nursing and home-help.

11. Special Relief.

What is known as special relief is given to active members who have exhausted their benefits or who need medical aid before they have been active members a sufficiently long time

to receive health insurance.[46] Such persons receive public assistance without legal disabilities. Where special relief is given to persons who have exhausted their health insurance benefits, it may not exceed what the sick club has paid during the past three years; but such person may then rejoin the sick club. Special relief is given to those who had no opportunity to become sick club members. If a person's ability to work is reduced to one-third or less, special relief is given to sick club members who are too debilitated to be accepted for invalidity insurance. It is also given to chronic invalids who are not insured for either sickness or invalidity and who during the last three years have not been qualified for admission to a sick club or society. Under certain conditions free medical attention and nursing, but not maintenance, are given to persons who exceed the age limit for admission to a sick club and have passed the invalidity limit. In cases of need special relief may be given to persons who are not active members of sick clubs, by way of medical attention, medicine, massage or bath treatment, and sick nursing where this will avoid hospitalization. Where a married woman living with her husband is taken to a hospital for a period of from a week up to six months, it is possible in case of need to grant a subsidy for a housekeeper provided that the wife is in a sick club and there is more than one child to be cared for in the home. Special relief also is given in the form of maternity help by the commune of the abode to women not members of a sick club. Special relief may be used to pay sick club contributions in case of need. Communal relief is given to those who might have insured for health insurance but neglected to do so. The effect of such communal relief is that the recipient loses his franchise and eligibility for election to public assemblies and councils. But such legal disabilities are not applied except in cases of protracted relief. In general, public assistance is given in the home, but with the consent of the physician the recipient may be sent to a hospital, nursing home, or the infirmary of a public institution.

B. *Finland*

The benefits paid by a benefit fund which grants health insurance benefits may under its rules consist of daily cash benefits and compensation for the costs of medical care or maternity aid, such as physician's fees, hospitalization, and

46. SOCIAL DENMARK, *supra* n. 15, at 124-126.

the price of medicines. In most cases the benefits granted by sick benefit funds include small amounts for funeral aid.

Of the 254 Finnish sick club funds in 1956, 254 gave sickness and maternity cash benefits to members, 226 give sickness and maternity care to members, and only 50 sickness and maternity support to family members.[47] With respect to sickness assistance 254 funds gave daily cash benefits to members and 87 such benefits for accidents. With respect to sickness care 187 funds gave hospitalization to members and 231 gave other sick care to members. As to other sick care 210 funds gave payments for doctors' visits, 211 for medicine and bandages, and 206 for other care and travel. Only 39 funds gave hospitalization to family members, and only 45 gave other care for family members.

Under Finnish law the municipalities and rural communes are responsible not only for public health but also for general medical care. Thus in rural areas medical care outside of hospitals is furnished by municipal doctors appointed and employed by local authorities and partly paid by the central government. Their charges to individuals are nominal. Sixty percent of the doctors are employed either in the public hospitals or in the public health service. Only 40 percent are in private practice, as against 50 percent in Norway where there is universal compulsory health insurance. The system of "municipal doctors" is found throughout the country.[48] Legislation passed in 1951 authorizes special state grants to encourage their appointment also in the smaller districts. The towns also employ one or more public physicians. There is a trend for private enterprises to appoint special company doctors who furnish medical care to employees.

Almost all Finnish hospitals are public, maintained by the state or by municipalities, and charge very low rates. A hospital patient pays from fifty cents to one dollar a day, and this covers the cost of surgery as well.

As of 1957, the communes are required to provide dental care for school children.[49] Previously many communes had provided for such care. In 1956 such care was available to 51 percent of all school children.

Many of the societies refund half the cost of medicine prescribed by a doctor.

47. STATISTIK ÖVER FINLANDS UNDERSTODSKASSOR FOR ÅR 1956 (1958).
48. FREEDOM AND WELFARE, *supra* note 7, at 328, 334.
49. SAMORDNAD, *supra* note 23, at 59.

In 1937 Finnish maternity grants were given to persons of small means as defined by their taxable income. Since 1949 these grants are given irrespective of income. The grant is conditional upon the expectant mother visiting either a physician, a midwife, or a maternity center before the fourth month of her pregnancy. The grant consists of a package with baby clothing and other child welfare items distributed just before confinement, and a lump cash sum, paid immediately after the birth of a child. As of 1953 the grant amounted in all to 4,500 marks, covering both the aid in kind and the aid in cash.

Daily cash benefits are perhaps the most important benefits granted by the health insurance societies. This is probably due to the fact that most members are industrial workers. Ordinarily the daily allowance amounts to 60 percent of average wages. In 1954 the largest item of health expenditures of the societies was for daily cash benefits, the second for medical and dental care, the third for medicine and drugs, and the fourth for hospitalization.[50] Cash benefits are usually paid starting with the fourth day of illness.

To a considerable extent Finnish employers are required by law and collective agreement to pay wages during sickness. In 1951 the Finnish social expenditures for sickness amounted to 12,783,000 marks; of this total 4,000,000 marks represented wages paid during sickness.[51]

Public assistance to sick persons is provided for. If hospital care is required the commune must provide it.[52] If the sick person cannot be cared for in his own home or in a suitable private household, the sick person may be sent to a home for the sick.

C. *Iceland*

The Icelandic law prescribes certain minimum benefits, but most sick societies give more. Generally speaking an insured person has the right to ordinary medical care, including physical therapy, specialist care though somewhat limited, medicines and drugs, hospital care, x-ray examination and treatment, partial payment of travel costs of the patient or doctor, maternity aid, and daily cash benefits.

The largest item in 1954 was for hospitalization, the second for medical care, the third for medicine and drugs, and the

50. *Id.* at 46.
51. SALOMAA, *supra* note 18, at 181.
52. *Id.* at 104.

fourth for daily cash benefits.[53] Iceland, like Norway, endeavors to pay a considerable part of the actual hospital costs.

1. Medical Care.

Under Article 85 of the Social Security Act of 1946 insured persons are entitled to receive medical assistance outside hospitals from doctors working for the Public Health Service on payment of one-fourth of the regular remuneration. The Social Security Institution may make similar arrangements with individual doctors when Public Health Service physicians are not available. When no such arrangements can be made, the Social Security Institution may pay to the insured 75 percent of the scheduled rate fixed by the Department of Public Health towards medical care expenses. Since January 1, 1957, necessary services from specialists are among the obligatory benefits.

The first doctor was sent to Iceland in 1760.[54] In 1800 there were only six physicians in Iceland, and in 1850 only seven. About 1845, Jon Signudsson, the great leader of the movement for Icelandic independence, proposed that a medical school be established in Iceland, but fear of great expenses hindered establishment of a medical college until 1876.

In 1951, Iceland had 1,272 doctors per million persons, Denmark had 1,110 in 1958, Norway had 1,040 in 1958, Sweden 789 in 1955, and Finland 561 in 1955.[55] The United States had 1,319 in 1955. Thus Iceland has almost as large a proportion of doctors to population as the United States.

In 1954 there was one doctor for each 852 inhabitants in Iceland, for each 898 in Denmark, for each 917 in Norway, for each 1,332 in Sweden, and for each 1,826 in Finland.[56] In Iceland, there were in all 181 doctors, of whom 45 were hospital doctors, 65 were physicians in the public service, and 71 were in private practice. Private practitioners are found only in the larger cities.

2. Hospital Care.

Under Article 84 of the Social Security Act of 1946, the Social Security Institution pays the expenses of insured persons who on orders of a physician are admitted to recognized hospitals, sanatoria, or maternity homes, including medical

53. SAMORDNAD, *supra* note 23, at 46.
54. GJERSET, HISTORY OF ICELAND 366 (1925).
55. *Prognoser rörande sjukvordsbehovet m. m.*, 55 SVENSKA LÄKARTIDNINGEN 2821 (No. 41) (1958), reprint at 48.
56. SAMORDNAD, *supra* note 23, at 51.

assistance, medicines, and surgical dressings. These expenses are paid in full, for as long a time as may be needed, subject to approval of hospitalization by the Chief Insurance Doctor, or by other doctors who represent him. In special circumstances, there may be payments for patients in recognized nursing homes.

Under Article 86 of the Social Security Act of 1946, the Social Security Institution shall enter into agreements with hospitals for services. If no agreement as to rates can be arrived at, the Department of Public Health shall fix the rates on the basis of fair remuneration. In the agreement or decision it shall be specified that any profits from the operation of the hospital shall be used for improving the services provided. To insure execution of this provision, the Social Security Institution shall have access to the financial records of the hospitals.

3. Dental and Other Benefits.

Under Article 85, the Institution may pay for dental treatment solely as to persons under 18. But no payments can be made for gold fillings. School children in the towns receive dental care; in 1954, dental care was available to about 65 percent of school children.[57] In 1954 there were only 39 dentists in Iceland or one for each 3,956 inhabitants. Thus, while Iceland has the highest proportion of physicians to population, it has the lowest proportion of dentists among the Scandinavian countries.

Under Article 87 of the 1946 Act the Institution shall pay in full for such medicines as the physician may deem essential. Essential character must be substantiated by a doctor's certificate or by an investigation satisfying the Chief Insurance Doctor. Half the cost of other necessary medicines and dressings are payable, provided they are prescribed by a licensed physician. The Institution is to make a list of essential and necessary medicines subject to the approval of the Department of Public Health. The list is to be revised at least once every two years.

Under Article 88 the Institution shall pay in full for x-ray examinations, provided that such examination is made on doctor's orders and by approved doctors or institutions. These payments shall be made by agreement. If no agreement has been made, the insured may after payment secure a refund.

57. *Id.* at 58.

Under Article 89 the Institution shall pay in full for x-ray therapy and radium treatment, and under Article 90 shall pay in full for histological and biological investigations ordered by a physician.

Under Article 92 the Institution may provide such nursing or assistance in a private home as the doctor may deem necessary. But such assistance is to be provided only under special circumstances under specific rules to be laid down by the Institution.

Under Article 94 special funds to defray the expenses of transporting physicians and patients are to be created in each community which has transportation difficulties. A national fund of 100,000 krónur is to be divided among these communities. Payments are made out of such contributions together with local funds. Under Article 95 a common fund for the whole country is established to help equalize deficits in local funds and to help individuals who are not entitled to help from any transportation fund. Disbursements to a local fund shall never exceed two-thirds of the fund, and disbursements to individuals shall never exceed one-third of the fund.

Under Article 96 the funds provided for in Article 94 shall be utilized to refund 75 percent of unavoidable travel expenses when physicians are called to attend sick persons, except as to the first ten kilometers; and 75 percent of unavoidable expenses when sick persons are transported to hospitals. If the local fund is exhausted, the parish makes good the deficit; but the parish in turn may be reimbursed up to 50 percent by the national fund set up under Article 95. Under Article 97 where an insured person is not reimbursable by the local fund under Article 94, the Social Security Institution may reimburse him in full or in part under Article 95, if he applies for such refund.

Under Article 91 the Institution shall pay for obstetrical aid given in the patient's home in accordance with rates issued by the Department of Public Health.

4. Maternity Benefits.

Two distinct birth allowances are given in Iceland. The first benefit is from the sickness society under Article 34 of the 1946 Act. Maternity allowances are the same throughout the country, irrespective of zone. But a distinction is made between women who do not go out to work, and those who do so. Women who do *not* go out to work receive a maternity

allowance of 200 krónur. Women who go out to work receive 90 krónur and 140 krónur a month for a period of three months running before and after birth, provided they cease work and receive no wages for that period; a married woman receives this allowance only if the husband is unable to support the family. Maternal aid may be given to a person who is temporarily outside of Iceland. The second benefit is from the Social Security Institution which pays all mothers 600 krónur plus an additional amount fixed according to the price index for each birth. The birth allowance must be claimed within twelve months unless good excuse is shown. Since 1957 the sickness societies no longer provide the maternity benefits, but they are now provided for through a 50 percent increase in the pension insurance.

5. Daily Cash Benefits.

Under Article 39 of the 1946 Act daily cash benefits are payable to men and women from 16 through 66, who suffer loss of income due to illness if their working capacity is so reduced that they cannot earn a minimum of 25 percent more than the daily cash benefit. Under Article 40 the daily cash benefit in the first price local zone covering towns was 6 krónur for married men whose wives do not work and 5 for others; in the second zone it was 5 krónur for married men whose wives do not work and 4 for others. Married women are not entitled to daily cash benefits except when their husbands are unable to support them. Sickness benefits may not exceed 75 percent of regular earnings. Under Article 63 if a recipient is confined at a hospital or some similar institution where his expenses are partly or wholly defrayed by the Social Security Institution or from public funds, his cash benefit may be reduced or ruled out, according to annual rules to be laid down by the Institution. In 1954 about 95 percent of all daily cash benefits were to persons in hospitals and only 5 percent to others.[58] However, the payments to persons in hospitals were in many cases to persons whose hospital costs had not been paid by the health insurance fund.

Under temporary provisions, paragraph 2 of the 1946 Act, it was provided that as long as the price level board's index figure is 110 or more, the cost of living bonus shall be payable as to daily cash benefits and on the Social Security Institution's grant for transportation of physicians and patients.

58. *Id.* at 46.

Likewise contributions from the insured and from the employer shall be collected with a surcharge according to the average index figure for the preceding year, and also the municipal and central government contributions.

Under Article 41 daily cash benefits are not payable when illness is due to alcoholism, the use of narcotics, or other causes for which the insured is himself responsible. During epidemics of measles, influenza, and scarlet fever benefits are not payable, unless the Social Security Council authorizes payment in each individual case.

Under Article 42 of the 1946 Act cash benefits in Iceland are paid from the eleventh day of illness provided the worker is ill for 14 days or more. But as to the persons having permanent positions entitling them to 14 days wages during illness they are paid starting the fifteenth day. Independent persons who employ two or more persons, not including wife or children, receive cash benefits starting the thirty-sixth day. Benefits are paid for seven days during the week, and may be paid up to six months during a year. For each of the first three children under 16 a supplement is paid. In 1954 an unmarried person in the urban area got 23.71 krónur and in the rural 18.87 per day.[59] A married person in the urban area got 28.45 krónur and in the rural 23.71. This corresponds to about 30 percent of the earnings of an industrial worker. With respect to each child under sixteen a supplementary benefit of 5.22 krónur in the towns and 3.91 in the rural areas is given.

Under Article 43 cash benefits cease on the day the insured becomes fit for work, even though he does not resume work or neglects to report that he has regained his health.

Under Article 44 one who applies for a daily cash benefit shall by a doctor's certificate report his illness to the Social Security Institution within ten days from the date when rendered unable to work by his illness; otherwise the waiting period shall start from the day when notification was received. The waiting period shall commence with the day when a doctor was first called in or the patient admitted to the hospital. The notification is to be accompanied by the certificate of two persons of good repute that the illness was uninterrupted. Upon receiving notification of illness the Insti-

59. *Id.* at 48. In 1956 daily cash benefits in England and Wales represented about 34 percent of average industrial earnings for a man, wife, and two children. TITMUSS, *supra* note 29, at 138.

tution may have the person examined by a physician, or by other means keep itself informed. A patient who neglects to follow the doctor's orders loses his right to a cash benefit.

Under Article 64 persons regularly employed are not to be deprived of their salaries during the first 14 days of absence from work on account of illness or accident, and they shall retain their salaries for a longer period if this is provided for by specific laws or agreements, or if this has been the practice in their line of occupation.

Under Article 66 the daily cash benefit is payable to the sick person or to his guardian if he has one. [Under Article 67 the benefit may be paid for a shorter period than a month and before the end of the month. The benefit shall be collected within a year unless good cause is shown. Under Article 68 the right to the benefit cannot be transferred or incumbered, nor is it subject to seizure, execution or distress nor to a bankruptcy claim.]

Under Article 70 if there is overpayment of cash benefits the Institution may claim reimbursement, or deduct from benefits later becoming due. If the payment is gotten through fraud by the recipient, the Institution may compel a refund up to double the amount overpaid; and the recipient is not excused from other existing penalties. Under Article 72 no cash benefits are paid to recipients sentenced to imprisonment, or otherwise compulsorily ordered into an institution.

Under Article 126 all Icelandic citizens are to be registered with the Institution, and under Article 127 insurance certificates are issued to all persons registered. Article 128 requires the certificate of insurance to be produced whenever compensation or sickness benefit is applied for.

Under Article 132 the following rules apply to persons who were personally responsible for payment of their contributions but defaulted. The right to daily cash benefits and to medical assistance shall be reduced by the same percentage as the defaulting of contributions out of the total due for the preceding insurance year. This also applies to the insured's wife and his children under 16. If contributions are payable monthly, the Institution may order that benefits be forfeited in cases of defaulting contributions for a period exceeding one month. Even where there is no monthly contribution, the benefits may be forfeited one month after payment became due. But there are no such rules as to maternity bene-

fits. A 1948 amendment provided that defaulting in the payment of contribution to sickness benefit societies in 1949 should involve the curtailment or forfeiture of the right to medical assistance in 1950.

Under Article 139 a person who uses fraud to obtain benefits under the Social Security Act is subject to fines or imprisonment up to six years. Prosecutions are handled as criminal cases.

Under Article 140 the provisions as to daily cash benefits were not to become effective until July 1, 1947, and the provisions for other health insurance benefits were not to become effective until January 1, 1948. Under a 1948 supplementary statute the provisions as to health insurance benefits in kind were to remain inoperative until 1950.

As of 1954 the Social Security Institution was paying daily cash benefits and transportation costs for the physician and the patient.[60] The obligatory benefits provided by the sickness societies were ordinary medical care and hospitalization. They also paid from 50 to 100 percent of the cost of medicine and drugs, depending on how essential they were, as well as for x-ray examinations. The societies may, but are not required to, pay transportation costs (especially in the rural districts), the costs of specialist care, and of physical therapy. Usually they do not pay for dental care or funeral aid. In 1954 maternity care was among the compulsory benefits, but that ceased on January 1, 1957, and is now provided through an increase of the penson insurance. From the same date necessary specialist care is among the compulsory benefits. Since 1957 daily cash benefits are paid by the sickness societies as the thought of abolishing the societies no longer prevailed. But the societies remain under the supervision of the Social Security Institution.

Under Article 17 of the 1946 Act, if an old age pensioner requires special care due to illness or infirmity and is unable to live on the pension allotted to him, the Social Security Institution may raise his pension by not more than 40 percent, or provide accommodation for him in a home for the aged.

An Icelander who is absent from Iceland may receive medical aid from Iceland, when he does not receive it already, but will receive it only at the Icelandic rate.[61] But daily cash

60. SAMORDNAD, *supra* note 23, at 49.
61. NORDISKE STATSBORGERES SOCIALE RETTIGHETER 34 (1955).

benefits are usually not paid. The member may preserve his membership so long as he can be regarded as having his home in the area of the sick club. Under Article 93 of the 1946 Act, the Institution may contribute towards the cost of medical assistance abroad in specific cases. Such contributions are payable only when the patient is abroad when he is taken ill, or when he suffers from an illness which in the judgment of the Chief Insurance Doctor and the medical committee is likely to be dealt with successfully abroad, and not in Iceland.

Under Article 137 the Minister may negotiate with foreign insurance institutions reciprocal rights for Icelandic and alien nationals to such benefits as the social security scheme confers.

Under Article 51 of the 1946 Act workmen's compensation includes health insurance benefits other than daily cash benefits.

Article 70 of the Constitution of Iceland provides: "Whosoever is unable to provide for himself or his dependents shall, subject to duties prescribed by law, be entitled to support from public funds, unless his maintenance rests upon others." Public assistance by way of medical attention is given to poor persons if proof is given that they cannot be aided otherwise. Assistance is given to patients who suffer from diseases of long duration such as tuberculosis, mental diseases, leprosy, and venereal diseases.

D. *Norway*

1. Medical Care.

The first major benefit of health insurance in Norway is medical care. This includes consultation and treatment by a general practitioner of the patient's own choice; and, if necessary, by a specialist. Such care is to continue until the illness, injury, or deformity is cured. But the patient is required to pay part of the costs of such care, except as to a few services. How much the patient pays depends on the circumstances of his case. The first and second visits to or from the doctor cost the patient more than the later ones.[62] This rule brings pressure on the patient who for no good reason drifts from one doctor to another, as he has to pay more for

62. EVANG, HEALTH SERVICES IN NORWAY 17 (1957). The fourteen benefits provided by Norwegian law are listed in Section 31 of the Norwegian statute.

consultations than if he had stayed with the same doctor. At the same time it would seem to bring pressure on the doctor who makes unnecessary visits, since the fees for later visits are less than those for the earlier. If the illness is of a kind that requires a long series of special examinations and tests, the patient's part of the fees will be lower, on the theory that one should not be penalized financially because one is seriously sick. On the average, between two-thirds and three-fourths of medical care fees are refunded to the patient. Bearing in mind the abuses which developed in England, it was thought that maintaining some financial responsibility on the individual patient would prevent abuse and also contribute to the total cost of the system. In workmen's compensation cases the insurance program pays all charges.

The Norwegian system up to 1925 paid for the whole amount of doctors' fees. Since then the patient has paid a part, one-third before 1956 and one-fourth after 1956. This prevents abuse of the system and places some responsibility on the individual. While the insurance system should carry most of the responsibility, some should be borne by the individual.

Excessive demands for medical care in England have led the English to see the value of the restrictions which exist in Norway. In April, 1952, the Ministry of Health in England imposed token charges — 14 cents for each prescription item, about $5 for glasses, $1 or $2 a day for special hospital beds, and up to about $10 for dentures.[63] These charges have cut demand sharply in some instances.

Norwegian doctors are paid on a fee for service basis, that is, according to the amount and kind of work they do. After negotiations between the Norwegian Medical Association and governmental authorities "normal rates" are set up for consultations, home calls, operations, and all the other services a doctor can render. The Norwegian Medical Association, of which all Norwegian physicians are members, then sets up the list of fees which its members may charge for their services.

Under section 35 of the Norwegian Act there are two methods of compensating the doctor. One is for the patient to pay the doctor and then receive a refund of three-fourths of the

63. Chicago Tribune, Dec. 15, 1957, pt. 1, p. 11; TITMUSS, *supra* note 29, at 137-138.

fee from the health insurance program. The other is free medical treatment by medical practitioners with whom the insurance fund has made a contract. The refund system applies where there is no contract. Under section 122 if there is a contract for free medical attendance the medical practitioner cannot demand payment for medical attendance from the patient. Under section 37 the insurance fund may, with the consent of the National Insurance Office, adopt a resolution that the amount be paid directly to the practitioner by the insurance fund.

The concept of medical care is very broad in Norway. It covers every case from any cause where the person needs medical help.[64] It covers visits to and from the physician, hospitalization, follow-up treatment, rehabilitation measures of whatever kind or duration, and maternity cases, whether the mother is sick or not. Hereditary diseases and congenital malformations are covered. The only exceptions are a few long-lasting diseases which are paid for directly by the government out of tax funds. Some Norwegians would extend the health insurance system to take over the costs of the illnesses covered by special laws, such as tuberculosis, mental illness, and blindness.

General physical examination for check-up purposes where there is no present illness possibly are not included under health insurance. However, in the rural elementary schools children are examined twice a year at the beginning and end of the school year. In the larger cities each school has its own doctor who not only gives routine general examinations, but carries on special investigations for eye trouble, ear, nose and throat ailments, orthopedic difficulties, and mental or emotional problems. Many adults are given an annual physical examination by doctors in industry. At present about 750 concerns employing over 250,000 persons employ such doctors. This figure is about one-third of all who could reasonably expect coverage by such a program. A 1956 statute gives the government power to require appointment of a company doctor when a factory or business needs one. In 1946 there was a voluntary agreement between the National Medical Association, the Norwegian Employers' Association, and the National Federation of Trade Unions setting up the system of company doctors. Under the plan each company employs a

64. EVANG, *supra* note 62, at 13.

doctor, usually on a part-time basis, and outfits an office on the premises where he can carry out medical examinations of all employees. If illness is discovered, the patient is directed to his own private physician for treatment. Some Norwegians think that the health insurance system should enter this field of private medicine and supply physical examinations for all.

The costs of medical care for syphilis and gonorrhea are not paid for even in part by the patient. What the health insurance does not cover is paid for by the government.

In the event of illness or confinement during a stay abroad insured persons are entitled to a benefit not exceeding the amount that the insurance fund would have paid for similar treatment in Norway. A family member who is residing abroad is not entitled to a benefit unless the member is also residing abroad, and is a Norwegian national. No daily cash sickness benefits are paid to members who reside abroad, but the Ministry of Social Affairs may authorize exceptions. A non-employed person temporarily residing abroad continues to be insured for three months and thereafter as long as he continues to pay his contributions on time. Where a person temporarily works abroad for an employer residing in Norway, the membership continues without time limit so long as the employee during the foreign stay has his residence in Norway.

The Norwegian patient is not bound to any certain doctor. He can select any general practitioner he pleases, although in isolated rural areas his choice is in actual fact limited to the nearest one.

It is normally the family doctor who determines whether a person shall go to a specialist or to a hospital. But if the patient disagrees he can go to another general practitioner. This approach is based on the fact that there are not enough specialists or available hospitals. In critical cases the doctor may send a patient to a hospital "for immediate treatment." The hospital must then accept the patient no matter how overcrowded it already is. When the patient is in the hospital, the hospital doctors take over his case, but send a report to the general practitioner on discharge. A specialist does the same when his treatment is finished.

When the patient is employed and must be absent from his job because of illness, his doctor makes out a sick-leave declaration which is not recalled until the patient has recovered enough to go back to work. The cash benefit will be paid by

the health insurance authorities on the basis of this declaration.

The percentage of sick persons in Oslo arose from 2.82 in 1956 to 3.37 in 1957, and was still rising in the first four months of 1958. But there was much Asiatic influenza during that time. Furthermore there were increased absences among those who received their regular salaries during illness.

There are several causes for loss of health insurance benefits, such as a patient's failure to report the illness to the insurance fund within 14 days, leaving the area of the insurance fund during an illness without informing the fund, failing without cause during an illness to comply with the doctor's advice or an order given by the insurance fund under the statute, being guilty during an illness of gross negligence with regard to his health, and refusing to be examined by the medical practitioner appointed for supervision purposes by the fund.

About 45 percent of Norwegian doctors are in private practice, either as general practitioners or as specialists. Above one-third of all Norwegian doctors whether in or outside of hospitals are specialists. The Norwegian Medical Association sets up the requirements for specialists and sees that they are met before it will officially recognize a man as a specialist. Because of the high requirements and the long period of study, specialists are allowed to charge higher fees than general practitioners. Distribution of general practitioners in Norway is satisfactory, since the public health doctors go into every district and are in active practice. But there is a tendency of specialists to cluster in cities. The Directorate of Health Services is endeavoring to improve this by experimenting with traveling specialists. The problem to be solved is how thinly populated areas may be provided with the services of medical specialists without their time being wasted by not having enough to do.

One cannot be admitted to study medicine in Norway until he has completed the elementary school which takes seven years and then the gymnasium or higher school which takes five years. This means that the average freshman student is about 19 years old. No tuition is charged, and there are only a few small charges for laboratory fees and examinations. But students must pay their own living expenses and for textbooks. Many of them take out long-term, low-cost loans which the government makes available.

There are two medical schools in Norway, one at the University of Oslo and the other at the University of Bergen. Both have the same curriculum, first planned by their medical faculties, then approved by the Ministry of Church and Education and by Parliament. The Director-General of Health Services from time to time issues recommendations on the number of medical students that the country ought to train. Since, however, the university clinics are limited in size, only about a hundred students a year can be admitted, and this is not quite enough. Only science majors with almost perfect records are accepted. Health insurance has in no way destroyed the interest in medicine as a career.

The Norwegian medical schools at Oslo and Bergen have a capacity for 600 students. In addition, there are at present between 450 and 500 Norwegians studying medicine in other countries. Before such students can practice in Norway they must take additional work at Bergen for two to three months, or half a year if they attend the University of Oslo.

There was a thorough revision of the Norwegian medical curriculum in 1951.[65] The theoretical part was reduced to six years to be followed by one and a half years of practical training at hospitals and with district doctors. The six-year theoretical program is divided into three divisions. At the conclusion of each division a comprehensive examination is given over the whole of it. The first division takes two-and-one-half years and includes study of Latin and philosophy before the basic courses in psychology, biology, biochemistry, anatomy, physiology, and health statistics. The second division lasts for the same length of time. There are advanced courses in some subjects taken in the first division; and also social medicine, internal medicine, epidemic diseases, surgery, skin and sexual diseases, eye diseases, pharmacology and taxicology, bacteriology and serology, x-ray diagnosis and treatment, pathological anatomy and physiology, ear-nose-and-throat diseases, neurology, tuberculosis, rheumatic diseases, physiotherapy, orthopedics, and an introductory course in psychiatry. The third division takes one year, and includes child birth and women's diseases, childhood diseases, psychiatry, hygiene, medical jurisprudence, and advanced courses in some of the subjects from the second division. Throughout the six-year theoretical part the student is given practical

65. *Id.* at 33-34.

experience in the pertinent special departments of the University hospital. After completion of the theoretical part the student becomes a salaried interne at a large hospital, spending six months in internal medicine and six months in surgery. His education is then completed with six months service as assistant to a district private health doctor. During this time he participates in preventive and administrative work as well as in curative practice. The student who is now 26 or 27 years old may begin medical practice on his own.

In 1957 Norway had about 4,000 doctors, or one for each 875 persons. On the basis that one doctor for each 800 persons is theoretically adequate in most countries,[66] Norway is quite well supplied, but because of vast distances and scattered populations more doctors are desirable. In 1900 Norway had only one-fourth of the present number of doctors, but by 1934 this number had doubled, and by 1957 it had doubled again.

A Norwegian doctor can settle where he pleases and there is no limit to the number of doctors who can practice in the various localities. This has produced a somewhat uneven distribution of doctors over the country, with a tendency to settle in the larger cities.

There are three main groups of physicians in Norway: public health doctors, hospital doctors, and doctors in private practice. About 11 percent of all doctors are public health or district doctors. There have been public health doctors for more than 350 years. Their main responsibility has been care of the sick, particularly the indigent sick, and fighting epidemics. Even today care of the sick is their main duty, though they also engage in preventive, regulative, and administrative health work. In about one-third of all health districts they are the only doctors available within the district. They are paid a salary by the central government for their administrative work, and are also paid for their services to patients by the health insurance program.

Under section 123 the Ministry of Social Affairs may, of its own motion or on the recommendation of the managing committee of an insurance fund, debar a medical practitioner or dentist or midwife from practicing before the fund if he has been guilty of an abuse in relation to the fund, is not discharging his medical duties in a satisfactory manner or is

66. *Id.* at 28.

failing to discharge his duties under the health insurance act.

Doctors enjoy a very high status in Norway. Their social position is respected in a very high degree, and they average larger incomes than most professional groups. The health insurance system is such as to give them a great responsibility both individually and as a national association.

Dr. Karl Evang states that Norwegian doctors as well as the masses of the Norwegian people unqualifiedly favor national health insurance.[67] The doctors are assured of more use of their services and at the same time are guaranteed prompt payment of their fees. Otherwise they are left professionally free.

The Norwegian Medical Association stated in a letter of August 29, 1955, to the Ministry of Social Affairs: "Health insurance has been the foundation and certainly the most important of our social insurances, and will in the future form the essence of our securities. That will certainly be the case when it is expanded to cover the entire population."[68]

2. Dental Care.

A second benefit is dental treatment.[69] The health insurance program does not provide for much dental care. It does not pay for dental care given free under other statutes. The patient gets a partial refund for tooth extraction and a number of dental operations or other treatment necessary for general health. Surgery to the jaw and treatment of gum diseases are covered. Patients with cleft palate and harelip are refunded according to normal rates the cost of orthodontic regulation which follows surgery, and financial assistance for artificial teeth is given. Upon application, the local insurance office can contribute to still other tooth or jaw treatment necessitated on medical grounds if the National Insurance Institution approves. In 1955 the health insurance program paid out 2.5 million kroner for dental benefits.

Most dental treatment in Norway is given by way of private practice by dentists who are at liberty to settle where they choose. Dental fees are not as yet regulated by any public authority. Under the first health insurance law of 1911 the only dental care provided was extractions and care necessary

67. *Id.* at 26.
68. OT. PRP. No. 52 at 9 (1955).
69. EVANG, *supra* note 60, at 56-62.

for medical reasons. For other dental care Norwegians had to pay their own bills. But various forms of publicly supported dental care were introduced from time to time.

Norway was the first country in the world to develop publicly supported dental care for school children.[70] Communal school clinics were established in Oslo and Bergen in 1910. A national law of 1917 provided that dental supervision shall be given to all elementary school children in towns and cities. Pupils receive a check-up at least once a year. Treatment is given in the communal office for school dentistry, if there is one, or in the dentist's own office. The dentist is paid a regular salary or is paid per patient or per hour, according to the agreement he has with the commune concerned. Each school dentist has a technical assistant provided by the commune. In 1940 about 40 percent of all elementary school pupils were included; in 1945, 55 percent; and in 1952, 82.5 percent. Since 1947 the program has included students in continuation schools. These are schools in which pupils who do not go on to the gymnasiums continue beyond the elementary school for a year or two. Some of the more prosperous communes have extended free care to younger children from three to six, and to children between 14 and 18. In a few communes local health insurance companies contribute for an annual check-up until the age of 21. More than 700 dentists are employed, 250 of them full-time. The annual cost is more than 12 million kroner. The communes give the chief financial support. The central government pays one-fourth of the expense for salaries in rural communes, and one-eighth in urban. Usually the county also contributes some support. Local voluntary organizations have in many cases aided in founding and financing school clinics.

In Norway all school children have had the right to free dental care since 1936.[71] The Public Dental Service Act of 1949 extended free dental services to all persons between six and eighteen. More than four-fifths of all children receive such care, those not receiving it are living in the northernmost rural areas.

In 1954 dental care was available to 85 percent of Norwegian school children. In practice there is but little dental care for children from 3 to 7, and from 14 to 18 except in large and

70. *Id.* at 57.
71. FREEDOM AND WELFARE, *supra* note 7, at 257, 354.

prosperous towns.[72] Among the Scandinavian states the Norwegian system is second only to the Swedish in percentage of school children cared for.

Provision merely for school dental care was ultimately thought insufficient because regular dental care was not continued after the pupils finished school. In 1949 a law was passed for public dental protection (folketannrøkt) aimed to protect the whole population of Norway. All persons between six and eighteen are to have free dental treatment. In some localities the lower age limit is three years. Dentists employed in this program work in public dental clinics. All adults may go to such clinics for treatment at standardized rates. But persons who go to private dentists pay charges fixed by the dentist himself. The program is administered on a county (fylke) basis and will include all communes regardless of location or financial status. Ultimately it will replace the school dental service. But for some time a given county may have both kinds of programs. When a county has worked out the plans for its clinics it submits them first to the communes in the county for comment and criticism and then to the Ministry of Social Affairs for approval. The Cabinet determines when the plan shall go into effect. Children between six and eighteen are assured of complete systematic prevention treatment and dental surgery and dentures, if necessary, all without cost and of straightening irregular teeth or defective jaws. Adult customers, who pay, can get any treatment needed. Expenses of the program are divided between the central government, the county, and the communes. The central government pays 60 percent of the salary costs in the rural areas and 30 percent in the urban areas. Placing the law into effect has been hampered by the lack of dentists, hence the four northernmost counties were provided for first. It is thought that eventually there will be a thousand district dentists. Two-thirds of them will be employed full time and one-third part time. Private practice in dentistry will continue even though on a somewhat reduced basis. In the fiscal year 1955 to 1956, 100 million kroner was paid to dentists in private practice, but only about 6 million was paid under the health insurance plan.

The public dental service commenced in Finnmark, the northernmost county, in July, 1950, and has been completely developed with 22 dentists giving full-time service. As of 1959

72. SAMORDNAD, *supra* note 23, at 59.

the public dental service in the county of Nordland had 33 clinics, most of which were modern with completely satisfactory equipment. Forty dentists worked in the clinics. In the course of the year seven new clinics will be added and ten new dentists. It is also hoped that orthodontia will be provided, and that two dental technicians will be hired.

Dentists are educated at the Norwegian College of Dentistry in Oslo. Only fifty new students may be admitted each year on the basis of their gymnasium records, and the competition is stiff. The course of studies lasts four years. Although tuition is free, students must pay for their own living costs, textbooks, and a few small fees. Not enough dental students are turned out. In 1956, 450 dental students were studying abroad. Such students must enroll first at the Norwegian College of Dentistry; they may attend only schools in other lands approved by the Norwegian authorities, and when they have completed their study abroad, come back for a supplementary course in Norway. A new dental college is being built at Bergen to operate as an orthodontic institute under a medical-orthodontic faculty. Forty new students may enroll there each year. It will also offer a postgraduate course taking one year.

In 1957 there were 2,100 dentists in Norway.[73] Although Norway and Sweden have more dentists in proportion to their population than any other country, the Norwegians themselves feel that they do not have enough dentists. Tooth decay is very widespread in Norway. Distribution of dentists is poor. While 70 percent of Norwegians live in rural areas and 30 percent in urban, only 30 percent of the dentists are located in rural areas and the rest in urban.

There is a shortage of dental technicians in Norway. Training consists of one year at a special school, followed by a five year apprenticeship. Their work is quite different from that of the dentist. They make inlays, bridges, plates, etc., following instructions and models supplied by the dentist.

3. Physical Therapy Benefits.

A third benefit is physiotherapeutic treatment prescribed by a medical practitioner in accordance with the regulations and scale of charges established by the Ministry. The consent of the health insurance office must be previously obtained.[74]

73. In 1954 there were 1,925 dentists, of whom 600 were active in the service for school children. SAMORDNAD, *supra* note 23, at 58.
74. EVANG, *supra* note 62, at 49-52.

Included are massage, gymnastics, electric treatment, sun lamps, x-ray or radium care, and medicinal baths.

There are about 700 physical therapists in Norway, of whom 250 are members of hospital staffs and 450 in separate institutions. Excluding hospital departments, Norway has about 225 institutions for physical treatment, of which 37 are operated by local insurance offices. Physiotherapists are educated at a private school, the Oslo Orthopedic Institute, which takes about 45 students a year. An applicant must be between 19 and 45 and have a three-year gymnasium degree, although most, in fact, have the five-year degree. He must have served full time in a hospital for at least three months. The course of study takes two years, and students pay their own tuition. More physiotherapists are needed in Norway because the demand for this type of treatment is increasing. Greater emphasis is being laid on its value as after-treatment of a number of diseases. It is also very useful in psychosomatic ailments.

The costs of physiotherapy come under health insurance when prescribed by a doctor according to rules and rates set up by the Ministry of Social Affairs. Norwegian physio-therapy includes remedial gymnastics, massage, exercise for pregnant women, and treatment by baths, heat, electricity, etc. Treatment may be had at a number of different institutions: at specialized hospitals or nursing homes for patients chiefly needing physiotherapy, such as those suffering from rheumatism, poliomyelitis, and similar diseases; at departments for physical treatment set up within the larger hospitals; and at institutions which give nothing but treatment, some owned and operated by local health insurance offices and some as private business enterprises. In 1958, 43 rheumatic patients were sent to Austria for a four-week period under the Norwegian health insurance which paid all expenses except those for travel.

4. Language and Speech Defects.

A fourth benefit is treatment for language and speech defects by a speech therapist in accordance with the regulations and scale of charges prescribed by the Ministry. The treatment must be prescribed by a physician and the consent of the health insurance office must be previously obtained. Congenital defects, defects arising out of operations on the mouth, defects from organic difficulties in the central nervous sys-

tem, throat difficulties, stammering, and word blindness are all included.

5. Drugs.

A fifth benefit is essential drugs.[75] Ordinary medicines, outside the hospital, are not paid for by the health insurance system in Norway. But for vital and important drugs used in the treatment of specific diseases the patient may obtain a refund of up to 75 percent of the cost. The first 50 kroner worth of medicine are paid by the patient. For a few diseases the entire cost of prescribed medicines will be refunded. The Ministry of Social Affairs makes the decisions as to what sicknesses are entitled to a refund on drugs. In 1957, the list included pernicious anemia, asthma, cancer in the breast and prostate glands or testicles, chronic infection of the large intestine and certain other diseases of the digestive system, diabetes, epilepsy, chronic toxemia, glaucoma, chronic heart disease, chronic bone infection, acute and chronic arthritis, overactive thyroid, tuberculosis of the lungs and other organs, a few chronic skin diseases, and diseases involving deficiency of hormones requiring constant hormone injection. The costs of medicine for syphilis and gonorrhea are free to the patient. Whatever the health insurance does not cover is paid for by the government. In the fiscal year 1955 to 1956, 150 million kroner was spent for drugs and medicines, but only about 5 million was spent under the health insurance program.

Until the 1956 statute the Norwegian health insurance did not pay for medicine. Hospital patients in Norway receive all medicines and drugs free, but non-hospital patients must pay except as to certain dangerous diseases where a refund is made. The Norwegian theory is that it is better to keep prices low as a benefit to all, rather than to risk possible waste if medicines were made free. Not all medicines should be paid for by the government. The production, distribution, advertising and control of drugs is nowhere on a purely rational basis. People often purchase medicines on the bases of emotion and superstition.

Norwegian pharmacists are trained at the Pharmaceutical Institute at the University of Oslo. An applicant for admission must have the five-year gymnasium degree. From 25 to 30 students are admitted each year on a competitive basis.

75. *Id.* at 20, 52-56.

The course of study takes four and one-half years, but there is a proposal to extend it to five years. The course is divided into three parts of 18 months each. During the second part students are given practical training in a pharmacy and are then paid 100 kroner a month. There is no charge for tuition, and only a small charge for examinations. After successful completion of the general examination at the end of the second part, students are qualified to serve as a clerk in any pharmacy.

There is a serious shortage of druggists and pharmacists in Norway. In the fall of 1958 there were only 28 new students at the Pharmaceutical Institute, only one man among them, although it had been hoped that there would be 40 new students. There has been much talk of reducing the training period from four and one-half years to three. There is a severe shortage of druggists in rural areas. There is need in Oslo for some drug stores to be open all night, and some to be open until nine in the evening.

There were 275 full-fledged pharmacies in Norway in 1957, and about 740 small retail dispensaries in other kinds of stores where simpler prepared medicines can be bought. A considerable number of pharmacies in the rural areas have very little business, but are assisted by reduced taxes. The central government decides at what place and at what time a new pharmacy may be opened, and who may have the license for it. The effort is to give the license to the best pharmaceutical chemist available. But once the license is granted the pharmacist operates his store as a private business until he reaches seventy, the retirement age. In 1956 there were about 1,200 licensed pharmaceutical chemists, about 400 candidates completing their training on duty, and a technical personnel of about 1,500 such as assistants and laboratory technicians.

Pharmaceutical sales have increased greatly in recent years. In 1939-1940 they amounted to only 30 million kroner; in 1954-1955 to 100 million kroner. In 1954 a little over one-fifth of the drugs sold were produced in Norway. To prevent sick persons from having to spend large amounts for drugs, the central government limits retail ceiling prices as well as the profit allowed on the sale of drugs. Advertising of drugs and medical preparations is strictly controlled by the government and Norwegian regulatory laws go further than those of most countries. The consumer can obtain reliable products

at prices lower than in most countries. The number of registered drugs and preparations has been kept down to 1,300, thus simplifying matters for both the phamacists and the public. In many other countries there may be as many as 20 or 30 thousand items.

6. Workmen's Compensation Cases.

A sixth benefit is necessary drugs, dressings, etc., for workmen's compensation cases. These are given free.

7. Free Hospital Care.

The seventh benefit of Norwegian health insurance is free hospital care.[76] Such care is given for as long a time as the patient needs it. Surgery, x-ray or other treatment, medicine and bandages, and care by members of the hospital staff are paid for in full by the insurance if the hospital is publicly owned, and most Norwegian hospitals are publicly owned. If the patient goes to a privately owned hospital, he must pay the difference himself. Where hospitalization is for one of a few long lasting sicknesses, such as tuberculosis, mental illness, feeble-mindedness, epilepsy, arthritis, and poliomyelitis, expenses are not paid by the health insurance nor by the patient, but by the public authorities under special laws. Under these laws the central government pays 40 percent and the county of residence 60.

Alcoholism is regarded as a sickness and entitled to medical care and rehabilitation under the health insurance program. When alcoholics are sent to supervised homes maintained by a private organization, the Blue Cross, the health insurance program pays a good part of the rate as a preventive measure. When alcoholics are sent by the local temperance committee to a sanatorium for treatment, care is paid for under the health insurance system as for other hospitals, and families of patients are eligible for cash allowances.

Every patient receives equal treatment and the same food and care. One cannot obtain a private room, a private nurse, or special food merely by paying more for it. There are many single and double rooms, and these rooms are assigned according to medical need. Those who are most sick or are dying get the private rooms and special care. The newer hospitals have abandoned large common wards, and maintain smaller rooms for all.

76. *Id.* at 18-19, 35-42.

About 80 percent of all hospital beds and a large majority of hospitals are owned and operated by the central government, the counties, and the communes. Each is free to build what hospitals it wishes, but by long-standing custom the central government assumes responsibility for hospitals for tuberculosis and mental diseases, and for the university clinics; the counties build large central hospitals, and the communes smaller local hospitals. Voluntary health organizations, operating as non-profit institutions, maintain 20 percent of hospital beds.

The Norwegian hospitals are thought by the Norwegians themselves to be overcrowded, and many isolated communities have no hospitals at all.[77] In 1956 there were nearly nine hospital beds per thousand inhabitants, of which 2.1 per thousand were in mental hospitals, 1.3 for tubercular patients, and the other 5.5 in other hospitals, mostly general. Since more beds are needed for general hospital care, many hospitals are now being enlarged and others are being built so that the need should be met within a few years. The lack of space in mental hospitals is the most serious medical problem in Norway, and will take a good deal longer to solve. Since 1932 all plans for building a new hospital of any type must meet the approval of the Directorate of Health Services. Hospitals costing over 300 million kroner are now being built, and will provide 6,000 beds at an average expense of 50,000 kroner per bed.

In the new hospitals stress is laid on flexible division into wards so that the same beds can be assigned to different uses as the need arises. There is also emphasis on out-patient departments for ambulatory patients, thus reducing the need for hospital beds. Emphasis is also given to rehabilitation. The larger and some of the smaller hospitals participate in the teaching of medical students and nurses, and give post-graduate training through short-term appointments for physicians who desire to improve their knowledge of a special field. The laboratories of the larger hospitals engage in important medical research. New drugs and medical equipment are tested.

It costs about 300 million kroner a year to operate the Norwegian hospitals, which have two main sources of income: the health insurance program and direct appropriations to hos-

77. *Id.* at 10.

pitals for tubercular patients, mentally ill, feebleminded and epileptics. Ceilings on hospital charges are fixed by the Ministry for Salaries and Prices. If these fail to cover costs, the hospital owner must make up the difference. The highest rates per day allowed in 1957 were as follows: 33 kroner in hospitals in Class I; 25 in Class II; and 20 in Class III. Classification of hospitals is by the Director-General of Health Services, according to size, equipment, and treatment available. On the whole operation costs are lower than in many other countries. There is some debate in Norway as to whether the health insurance ought to pay all hospital costs, or whether the hospital owner should continue to pay part, and if so, how much.

It has been asserted that health insurance pays inadequately for x-ray treatments given in hospitals so that the costs are largely shoved over on the hospitals instead of on the health insurance. Such a complaint was made in 1958 by Dr. Otto Harsem of the x-ray division of the St. Francis Hospital at Hønefoss.

In 1954 the largest item of health insurance costs was for hospitalization, the second for daily cash benefits, the third for medical care, the fourth for travel expenses, the fifth for maternity aid, the sixth for physical therapy, the seventh for burial aid, the eighth for dental, and the ninth for drugs and medicines.[78] Norway, like Iceland, endeavors to have the health insurance pay a considerable proportion of actual hospital costs. Norway, unlike England,[79] has gone ahead vigorously in the construction of new hospitals despite heavy costs. In 1957 the expenditures in order of amount in Trondheim were for hospitalization (40 percent), daily cash benefits (28 percent), medical care (15 percent), maternity care, burials, and medicines. Lesser amounts were spent for dental care, expensive medicines and orthopedic aids.

Hospital doctors constitute about 30 percent of all Norwegian doctors. The proportion of such doctors has been increasing because of reduced hours of service, construction of many new hospitals, the development of new specialties, and the giving of more intensive treatment to hospital patients. Most hospital doctors work full time at a regular salary. The superintendent has permanent tenure and the other doctors have

78. SAMORDNAD, *supra* note 23, at 46.
79. It has been asserted that in the first ten years of the present English program no new hospitals were built. Chicago Tribune, Dec. 15, 1957, pt. 1, p. 11.

tenure in proportion to the importance of their posts. Procedure for filling senior staff vacancies is such as to secure the most competent men. First, announcement of the vacancy is made. All doctors seeking the post submit applications to the Directorate of Health Services. The Director-General nominates three, listing them in preferential order. The list is based on medical qualifications only, such as degrees, post-graduate training, experience, research, and publications. If the Director-General is in doubt, he may consult with an advisory committee of three colleagues elected at regular intervals by the appropriate specialist branch of the Norwegian Medical Association. The list of three nominees is then sent to the hospital management board. That board may take into account personality and administrative ability. If the board chose an applicant not on the list, the Norwegian Medical Association would advise such doctor to refuse the offer. If the applicant accepted anyway, he would be automatically excluded from the Association. Consequently the accepted procedure is almost always followed.

For state-owned hospitals salary rates of doctors are negotiated between the Norwegian Medical Association and the Ministry of Salaries and Prices, with public health authorities sitting in as technical experts. Salaries in other hospitals are negotiated between the Medical Association and the hospital owners, having the results reached in State hospitals before them. Some of the specialists in higher posts in hospitals are given the right to take private practice outside the hospital in addition to their staff work.

The value of using only hospital doctors during a hospital stay is that the hospital doctors and nurses, from long working together, make up a well-coordinated team with valuable experience in treating all kinds of cases. Such doctors often are connected with the teaching of medical and nursing students and post-graduate training. A few private hospitals permit the private practitioner to continue treatment of the patient in the hospital. But the tendency in the private hospitals is towards adopting the system of the public hospitals. The present English system is like the Scandinavian in handing the hospital patient over to the hospital doctors.

Intensified hospital treatment has reduced the average stay of a Norwegian patient from 30 days per patient in 1938 to 20 in 1957.

8. Rehabilitation Benefits.

An eighth benefit is maintenance and treatment in an approved rehabilitation center in accordance with the regulations and scale of changes prescribed by the Ministry. This benefit is given if it takes the place of an otherwise necessary hospitalization or if it may be expected to improve the working ability of the insured. Usually the benefit is not given for more than 12 months, and by July, 1956, it stood at 20 kroner a day minus what the insured pays himself because he has income from work. If the maintenance and treatment are given under another law and program, the health insurance fund need not pay for it. In effect, expenses of rehabilitation of the physically handicapped are paid for partly through the health insurance program and partly by the central government under laws on assistance to the physically handicapped.

9. Transportation Allowances.

A ninth benefit is transportation allowances. In rural areas this may be very important since the trip to the doctor or hospital may cost much more than the treatment or consultation. All travel expenses are refunded if the doctor certifies that the trip was necessary. If the patient is unable to travel, the travel expenses of the doctor to the patient will be paid. The same rule applies to dental and physiotherapeutic treatment and maternity cases.

10. Refund of Expenses.

A tenth benefit is a refund of expenses incurred for sending a patient home in connection with injuries or illnesses under the workmen's compensation laws.

11. Payment for Accommodations.

An eleventh benefit is payment for accommodations during necessary ambulatory medical or physiotherapeutic treatment and in the event of confinement away from the place of residence, under regulations and a scale of charges prescribed by the National Insurance Institution. The previous consent of the health insurance office must be obtained. In 1956, seven kroner per day was paid for food from the fourth day after the doctor was consulted at the place of stay. Eight kroner per night was paid for lodging during the same interval.

12. Funeral Benefits.

A twelfth benefit is a funeral allowance. 300 kroner is paid at the death of a member or a family member, but the person claiming the funeral grant must report the member's death to the insurance fund within one month.

13. Maternity Benefits.

A thirteenth benefit is maternity benefits. The cost of services of a midwife are paid for, as well as those of a physician. Free nursing and treatment in a public maternity home may be provided at the time of confinement in lieu of the services of a midwife and a physician. There is also a refund of necessary expenses for travel to or from the physician, the hospital, or the maternity home. There is also a refund for food and lodging in the event of confinement away from the place of residence, under regulations and a scale of charges prescribed by the National Insurance Institution. The payments commence from the date the woman came to the present location and run to the time she enters the maternity home or hospital; and ten days is the maximum period. Seven kroner a day for food and eight for lodging are paid. Cash maternity benefits are also payable. A member who is entitled to daily cash sickness benefits shall be paid a maternity benefit for a period of 12 weeks, including a period at least six weeks after confinement. The maternity cash benefit is the same as the daily cash sickness benefit in amount and is paid for each day except Sundays. If the woman is staying in a hospital or maternity home she receives but one-third of the regular cash benefit with supplementary benefits if she maintains a spouse or children under 18 who are insured as family members. These supplements are the same as for daily cash sickness benefits during a stay in a hospital. No cash maternity benefit is payable unless the woman, during the ten months last preceding confinement, was insured as a member in a class qualifying for cash sickness benefit. Any interruption of eight weeks or less in the ten months shall be disregarded if the woman was insured uninterruptedly for the first two months. Where it is reasonable to do so, the National Insurance Institution may waive such conditions. Members who are insured merely as family members receive a grant of 150 kroner. The same is true as to members insured as independent members who do not meet all the qualifications so as to receive the weekly benefits. The grant is not payable if the

insured person is admitted to a maternity home and the insurance fund pays the cost of maintenance in such home.

Under a 1915 law the commune of residence must give financial assistance for six weeks before delivery if the woman lacks a means of livelihood, and for three months after delivery (or in special cases up to six months) if the mother would otherwise have to give up her baby. Assistance before delivery is given to a married mother only if her husband is dead or has deserted her. Many communes, including about half the population of the country, have set up a system of economic aid to single mothers. Parliament is now considering expansion of aid to pregnant women and mothers, not only in the form of money, but also in practical, legal, and social advice and assistance.

Two schools for education of midwives are maintained in Norway, one at Oslo which can take 25 students a year and one at Bergen which can take 50. To be admitted one must have completed nurses' training and be between 22 and 35. The training lasts one year. Students receive 130 kroner a month, and free board and room. Until a generation ago most births took place in private homes and because of lack of hospitals and long distances midwives were necessary. But now 80 percent of births occur in hospitals or maternity clinics. Consequently the number of public midwivery districts has gone down from 1,100 to 800, and is still declining. The public midwives receive a salary from the state, and, in addition, a fee for each delivery paid for by the health insurance, though originally by the patient.

Norway has one of the lowest mortality rates from diseases of pregnancy and childbirth with a 1954 death rate of only six per thousand births. Norway also has one of the lowest infant mortality rates during the first year after birth; in 1954 it was 21.4 per thousand born alive.

14. Daily Cash Benefits.

A fourteenth benefit is daily cash benefits.[80] These are payable to three groups: (1) members insured as employed persons; (2) members insured as non-employed persons who have taken out supplementary insurance for cash benefits; and (3) insured persons who sustain an injury or contract a disease covered by the workmen's compensation law. Per-

80. See Sections 41-51 of the Norwegian statute; EVANG, *supra* note 62, at 21-23.

sons covered by the Act of February 15, 1918, on civil service are not entitled to such benefits. Persons who are employed in the service of the State, a commune, or a country, and who are guaranteed full pay during sickness for at least three months, but are not covered by the Civil Service Act, are entitled to cash benefits after they have received sick pay for three months.

Daily cash benefits are not automatically payable to all premium paying members of whom there are two kinds: (1) those who work in the employment of others, and (2) those who are self-employed, students, retired on pensions, etc. Until July, 1956, the former were compulsory members of the insurance, while the latter were allowed to join as volunteers; since that date all are compulsory members. Premiums for medical care, as distinguished from cash benefits, are now the same for both groups, graduated according to income below a certain level. But the second group are not entitled to cash benefits unless they have an earned income of at least 1,000 kroner a year, pay a small extra premium on a voluntary basis for the cash benefit, and were in good health on taking out such supplementary insurance.

Employed persons who earn less than 1,000 kroner are not insured as employed persons and do not make contributions as employed persons under Section 8 of the Norwegian act; they do not receive daily cash benefits as employed persons under section 41, or as non-employed persons under section 61, as they may not take out supplementary insurance for cash benefits.

Daily cash benefits may be paid on two theories. One is that of minimal existence; the other that of loss of income. The Norwegian and Swedish systems are based on the latter concept. The former system is simple and involves payment of the same amount to all; the latter is complex, but results in more effective insurance. The amount of the daily cash benefits should be related to the number of dependents the insured has, and this is the case under the Norwegian and Swedish systems.

In Norway prior to the 1956 statute, insured workers were grouped into five classes with allowances ranging up to 6 kroner, the latter amount payable to those earning 4,500 kroner a year.[81] This was supplemented by two kroner a day

81. FREEDOM AND WELFARE, *supra* note 7, at 408.

to a married person and one krone a day for each child under sixteen. No member could receive more than 12 kroner a day or 90 percent of his normal earnings. The average benefit paid was 5.5 kroner, which was less than the daily allowance for unemployment insurance.

Under the 1956 law, as amended by Act No. 11 of June 28, 1957, there are now seven classes with respect to daily cash benefits. For persons with annual income from 1,000 and 2,000 kroner, the benefit is three kroner; from 2,000 to 4,000 kroner, five kroner; from 4,000 to 6,000 kroner, seven kroner; from 6,000 to 8,000 kroner, 9 kroner; from 8,000 to 11,000 kroner, 11 kroner; from 11,000 to 14,000 kroner, 13 kroner; over 14,000 kroner, 15 kroner. In the case of an injury or disease covered by the workmen's compensation act for industrial workers, the rate of sickness benefit shall be that for the class determined by the person's earned income at the time of the injury, but shall not be less than that prescribed for the second class; as to seamen the rate shall not be less than that prescribed for the seventh class. In the case of persons who are maintaining a spouse or children under 18 who are insured as family members, 2 kroner is paid each day for each dependent. If the sick person lives with a spouse who is permanently incapacitated for work, or has no spouse and lives with a child for whom a supplement is paid, the cash benefit is supplemented by 2 kroner a day for home help. Thus, the Norwegian trend has been to make the daily cash benefits depend on the amount of income, and to increase the amount paid to dependents. Prior to 1957 there had been five instead of seven income classes, and the first dependent received two kroner but other dependents only one krone. These seven classes also determine the amount of contributions to be paid by members. If the family bread winner goes to the hospital, his own sickness benefit is reduced since his food and lodging are provided by the hospital. But as to his dependents the cash benefit paid to him on their behalf continues so that they may meet expenses such as rent. A member who is in the hospital receives cash benefits at one-third of the rate paid if he were not in the hospital. In the case of such a member who has dependents of the kind described above the cash benefit is to be supplemented while he is in the hospital at the following rates: one-third of the rate for non-hospital sick though at least 2 kroner for the first dependent, 2 kroner each for the other dependents, and 2 kroner for house help as mentioned

above. A member who has no dependents shall not be paid a cash benefit while he is in receipt of sick pay prescribed by law during a stay in the hospital.

By an agreement between the national labor organization and the employees' association effective in 1957, provision is made for supplementary daily cash benefits to employees to be paid for by employees and employers. Something like 30 percent of all employees will benefit by this agreement judging by the statistics of the Trondheim health insurance office.

Under section 43 of the statute, the insured person must be incapacitated for work by sickness to be entitled to a daily cash benefit. One is incapacitated for work if the illness has caused a total loss of working capacity, or if the doctor certifies that treatment of the disease makes it necessary for the person to stop working. Under section 49 a person applying for a daily cash benefit must prove by medical certificate that he is incapacitated for work. The certificate is given by the attending practitioner on request and without special payment from the insured person.

A member who is insured as an employed person is not entitled to a cash sickness benefit as to an illness that developed before he was so insured for 14 days. One insured as a non-employed person who has contributed for cash benefits is not entitled to such benefit for an illness that developed during the first six weeks after the date on which the insurance fund received his application unless the illness is caused by an accident or unless he had been insured immediately before taking out the supplementary insurance as an employee for three months or more without interruption.

No cash benefits are payable for the first three days of illness. This prevents the beneficiary from abusing the system and keeps expenditures down. Thereafter, on certification of the doctor benefits are paid for each work day lost, excluding Sundays. A non-employed person who contributes for cash benefits has an option as to when cash benefits start. He may have them start after a waiting period of three days, as in the case of employed persons, or after 90 days. In the latter case he pays a much lower weekly rate, about one-third of the rate he would pay if the waiting period were three days.

Cash benefits are payable up to 52 weeks for any one ordinary illness and up to 104 for a group of long illnesses. After the time limit has run out no further cash benefits may be paid for the same illness until after the beneficiary

has been fit for work for at least 52 weeks.[82] For a few illnesses, such as tubercular diseases, cancer, chronic polyarthritis, and poliomyelitis, the cash benefit may be paid for two years and by regulations for an unlimited time as long as the patient is under curative treatment. Cash benefits are exempt from taxes. Cash benefits are not payable to dependents, but the amount paid to the insured takes account of the dependents. If an insured person receives full pay during an illness, the employer is entitled to the sickness cash benefit or to deduct the value from the wage.

Where an insured person is only partially incapacitated for work the insurance fund may pay half sickness cash benefits. Such benefits and income earned by an insured person when he is sick shall not in the aggregate exceed 90 percent of the income on the basis of which he was classified when the illness began. Norway and Sweden are the only Scandinavian countries which make provision for half sickness cash benefits.

The Norwegian experience has been that relatively few persons who are not really sick seek payment of daily cash benefits. Isolated cases do occur in which a doctor has been lax in granting a sickness certificate. Such a case arose in the Oslo Municipal Court in September, 1958. The doctor had given improper certificates to four persons. The health insurance officials check such cases and report them to the police, and the improper recipients and the doctor are both subject to legal proceedings. The control system of the health insurance organization and the police can be relied on to prevent any considerable amount of fraud. A control physician examines rather closely each year about 10,000 applications for health insurance, but only a few genuine cases of fraud are discovered. However, there will always be some asocial persons who will accept a position, apply for sickness benefits a short time later, and then spend the money for liquor.

Under consideration in Norway is a proposal that health insurance pay for nursing at home.[83] During the fiscal year 1955-1956, the Norwegians spent 30 million kroner for home nursing. Under Section 31 of the Norwegian statute the Ministry of Social Affairs may decide that insured persons shall

82. As of February 1959 there was pending in the Norwegian Parliament a proposal to establish disability insurance. Such insurance would presumably take care of most persons ill longer than a year.
83. EVANG, *supra* note 62, at 21.

be paid a home nursing allowance in accordance with the regulations and scale of charges that it shall prescribe.

In 1954, 9,525 fully trained registered nurses were on active duty in Norway, or one for every 356 inhabitants.[84] Thus, Norway was second only to Denmark among the Scandinavian states in the proportion of nurses to population. There were 6,597 nurses in the hospitals, and 2,928 working independently or in the government service. If registered nurses not in service are counted, the total is 13,150, or one for every 260 persons. But the Norwegians do not regard this relatively high number as adequate because of the high standards of medical treatment, the emphasis in hospitals on intensive care, and the fact that the entire population is insured and makes full use of health facilities.[85] It follows that there is supplementation by a considerable number of other helpers who have not had full nursing preparation.

A woman who chooses nursing as her career in Norway must be between 19 and 30, and have a wide general knowledge, preferably with a degree from a three-year gymnasium, but at least one year's education beyond elementary school. The Ministry of Social Affairs must approve the schools and their curricula. There are 28 nursing schools, and about one thousand students commence training each year. The course takes three years, and is concluded by a comprehensive standardized examination given at the same time on the same day in all the schools. While in training, students are paid from 90 to 180 kroner a month, together with board and room, laundry, and free instruction.

E. *Sweden*

Prior to 1955 the benefits[86] under the Swedish system were as follows: Two-thirds of doctors' fees were paid. Free hospital care was given. Maternity help was supplied to members as a compulsory benefit. Some funds voluntarily paid for medicines and for medical baths, massage, electric and light treatment. Some dental care given at the central dental clinic, dental school or general hospital was paid for. But no burial assistance was given. A small amount was paid for travel expenses. Daily cash benefits were paid, and this was the chief item of expenditure. In 1954 the largest expenditure item was

84. SAMORDNAD, *supra* note 23, at 51.
85. EVANG, *supra* note 62, at 43.
86. SAMORDNAD, *supra* note 23, at 51.

for daily cash benefits, the second for medical care, the third for hospitalization, the fourth for medicine and drugs, the fifth for maternity aid, the sixth for physical therapy, the seventh for travel expenses, and the eighth for dental care.[87]

All members are now insured for medical care. Benefits consist of refunds on expenditures for (1) doctor's care, (2) hospital care, (3) travel necessary to get such care, and (4) prescribed medicines.[88] According to law, the funds may also give additional medical benefits, but they are not obliged to do so.

Patients first pay the doctor's fee out of their own pockets, after which they are reimbursed up to three-fourths by the public sickness funds. Doctors are not required to abide by the fee rates laid down as to reimbursement, but most of them do so in actual practice. As before, the patient may choose his own doctor. Three-fourths of the doctor's travelling expenses are paid by the health insurance system. The period during which doctor's fees are payable is not limited as in the case of hospital treatment. Prior to 1955 only two-thirds of the doctor's bills were paid. Since the specified fees were too low, particularly in the cities, an effort was made under the new plan to raise these specified fees to conform with the existing economic situation. But a number of private doctors in the cities charge higher fees. It should be noted that if the physician charges a lower fee, the patient is reimbursed only for three-fourths of what he actually paid. If the patient goes to a public medical officer, such officer may charge only the relatively low fees laid down in another schedule. From January 1, 1956, assistance may be obtained as to medical service received outside of Sweden, but special regulations are applicable.

Health insurance is coordinated with workmen's compensation in Sweden. During the first 90 days, a person's injuries are equated with illness. If his incapacity extends beyond 90 days, the case is transferred to workmen's compensation. Since most injuries terminate before 90 days, this coordination averts many of the inconveniences and annoyances that used to develop in determining whether or not an injury or disease was subject to the provisions of the workmen's compensation law. It was often hard to determine whether such maladies as rheumatism and eczema were occupational or not.

87. *Id.* at 46.
88. TEGNER, SOCIAL SECURITY IN SWEDEN 72-73 (1956); MICHANEK, SJUKFÖRSÄKRING FÖR ALLA (1955).

Likewise, it was often hard to determine whether the injured person was employed and so eligible for workmen's compensation or whether he was self-employed and therefore not eligible. Workmen's compensation now does little but give out life annuities in cases of invalidism and survivor's benefits in cases where death ensues. Some slight disadvantages are now suffered by those who formerly could get workmen's compensation. Thus, there is a three-day waiting period, whereas formerly workmen's compensation daily benefits were paid from the day after the accident occurred, provided that more than two full days of illness resulted from the accident. The insured must now pay a small part of doctor's bills, medicines, and transportation expenses, whereas formerly he paid nothing. However, after 90 days the insured receives the workmen's compensation rates, and does not suffer the reduction that occurs in health insurance daily benefits. In Sweden ordinary illnesses are six times more frequent than sicknesses resulting from injuries in employment.

In 1956 Sweden had 5,800 doctors or one for every 1,320 inhabitants. There are 600 public medical officers who are on state salaries. They also treat private patients at a very low rate fixed by the state.[89]

Counting total personnel trained for medical care, including physicians, nurses, midwives, and assistants, Sweden has the highest number in the world: 8,063 per million people in 1955.[90] In contrast, Denmark in 1958 had 4,664, Norway in 1958 had 4,195, Iceland in 1951 had 4,076, and Finland in 1955 had 3,784. The United States in 1955 had 6,338.

As of 1955 the average income of Swedish physicians was from $5,000 to $6,000 a year. At the same time the average English physician earned about $6,272 a year.

Swedish doctors are not opposed to compulsory health insurance.[91] They may differ as to details and as to how the system may be improved, but they believe in the concept of insurance, and object to the use of the term "socialized medicine" as misleading. Since one does not refer to free public schools as "socialized education," it seems unfair to refer to health insurance as "socialized medicine."

89. TEGNER, *supra* note 88, at 42. In 1954 there were 5,433 doctors, of whom 2,898 were in hospitals, 878 in the government service, and 1,657 in private practice. SAMORDNAD, *supra* note 23, at 51.

90. *Prognosen rörande sjukvårdsbehovet m. m.*, p. 48 of reprint from SVENSKA LÄKARTIDNINGEN 1958, 55:2821 (No. 41).

91. SHIREN, THE CHALLENGE OF SCANDINAVIA 145 (1955).

The Swedish Medical Association is very critical of the importation of foreign physicians from countries outside Scandinavia. They point out that there must be intimate contact between doctor and patient and that this is very difficult if not impossible when the physician comes from a wholly different culture. Many such physicians come from Austria and are used as district physicians in rural areas or as psychiatrists. But as of 1958 fewer Austrian doctors were willing to go to Sweden. In that year 55 doctors were sought; only 80 applied and 35 were accepted, compared with a previous year in which 200 applied and 45 were accepted. On coming to Sweden they are first given a month's training in the Swedish language. The Swedish Medical Association pointed out that of the first group of 45 Austrian physicians only 8 went into the country areas while 37 became associated with city hospitals. During the decade 1930-1940 there had been a great oversupply of doctors in Sweden. However, existing high taxes, building restrictions, and the shortage of nurses make it difficult to plan for a much higher number of doctors. The Swedish medical schools are increasing the size of their student bodies substantially, so that by 1962 there will be no shortage of doctors. If the Swedish medical schools accept too many students the quality of medical development will go down, since they do not have the resources and the teaching staff to take care of more students.

On the other hand it has been pointed out that there are now 500 medical vacancies which are filled by foreign physicians.[92] There are insufficient physicians in the rural areas and for mental cases. There are not enough district physicians, and several serve as many as three districts. Forty percent of the physicians' posts in mental institutions are vacant. Sweden has fewer physicians per thousand than any other advanced country except Finland. The Swedish Medical Association nevertheless has favored a decrease in the number of Swedish medical students. A conservative newspaper has asserted that the Swedish Medical Association is concerned chiefly about maintenance of its high income and has little concern for the public welfare. Professor Stan Friberg of the University of Stockholm Medical School asserted in 1958 that

92. See STERNER, *Läkarfunfundet och lakärbristen*, TIDEN, July 1958, p. 396. The American Medical Association has also sometimes fought an increase in the number of physicians. Note, 63 YALE L. J. 938, 971 (1954).

there is no risk of over-production of doctors during the next quarter of a century. More doctors are needed for hospitals and for research, for rural areas, and in psychiatry, according to the Swedish Director of Insurance, Richard Sterner. More and better care for the aged and for children must be developed, as well as other specialties. If the long working hours of doctors are to be reduced, more doctors will be required.

In 1954 an editorial in the New York Times concluded as to Sweden that the "quality of medical care is high and the hospitals compare favorably with ours .... If a high expectancy of life at birth and the lowest infant mortality rate in the world mean anything the Swedes are a healthy people." Waldemar Kaempffert, science editor of the New York Times who visited Sweden, concluded that "the quality of medical care, whether rendered in a physician's office, at home or in a hospital" is "as high as and possibly higher on the average than ours." Swedish experience shows that a nation can have compulsory health insurance, "yet guarantee the best kind of medical care."

The present Swedish system of health insurance was not adopted with political unanimity. The conservatives wished for postponement on the ground that the time was not ripe and that the country's medical facilities would be over taxed. In reply it was pointed out that the daily cash benefits were of the greatest importance in the new reform, and would promote economic security. The various health insurance benefits were sufficiently modest so that there would not be a run on doctors' offices and pharmacies; or on hospitals as hospital charges had been moderate in the past. The number of hospitals and doctors could be increased to meet the needs of the people.

Just before the 1955 law went into effect, some Swedish physicians feared that their work would be doubled or tripled, and that they would have to spend much time filling out forms. But the majority of practitioners adopted a wait-and-see attitude. As of the present moment Swedish doctors on the whole seem to feel that the 1955 law is working very well and that the doctors have not been overwhelmed with work or red tape.

1. General Benefits.

Swedish patients pay nothing for beds in wards in public

hospitals. The benefit is paid for a period not exceeding two years for each illness. For a person in receipt of the national pension and for a national pensioner under 67 who is not gainfully employed, the maximum period is 90 days for each illness. There are proposals pending to extend this to 180 days.

Sweden has about the same number of hospital beds per 10,000 population as the United States. In 1954 there were 704 beds per 100,000 inhabitants in Sweden, 673 in Iceland, 542 in Denmark, 508 in Norway, and 339 in Finland.[93] Average daily operating expenditures of a Swedish general hospital run to 45 kronor or $8.55 per patient.

As in other countries the supply of nurses is inadequate because of long hours and low pay. But plans are being made to establish a 45 hour week for nurses in Sweden. In 1954 Sweden had one nurse per 468 inhabitants compared with one for 326 in Denmark and one for 356 in Norway.[94]

On his first visit to a doctor, the patient must bear all costs for travel under four kronor. If his travel cost exceeds that amount, the health insurance society refunds three-fourths of the excess. When there are additional visits for the same illness, the patient is reimbursed for three-fourths of travel costs over one krona. But he is never required to bear expenses over two kronor for such additional visits. If he goes to a hospital he is compensated in full for his travel costs to the hospital, while the costs of his return from the hospital in excess of four kronor are fully compensated. If an attendant is required, his travelling expenses are also paid. By and large, the travel benefits are new, since the old system usually granted compensation only for transportation to a hospital. A number of other nations pay transportation expenses.

Compensation for the costs of medicine is provided for by a Royal Decree of 1954. The patient pays nothing in cases of certain chronic and serious diseases of a protracted nature such as asthma, cancer, diabetes, epilepsy, and tuberculosis. The patient is given a special card entitling him to free medicine. As to most other medicines, the purchaser pays the first three kronor, and is reimbursed for 50 percent of any amount above that price. A doctor's prescription must be presented. If a doctor's prescription calls for a number of medicines, price cuts are computed on each medicine and

93. SAMORDNAD, *supra* note 23, at 52.
94. *Id.* at 51.

not on the total cost, that is to say, the purchaser must pay the first three kronor on each medicine. Even if the same medicine is involved, if there are several kronor of purchase, price reductions are computed on each purchase separately. Pharmacists deduct the proper amount from the price at the time purchase is made, and send a statement to the National Health Insurance Office so that they in turn may be reimbursed. Most of the cost is covered by member contribution to the health insurance plan, but a government subsidy is also available. No cost reduction is given on such things as tonics and bandages, even if they are prescribed by a doctor.

Under the Swedish system an insured is compensated for three-fourths of the costs of therapeutic gymnastics and massage, as well as the shortwave, diathermic and other heat treatment connected with such therapy. The health insurance law does not require the giving of such benefits, but permits a health society to give them with the consent of the National Health Insurance Office. The health insurance societies have decided to give such benefits, and have secured the approval of the National Health Insurance Office. Benefits are given on a written notice from a doctor that the treatment is necessary. No compensation is given for travel costs.

The law permits, but does not require, the health insurance societies to give convalescent care. The health insurance societies have decided to give such care, and have secured the approval of the National Health Insurance Office. A doctor's order is necessary. No travel costs are paid. A number of other nations make provision for home-nursing services.

The law permits, but does not require, the health insurance societies to give speech therapy. The health insurance societies have decided to give such treatment, and have secured the consent of the National Health Insurance Office. Written notice from a doctor that the care is necessary is required. Travel costs are not paid.

While funeral benefits are paid in Denmark and Norway, none are paid in Sweden and Iceland. Most social insurance systems in other countries provide for some kind of funeral benefit, commonly payable under the health insurance program.

2. Dental Care Benefits.

There is no compensation for ordinary dental work. But compensation may be given for special dental work carried out at a central dental polyclinic, a school of dentistry, or a general hospital.

There is one dentist for each 1,750 inhabitants in Sweden, for each 1,762 in Norway, for each 2,350 in Denmark, for each 2,780 in Finland, and for each 3,956 in Iceland.[95] Sweden, like Norway, has the largest number of dentists in proportion to its population of any country in the world. In 1954 there were 4,139 dentists, of whom 375 came from other countries.

About 250,000,000 kronor a year is spent in Sweden for dentists' bills.[96] In order to insure adequate and reasonably priced dental care for the whole population, and for children in particular, a national dental service was organized in 1938. The service is administered locally by county councils together with municipalities and towns. Most of the dentists in the service are employed in district clinics. Others are in central clinics, of which there is one in each county. These clinics handle the more difficult cases. The National Dental Service gives treatment free of charge to all children between 3 and 15. There are 520 clinics, and they employ 1,100 dentists, or about one-fourth of all dentists in Sweden. In 1956 the clinics treated 650,000 children. It costs about 50,000,000 kronor a year to run the National Dental Service.

In 1954 dental care was available to 94 percent of Swedish school children,[97] and in 1954 about two-thirds of those to whom it was available made use of it. No charges are made as to children up to 16, and children between 16 and 19 are charged a low rate. Dental care is available to adults at low rates, while poor persons may get aid from the commune. Women receiving maternal aid are given dental care. In 1954 the costs of the Swedish Dental Service were borne as follows: 15 percent from the State, 33 percent from the patients, and 52 percent from the counties and communes.

3. Maternity Benefits.

The great majority of nations having health insurance legislation provide cash and medical maternity benefits. In Sweden maternity benefits are provided for under a special

95. *Id.* at 58.
96. TEGNER, *supra* note 88, at 52.
97. SAMORDNAD, *supra* note 23, at 58.

law, but are financed as part of the obligatory health insurance system. The annual cost is estimated at 52 million kronor. More than 95 percent of all Swedish births are in hospitals.

All Swedish women are registered for maternity insurance.[98] Gainfully employed mothers receive maternity cash benefits corresponding to cash benefits for sickness. A mother is reimbursed for the actual costs of delivery in accordance with the same regulations which apply to illness. There are free midwives' services, free confinement, and travelling allowance. But otherwise pregnancy and illness are sharply distinguished. There are two kinds of maternity cash allowances: a fixed basic allowance, and a running supplementary allowance. All women are entitled to the basic allowance of 270 kronor, half of which is payable three months before confinement and the other half immediately after birth. A mother who already has a child under ten living at home receives an additional 20 kronor.

A gainfully employed mother earning at least 1,800 kronor a year is compulsorily insured, and receives in addition to the above daily cash maternity benefits a daily cash benefit, provided she has been insured for at least 270 days or the whole period of her pregnancy. This benefit gives her the amount she would have received during an ordinary illness, but three kronor of this benefit are included in the basic maternity grant for which all women are eligible. Thus the benefit will vary from one to 17 kronor depending on her income. It is paid only if the period of leave from employment is taken without interruption, and is limited to 90 days. Payments may begin, at the earliest, 45 days before confinement is expected, and, at the latest, the day of delivery. The benefits will usually amount to two-thirds of her normal income.

Women who are merely voluntarily insured for additional daily benefits within the health insurance plan, as self-employed or housewives, cannot obtain a corresponding daily benefit. If they were permitted this benefit, only those planning to have children would subscribe, and this would drive up the costs of insurance.

In addition to these benefits, needy mothers, whether married or unmarried, may receive maternity grants up to 600

98. TEGNER, *supra* note 88, at 75-78.

kronor after passing a means test. The money is used for equipment for mother and child, board and lodging, domestic help, etc. Application must be made not later than 60 days before childbirth, and decision rests with the local maternity assistance board.

Treatments for physical disturbances which are normal during pregnancy do not come under the health insurance system, as Sweden has special maternity clinics where such treatment is given without any charge.

4. Daily Cash Benefits.

Finally there are the daily cash benefits which are of great importance in Sweden. The advantage of adequate daily cash benefits is that it saves people from being forced to apply for poor relief during illness. While some labor contracts provided for such benefits, many employees were not covered by such contracts. It has been estimated that of all those who received poor relief before 1955, more than one-third did so because of illness. Prior to the present Swedish statute daily cash benefits were law, averaging 2.25 kronor, excluding children's supplements[99] — a higher figure than the Danish average of 1.65 kroner. Under the present Swedish statute,[100] all employed members with an earned income of 1,200 kronor or more must insure themselves for a basic allowance of three kronor a day. This also applies to married women working at home. Furthermore there are children's supplements of from one to three kronor a day. All employed persons with an earned income exceeding 1,800 kronor must secure supplementary allowances varying according to the amount of earnings from one to 17 kronor. The maximum daily allowance will thus amount to 20 kronor.

Graduation of daily benefits according to income should be and is compulsory for persons who work for an employer, but it should be and is voluntary for persons who are not employed by others. Many of the latter do not need daily compensation, especially for shorter illnesses. Since, obviously, there are no employer contributions for these people, their rates will be somewhat higher. On the Swedish theory that even they should receive some cash assistance during illness, they are entitled to three kronor a day and make a contribution for that amount. Nearly all countries which have health

99. FREEDOM AND WELFARE, *supra* note 7, at 408.
100. TEGNER, *supra* note 88, at 73-74.

insurance make provision for cash sickness benefits during illness.

Daily cash benefits are compulsory for employed persons, but not for others. Only a few countries cover self-employed persons for cash sickness benefits, in view of the difficulty of establishing that they have undergone a genuine wage loss when they are sick. But cash benefits exceeding three kronor may be obtained by farmers, artisans, shopkeepers, housewives, and students by subscribing to a voluntary plan. A housewife and a student may not insure for a greater benefit than six kronor, but the others may insure up to 20 kronor, the maximum for employed persons.

While a man must have an annual income of at least 1,200 kronor from earnings to receive daily cash benefits, cash benefits are payable to married women working at home, irrespective of income. This includes also women working at home who are judicially separated or divorced, as well as widows, if they live together with their children under 16, and applies even if husband and wife are living apart without a formal separation. Such women receive three kronor a day for the first 90 days and three kronor a day thereafter. A woman in a hospital who has children under age ten living at home receives three kronor a day with a supplementary family allowance of at least two kronor.

While under most systems of health insurance a housewife receives no daily cash benefit, in Sweden she receives a basic benefit of three kronor a day and may voluntarily insure so that she gets a total of six kronor. It is true that the housewife suffers no loss of income during illness, but the economy of the household suffers, and outside help must frequently be hired or a member of the family forced to miss work to care for the home.

Persons in receipt of retirement pensions may take out voluntary insurance for daily cash benefits, but the applicant must have been a member of a recognized sickness benefit society at the end of 1954 and not insured for cash benefits under the present law. The daily cash benefit runs from one krona to three kronor a day, depending on the choice of the applicant in large part. For persons receiving hospital treatment the cash benefit in excess of 1.5 kronor per day is reduced to 1.5 kronor. The cash benefit is not payable for longer than 90 days for each illness. The annual contribution is twelve times the sickness benefit received per day.

The Swedish system protects to a considerable extent the right to daily cash benefits of one who may be unemployed during a part of the year. Everyone insured for daily benefits is classified according to his estimated annual income. Consequently the insurance is valid for the entire year even if the individual is between positions, seasonally employed, or temporarily unemployed, and he receives the same daily cash benefits throughout the year. He is paid quickly without time-consuming investigations of his income circumstances. The insured person must notify the local office of any lasting changes in income. Employers also give notice when an employee starts and stops working for them. Tax records are also available to the local office.

A Swede who is temporarily in another country retains his right to payment of daily cash benefits. The same rule applies to other nationals who are covered by Swedish health insurance.

Daily cash benefits are paid in Sweden at a rate proportionate to the income of the patient. A basic sickness benefit of three kronor per day is paid to everybody earning at least 1,200 kronor per year from work. The average annual wage for a worker is between 8,000 and 12,000 kronor. There are 13 classes of wage-earners, and the benefits are reduced in the higher classes after the first 90 days.[100a] But in cases of workmen's compensation the sickness benefits continue at the same rate after the first 90 days until such time as they may be superseded by life annuities.

In principle daily benefits in Sweden for persons in above average income brackets is supposed to equal two-thirds of the income lost through illness. But the benefit may be more when there are children. Furthermore as the benefit is not subject to tax, the proportion will depend on the level of income

100a.

Class	*Income Bracket* (In Kroner)	*Cash Benefits (in kroner)* *First 90 Days*	*After 90 Days*
1st	1200-1800	3	3
2nd	1800-2400	4	4
3rd	2400-3000	5	4
4th	3000-3600	6	5
5th	3600-4200	7	6
6th	4200-5000	8	6
7th	5000-5800	9	7
8th	5800-6800	10	7
9th	6800-8400	12	8
10th	8400-10,200	14	9
11th	10,200-12,000	14	9
12th	12,000-14,000	18	11
13th	Above 14,000	20	12

after taxes, and taxes vary according to where one lives and whether one is single or married. A single person without children and in an average income bracket gets a daily benefit after two weeks of illness equal to about 65 percent of his income. After one month of illness, he receives more than 70 percent. If the illness lasts only one week he receives about 45 percent, due to the waiting period of three days. The lower the income level, the higher the ratio of compensation. For some families with low income and many children compensation may exceed 100 percent. But it is anticipated that such cases will be rare and will usually involve offsetting extra expenses connected with the illness. In most countries which have health insurance laws the benefit rate is between 50 and 75 percent of average earnings during the last preceding year. A considerable number of countries provide supplements to recipients who are supporting a wife or children. A number of countries reduce the usual benefit rates while beneficiaries are hospitalized, the reduction usually being greater for single persons than for those with dependents.

Children's allowances are added to the daily cash benefit for patients with children under 16. One krona a day is paid for one or two children, two kronor for three or four, and three kronor for five or more. If a child is insured through the father, the allowance is not given when the mother is ill unless she is confined to a hospital. If a parent contributes to the support of children who do not live with him, he receives a daily allowance for them while he is sick, but an allowance for the same child may not be paid to two persons at the same time.

Daily cash benefits are also payable during hospital confinement. They are reduced by three kronor a day for all but the first three classes, but cannot be reduced by more than one-half. If a person is entitled to five kronor a day, he will receive at least a benefit of 2.5 kronor; if he is insured for only three kronor, he will receive at least 1.5 kronor. Child allowances are added to these benefits just as they would be to ordinary cash benefits when the insured is sick but not hospitalized. Special rules apply to women who have children under ten years of age at home. Such mothers get at least three kronor a day and a child allowance of not less than two kronor. If she works or has many children who are insured through her, she gets a higher amount. But no mother with

children under ten at home receives less than five kronor a day while she is in the hospital.

To receive daily cash benefits the insured person must be wholly unable to work, or forbidden to work by his doctor. But if a person's capacity for work is reduced to half his normal capacity, he is entitled to receive half the daily cash benefit and half the family allowance.

There is no qualifying period for either cash or medical benefits in Sweden. In this respect the Swedish law is more generous than those of Denmark and Norway and most other nations. Nearly all health insurance programs require claimants for cash benefits, in addition to being incapacitated, to have completed some kind of a minimum qualifying period of contributions or insured employment. The purpose of such restriction is to make sure that benefits are limited only to persons who derive their livelihood from employment, and consequently to those who suffer a genuine wage loss when ill, and to secure a reasonable balance between expenditure and revenues.

Daily cash benefits do not begin until the fourth day of illness. The waiting period in most countries having health insurance varies from two to seven days. One of the chief purposes of the waiting period is to keep down benefit and administrative costs by ruling out claims for a large number of very brief illnesses during which the loss of income is small. No benefits are paid in Sweden for any day before the insured has notified his health insurance society that he is ill, unless special difficulties prevent the giving of notice. If a person gets sick within 20 days of a previous illness, daily benefits begin immediately. In the case of voluntary insurance provided under the act, it is, as a rule, possible for the insured to choose when the benefit starts: after 3, 18, 33, or 93 days.

Daily cash benefits are payable for not longer than two years for each illness. In most countries the limit is 26 weeks. Persons in receipt of retirement pensions and national pensioners under 67 who are not gainfully employed may not receive daily cash benefits for a period exceeding 90 days for each illness; there are proposals pending to extend this to 180 days. Daily cash benefits are payable for every day in the week, including Sunday.

If the insured has received daily benefits at any time during the 60 days immediately preceding an illness, the 90 day period during which unreduced benefits are paid is corre-

spondingly cut. If, for example, he has received benefits from April first through the 15th and becomes ill again by June 5th of the same year, he receives unreduced daily benefits for not more than 75 days after that date.

In general, it is possible through collective bargaining between employer and employee to receive health insurance over and beyond that provided by the health insurance legislation.

Individuals are, in general, free to take out additional health insurance with a private insurance company or an independent health insurance society. But insurance institutions are required to guard against over-insuring so that an individual's combined benefits become so large that his economic situation is better during illness than when he is well.

IV. FINANCING

Historically health insurance was financed solely or principally by individual contributions of those covered.[101] This was particularly true of systems of voluntary insurance. Increased contributions are likely to be required even in systems of compulsory insurance when daily cash benefits are differentiated according to income and where budgetary difficulties arise. In Norway contributions from the employer are collected apparently because historically the insurance system was confined to wage earners. In Finland employers contribute to the voluntary insurance system. Under the new Swedish compulsory system employers also contribute. Because the costs for hospitals are met almost entirely by the public, the public contribution to health insurance is very large. Furthermore, contributions have not always been raised except very slowly and at the same time that larger benefits were being paid; the public makes up the difference between contributions and benefits. It seems a fair statement that the problem of financing health insurance has not been regarded by the Scandinavian states as one which is overwhelming or insuperable.

In a large number of nations having health insurance employees contribute specifically for health insurance: this is true in all the Scandinavian states. In many nations the employer also contributes: this is the case in Norway and Sweden, though not in Denmark and Iceland. In Finland employers contribute substantially on a voluntary basis. In most nations of the world there is also a contribution from the gov-

101. FREEDOM AND WELFARE, *supra* note 7, at 395.

ernment, and this is true in the Scandinavian states except Finland.

In 1954 Denmark spent 266,085,000 kroner on health insurance, Finland 768,000,000 marks, Iceland 49,369,000 krónur, Norway 380,158,000 kroner, and Sweden 231,369,000 kronor.[102] In 1955 Denmark spent 284,213,000 kroner, Finland 909,000,000 marks, Iceland 55,378,000 krónur, Norway 407,245,000 kroner, and Sweden 814,774,000 kronor.[103]

A. *Denmark*

In 1942 the Danish sick clubs spent about 98,000,000 kroner.[104] Of this about 60 million was for compulsory benefits and 38 million for voluntary benefits. Of the compulsory benefits, the items listed in order of amounts were: medical care, hospital treatment, daily cash benefits, maternity aid, burial assistance, and vital medicines. Of the voluntary benefits, the items listed in the order of amounts were: medicine, dental treatment, specialist treatment, other hospital treatment, home nursing, bandages and surgical appliances, spectacles, medicinal baths and massage, and convalescent treatment.

Of the 98 million kroner spent by the sick clubs in 1942, the State and the communes contributed directly 25,294,000 kroner. In other words member contributions paid 70 percent and the central government and the communes 30 percent. In addition the State and communes paid the following subsidies to cover the above expenditures: 2,494,000 kroner for contribution aid to sick club members, 418,000 kroner to the Directorate of Sick Clubs, and 1,237,000 kroner as voluntary communal subsidies.

Account should also be taken of other expenditures not included in the above. Direct State and communal expenditures for hospital outlays were 100,794,000 kroner, thus slightly exceeding the total sick club expenditures; 15,478,000 kroner for other outlays on medical services; and 8,678,000 kroner for free conveyance of sick club members.

In 1954 the costs of Danish health insurance were paid for as follows: 61,263,000 kroner from the State, 31,306,000 from

102. SAMORDNAD, *supra* note 23, at 16.
103. *Grönqvist, De Sociala, Utgifterna i de Nordiska Länderna År 1955*, 1958 SOCIALA MEDDELANDEN No. 10, 585 at 586.
104. SOCIAL DENMARK 50 (1947).

the communes, and 187,082,000 from member contributions.[105]

The subsidies are fixed by the law as follows. The State pays two kroner for every sick club member without means, and one-fourth of sick club expenditures for medical care, treatment outside the home, daily cash benefits, midwife assistance, dental treatment, home nursing, and convalescent treatment at a home. The State also pays three-eighths of the extra expenditures of the clubs in assisting members who, on admission or readmission as active members, suffer from an intermittent or incurable disease or physical disability. The local authorities contribute another three-eighths of such expenditures. Thus the clubs only pay one-fourth of such expenditures.

With respect to indirect grants to sick clubs and their members, there are reduced hospital charges. The Danish statute provides that members are to pay only one-half of what a non-member would pay; and what a non-member would pay is very low. Outside Copenhagen sick clubs pay on an average of 3 kroner a day, an amount representing only one-tenth of actual daily cost per bed. In Copenhagen the clubs pay only six-tenths of a krone. In tuberculosis hospitals and sanatoria a member pays only 1.5 kroner a day; and in mental hospitals 2.5 kroner.

In the sick clubs more than 70 percent of their income comes from contributions of the active members. Twenty percent of the income comes from state subsidies. The state subsidy is calculated in part as 25 percent of the expenditures for benefits (apart from important and other medicine and prostheses), and part as an amount corresponding to five kroner yearly per active member. A special state and municipal subsidy is granted towards the excess expenditures as to chronically ill persons. The state meets the full expenditures of the clubs for vital medical preparations. The locality meets the full expenditure of daily cash benefits to women factory workers in case of confinement. The localities pay transportation costs as to medical treatment, midwife's assistance, and hospitalization. In certain cases the locality pays the contributions of needy members of the sick club. The locality gives a reduction of 50 percent in hospital rates to active members of the sick clubs.

105. SAMORDNAD, *supra* note 23, at 18. In 1955 the total expenditures were 284,213,000 kroner. GRÖNQVIST, *supra* note 103, at 586.

The sick societies or continuation funds do not receive state subsidies. All costs are met fom members' contributions. The missing subsidies are compensated by cutting down benefits rather than by raising contributions. Hence members of both sick clubs and sick societies pay about the same in the way of premiums.

In 1938 the average sick club contribution per member was 24 kroner a year. In 1942 it had arisen to 30 kroner. The average contribution of Danes for health insurance is not high in amount. In 1954 the average member of a sick club contributed 75.20 kroner or $11.28, and the average expenditure per member was 99.10 kroner or $14.87. During the same year the average member of a sickness society contributed 78.85 kroner or $11.83, and the average expenditure per member was 78.26 kroner or $11.74. Member contributions vary a good deal depending on the number of optional benefits granted by the individual club or society. In 1955 the membership contribution in Danish sick clubs and societies varied from 50 to 100 kroner a year. As of January, 1958, the average contribution was 90 kroner or $12.00 a year. The annual contribution of each adult member of a Danish sick club or society corresponds to two or three days' wages for an unskilled laborer. The obligatory passive membership costs only 2.4 kroner a year. The wife pays a contribution independently of the husband. But the children up to 14 are covered without contributions from them or on their behalf. Contributions are payable monthly in the towns and quarterly in the rural areas in Denmark.

In cases of undeserved distress the commune helps towards whole or partial payment of the needy person's sick club contribution. During unemployment the commune pays the dues of the insured person. When an active or passive member without means becomes wholly or partially unable to pay his contributions through specified causes not of his own making, the commune must give him the necessary assistance so long as he needs it. If it were not for this aid the member would have to resign from active membership and then possibly later be obliged to pay the higher rates payable by people who joined sick clubs at a late age in life. In 1942 there were 112,500 members receiving such help, about one-third of them in Copenhagen.

The Danish system offers a model to those countries which would find it difficult to finance a comprehensive compulsory

system. Such is the conclusion of Miss Alice Bruun of the Directorate for Sickness Insurance Services of the Danish Ministry of Social Affairs.

B. *Finland*

Health insurance is financed primarily by member contributions and employer subsidies. Members cover most of the costs, with employers contributing to a certain extent on a voluntary basis. There are no public subsidies. It should be remembered that there is no nation-wide scheme of health insurance and that only five percent of the Finns are covered. When a government committee in 1958 examined the problem of health insurance and unemployment compensation, the majority of the committee thought the coverage problem the more serious, and that while health insurance should eventually come, unemployment compensation deserved whatever additional money could be raised.

In 1954 the average insured person contributed 3,868 marks, and the employer 2,380 for a total of 6,248 marks.[106] That is to say, the insured contributed $12.30 and the employer $7.65 for a total of $19.95.

In 1954 the Finnish health insurance costs were paid for as follows: 318 million marks from the employers, and 517 million marks from member contributions.[107] At the end of 1956 the sick club funds had assets of 1,258,900,000 marks or about $40,000,000 and the burial funds 193,100,000 marks or $603,438. Contributions to the sick club funds were 56.1 percent from members and 37.4 percent from employers.[108] Contributions to burial funds were 81.1 percent from members and about one percent from employers.

Following the wars with Russia, Finland had three immense problems: (1) to repair the heavy war damages; (2) to resettle the dispossessed population from the areas ceded to Russia; and (3) to expand industry so as to insure prompt delivery of reparations to Russia.

Budgetary difficulties have caused Finland to reduce the amount spent on social expenditures. In 1953 Finland spent 12 percent of its income for social expenditures, 11.2 percent in 1954, and 9.9 percent in 1955. Finland spends almost one-third

106. SAMORDNAD, *supra* note 23, at 45.
107. *Id.* at 20. In 1955 the total expenditures were 909 million marks. GRÖNQVIST, *supra* note 103, at 586.
108. STATISTIK ÖVER FINLANDS UNDERSTÖDSKASSOR FÖR ÅR 1956 (1958).

of its money for social expenditures on family allowances whereas no other Scandinavian state spends as much as 20 percent. An unusually high percentage of social expenditures, 24.8, comes from the employers and an unusually low percentage, 5.9, comes from the general population. All these factors point to harsh financial conditions. The proposed budget for 1959 recommends reduced expenditures for hospitals.

Finland has never recovered from the drain of war reparations paid to Russia. In 1954 when price controls on foods were removed a general strike followed. This brought wage increases, followed by price increases, and again by smaller wage increases. The outcome was a sharp reduction of purchasing power and reduced tax revenues. The Bank of Finland devalued currency by 39 percent in 1957, and a recession followed. The national income has fallen back to 1954 level; more than ten percent of the working force is unemployed; and Russia has been holding back on economic relationships with Finland.

Total production in Finland was lower in 1958 than in 1957, and export trade slackened. A total of 100,000 unemployed was anticipated for the spring of 1959, compared with 30,000 in Denmark, a country with a comparable population. Nearly 20 percent of Finnish trade is with Russia, but Soviet economic pressure forced the resignation on December 4, 1958, of the coalition government headed by Premier Karl August Fagerholm.

C. *Iceland*

In 1954 the costs of Icelandic health insurance were paid for as follows: 10,432,000 krónur from the state, 9,386,000 krónur from the employer, 27,248,000 krónur from member contributions,[109] for a total of 48,486,000 krónur. Members paid 56 percent, the state 22, the communes 19, and the employer 2 percent. In 1955 the total expenditures were 55,378,000 krónur.[110]

In 1954 the average insured person contributed 289.24 krónur, the employer 10.73, and the government 211.92 for a total of 511.89 krónur.[111] That is to say the insured contributed $14.46, the employer $.54 and the government $10.59, for a total of $25.59.

109. SAMORDNAD, *supra* note 23, at 22.
110. GRÖNQVIST, *supra* note 103, at 586.
111. SAMORDNAD, *supra* note 23, at 45.

Within an individual sick club fund, in Iceland the contributions of individuals are equal for all members, but they vary from one commune to another. The central government and the commune each make a contribution of one-third of the premium income. Thus 40 percent of the costs are borne by the central and local governments.

The 1948 Act amending the Social Security Act of 1946 provided that the minimum contribution to sickness benefit societies, except those confined to a school, should in 1949 be 5 krónur per month.

The contribution to the health insurance societies ranged in 1952 from 120 to 324 krónur per year, the rates being higher in the urban areas.[112] To these premiums should be added a part of the compulsory national insurance premiums. In 1954, 94,500 adult persons belonged to sick societies, while 90,436 paid national insurance premiums.[113] As of January, 1958, the insured person contributed from 120 to 540 krónur a year for membership in a sick club; and about ten percent of the contribution of the insured person under the Social Security insurance program was tranferred to this program. The employer contributed nothing; and subsidies equal to about 66 percent of the contributions of the insured person were paid to the sick clubs by the central government and the communes.

Under the 1946 Act financing is common for the various types of social insurance. Under Article 98 all expenditures of the Social Security scheme are defrayed by one general insurance fund which is under the management of the Social Security Institution. Under Article 99 the funds of the sickness benefit societies formed under the Social Security Act are placed under the control of the Institution. Under Article 101 the funds of the sickness benefit societies are to be utilized to secure the most comprehensive public health service in the districts of the respective societies.

Under Article 102 the following are the sources of revenue of the insurance fund: (1) contributions of the insured, (2) ordinary employer's contributions, (3) employers' special risk premiums for workmen's compensation, (4) municipal contributions, (5) central government contributions, (6) fines for violation of the Act, (7) and any other revenue, such as refunds, that may accrue to the fund.

112. FREEDOM AND WELFARE, *supra* note 7, at 410.
113. SAMORDNAD, *supra* note 23, at 45, 48.

Under Article 14 of the 1946 Act Iceland is divided into two price level zones, the first zone consisting of all towns having a population of 2,000 or more, and the second consisting of the balance of the country. Premiums are 25 percent lower in the second zone than in the first, and there is a corresponding difference in the cash benefits. Towns and villages may be transferred from one price level zone to the other at the request of the local government and if investigation of the cost of living in the locality justifies the transfer.

Under Article 107 annual contributions to social security insurance are to be as follows: In the first price level zone married men contribute 180 krónur, unmarried men contribute 144 krónur, unmarried women 108; in the second price level zone married men contribute 138 krónur, unmarried men 108, and unmarried women 84.

The expenditures for social insurance, with the exception of health insurance, are paid one-third by the insured, one-sixth by the employer, and one-half by the government.[114] The personal premium which is paid for social insurance covers daily cash benefits for sickness, old age insurance, invalidity insurance, workmen's compensation, maternity insurance, insurance for widows, children's allowances, and family allowances. The premiums in the second zone are about 80 percent of those in the first. Those bound to pay premiums are married men, unmarried men, and unmarried women. The premiums are paid starting at age 16 and ending at age 66. They are paid regardless of the person's income and number of children, although for the poorest the commune pays a part. The employers' contribution consists of a weekly premium for workmen's compensation for each insured wage earner and of a weekly premium for pension insurance for the same persons. In 1954 the central government made a fixed annual contribution and in addition guaranteed the social security system, while the communes contributed a fixed annual sum apportioned among them on the basis of population, income, property value, and social security expenditures in the commune. In 1956 the guaranty of the central government ceased, while the contributions of the central government and the communes was fixed as a certain fraction of each year's expenditures. Since 1957 daily cash sickness benefits are paid by the local health insurance fund.

114. SAMORDNAD, *supra* note 23, at 49.

Under Article 114 of the 1946 Act the municipalities contribute 4,500,000 krónur to social security insurance. This is in addition to payment of premiums of indigent persons and payment for travel expenses. In determining what each municipality contributes account is taken of three factors: (1) the amount of social security expenditures in the district; (2) the taxable income of persons and companies in the district; and (3) the number of persons from 16 through 66 who reside in the district. Under Article 115 municipal contributions are payable quarterly.

Under Article 116 the central government guarantees the cost of compensation and the cost of the health service under the Act. Each Finance Act is to supply a provisional amount up to 7,500,000 krónur plus the index figure compensatory increase. The treasury guarantee beyond this shall not exceed 75 percent of that contribution. Where the former figure is inadequate, the government may direct the Social Security Institution to raise the contribution of the insured and the employer by as much as ten percent. Then, if there is still a deficit, the government may propose amendment of the Act.

Under the 1948 amendment, the Social Security Institution may grant money to sickness benefit societies which have had to meet exceptional expenses for transportation of physicians and patients.

Under Article 117 of the 1946 Act, the collectors of income and property taxes also collect the contributions. Under Article 119 the dates for payment of contributions are to be fixed by regulations. Under Article 120 the wage earner's contribution is paid by the employer withholding the amount of the contribution and turning it over to the collector. Under Article 129 the wage earner's rights are not impaired by neglect of the employer to retain insurance contributions. Under Article 136 all contributions for social security are deductible when taxable income is assessed.

Contributions for aged persons and invalids for health insurance are paid in Iceland by the Social Security Institution. Under Article 85 of the 1946 Act with respect to persons receiving old age or disability pensions, the Institution shall pay for their medical assistance at the rate they should have been paying according to the schedule fixed by the Department of Public Health. Under Article 1, Section 2 of the 1948 amendment, the Institution may, during 1949, pay insurance contributions on behalf of such old age and invalidity pen-

sioners who apply for this and whose income added to their pension does not exceed the amount of the pension payable under Article 15 of the 1946 Act.

Under Article 109 of the 1946 Act contributions of indigent persons are to be paid by the parish. Such payments are not to be regarded as poor relief, and the rules as to arrears in contributions do not apply.

Inflation has created difficulties in Iceland. Failure to achieve agreement on measures to cope with an inflationary spiral led to the resignation of the coalition headed by Premier Hermann Jonasson of the Progessive Party on December 4, 1958.

D. *Norway*

The Norwegian health insurance system cost about 20 million kroner a year in 1911, about 40 million in 1930, about 100 million in 1935, about 200 million in 1945, 280 million in 1952, over 380 million in 1954, and 407 million kroner in 1955.

In 1954 the costs of Norwegian health insurance were paid as follows: 55,908,000 kroner from the state, 54,975,000 kroner from the communes, 71,095,000 kroner from the employers, and 223,455,000 kroner from member contributions.[115]

In 1957 it was estimated that Norwegian health insurance would cost 580 million kroner a year.[116] Most of the costs, 413 million kroner, would be for benefits in kind: 220 million kroner for hospital care, 110 for doctors' fees, 43 for transportation, 16 for maternity care, 13 for physiotherapy, 6 for dental care, and 5 for medicine and drugs. Various cash benefits would cost 128 million kroner: 115 for daily cash benefits, 5 for maternity allowances, and 8 for funeral benefits. Administrative expenses would be 25 million kroner, or only four percent of all expenditures. Grants for preventive medicine might be made up to 4 million kroner. The local insurance offices do not own hospitals or health resorts, but in a few cases own convalescent homes. The National Insurance Institution makes loans to hospitals.

Contributions towards the payment of the costs of Norwegian health insurance come from four different sources: 50 percent from contributions of insured members, about 30 percent from employers, 11 percent from the communes, and 10

115. *Id.* at 24.
116. EVANG, *supra* note 62, at 25.

percent from the central government. Thus general taxes pay about one-fifth of the costs.

The National Insurance Institution prescribes the scale of contributions for each insurance fund after hearing the managing committee of the fund. In the case of an employed person the employer pays a contribution equal to 60 percent, the commune 22 percent, and the State 20 percent of the member's contribution. The employer pays the member's contribution together with his own contribution quarterly, monthly, or weekly in accordance with the instructions of the insurance fund. The employer has the right to deduct the member's contributions from his wages. A non-employed person pays his contributions directly to the insurance fund in advance and at least quarterly. For him the commune pays a contribution equal to 22 percent and the State 20 percent of the member's contribution. During the time such a member receives poor relief, his contribution is paid by the poor relief authorities. Special rules are laid down for fishermen and seamen in foreign trade. The state pays the premium for ordinary military personnel. Those insured as family members pay no premium.

Prior to the 1956 law the cost of health insurance to the insured varied from $4.20 a year in the lowest wage group to $31.00 in the highest. Voluntary members paid about 25 percent more, according to their income group. Contributions, while graduated according to income, did not exceed 165 kroner or $23.00 a year for compulsory members and 220 kroner or $31.00 for voluntary members.[117] These contributions covered also the wife and children of the insured, and included daily cash benefits.

In 1954 the average insured person contributed 104.82 kroner, the employer 33.35, and the government 52.02 for a total of 190.19 kroner.[118] Thus the insured contributed $14.67, the employer $4.67, and the government $7.28 for a total of $26.62.

The amount of contributions paid by a member depends on the class to which he belongs. There are seven classes of members for purposes of contributions as well as cash benefits. Non-employed persons make additional contributions if they are to receive cash benefits. Under section 87 of the Norwegian statute the standard scale of contributions from insured members is to be reviewed at least once every five years.

117. FREEDOM AND WELFARE, *supra* note 7, at 409.
118. SAMORDNAD, *supra* note 23, at 45.

As of 1957 the premiums paid over all of Norway ranged mostly from 85 øre per week, or about $6.20 per year paid by students, to 4.75 kroner per week, or $34.60 per year from the highest income group which at present includes about half of those paying premiums.[119] On an average basis, the premium payments amount to from 1.5 to 2.3 percent of the payer's income. Payments from wage-earners are automatically withheld by the employer so that the wage-earner need keep no records. Other payers are billed by their local insurance office, and they must keep their payments up-to-date themselves.

In 1958 insured employees in Bergen earning from 1,000 to 2,000 kroner paid 160 øre a week in contributions or about $11.65 per year; those earning from 2,000 to 4,000 kroner paid 210 øre a week or about $15.30 a year; those earning from 4,000 to 6,000 kroner paid 280 øre a week or about $20.40 a year; those earning from 6,000 to 8,000 kroner paid 355 øre a week or about $25.85 a year; those earning from 8,000 to 11,000 kroner paid 435 øre a week or about $31.70 a year; those earning from 11,000 to 14,000 kroner paid 515 øre a week or $37.50 a year; those earning from 14,000 and up paid 600 øre a week or $43.70 a year. The above payments were for all benefits but daily cash benefits. Members in the first class paid 30 øre a week for daily cash benefits or $2.20 a year; the second class 35 øre a week or $2.40 a year; the third class 50 øre a week or $3.65 a year; the fourth class 65 øre a week or $4.75 a year; the fifth class 80 øre a week or $5.80 a year; the sixth class 95 øre a week or $6.90 a year; and the seventh class 110 øre a week or $8.00 a year.

In 1958 non-employed insured in Bergen who earned up to 1,000 kroner a year paid 80 øre a week or $5.80 a year for insurance not including daily cash benefits. Those earning from 1,000 to 2,000 kroner paid 160 øre a week or $11.65 a year for insurance not including daily cash benefits, 225 øre a week or $16.50 a year if they also received daily cash benefits after a three-day waiting period, and 180 øre a week of $13.10 a year if they received daily cash benefits after a 90-day waiting period.

119. EVANG, *supra* note 62, at 23. As of January 1958 the insured person paid from .90 to 6.60 kroner a week according to the seven annual income classes. SOCIAL SECURITY PROGRAMS THROUGHOUT THE WORLD 52 (1958).

In 1958 the rates in Trondheim were somewhat higher, starting at 170 øre a week or $12.40 a year for the first class and running up to 630 øre a week or $45.85 a year for the seventh class, with extra payments for daily cash benefits starting at 30 øre a week or $2.20 a year for the first class and running to 110 øre a week or $8.00 a year for the seventh. The rates for non-employed workers started at 100 øre a week or $6.30 a year for those earning up to 1,000 kroner a year and finished at 645 øre a week or $46.95 a year for those in the seventh class. This did not cover daily cash benefits.

Although it would appear that the Norwegians are paying more for health insurance than the other Scandinavians, it must be borne in mind that the benefits are numerous and generous. Moreover, the Norwegians endeavor to pay a larger proportion of actual hospital costs.

With respect to the percentage of social expenditures going health insurance, the percentage figures for 1955 were as follows: Norway 22, Iceland 20, Sweden 17, Denmark 9, and Finland 1.[120] The percentage of all health expenditures was as follows: Sweden 37.4, Norway 36.9, Iceland 34.9, Denmark 30.3, and Finland 17.6. With respect to the percentage of total national income going for social expenditures the figures were: Denmark 12.1, Sweden 11.6, Finland 9.9, Norway 9.2, and Iceland 8.9.

The British system now costs about two billion dollars a year or about $50 per person.[121] About 75 percent of the costs of the system come from the national treasury, 20 percent from wage deductions, 5 percent from token fees for services, and the small balance from local property taxes. The Norwegian system has not proved to be anywhere near as expensive. As Dr. Karl Evang, Director-General of Health Services in Norway, says: "The average Norwegian is in favor of national health insurance because it gives him so much medical service for so little money."[122]

No contribution from the insured or others on his behalf is payable during the period when a member is receiving a cash sickness benefit or maternity benefit, or a member is

120. GRÖNQVIST, *supra* note 103, at 586.
121. U. S. News & World Report, Apr. 12, 1957, p. 66; Chicago Tribune, Dec. 15, 1957, pt. 1, p. 11. A leading English expert has pointed out that English costs have not been excessive. In 1949-1950, 3.75 percent of the gross national product went for health expenditures. In 1955-1956 only 3.23 was so expended. TITMUSS, ESSAYS ON THE WELFARE STATE 148-149 (1959).
122. EVANG, *supra* note 62, at 26.

being cared for in a hospital or maternity home at the expense of the insurance fund, or is receiving curative treatment in a hospital at public expense, or is in an institution, nursing home, or prison and while in such place is guaranteed medical attendance at public expense.

The unemployment insurance program pays the premium for health insurance so long as the insured person receives daily cash benefits for unemployment plus the 7-day waiting period. Since he has no employer during that time the unemployment insurance program also pays the employer's share of the premium. It should be noted, however, that the payments for unemployment insurance can be made only up to 15 weeks a year, and that many people are not covered by unemployment insurance. The commune pays the premiums for old age pensioners.

E. *Sweden*

Prior to 1955 the health insurance system was financed as in Denmark from member contributions and from state grants. The contribution for daily cash benefits depended on the daily benefit paid but not on the number of children of the member. Some sick funds received voluntary contributions from the commune and the employer. In 1954 the costs of Swedish health insurance were paid for as follows: 60,420,000 kronor from the state, 5,199,000 kronor from the communes, 80,000 kronor from the employers, and 143,011,000 kronor from member contributions,[123] for a total cost of 218,710,000 kronor.

It was estimated that the new system of health insurance would cost Sweden about 740 million kronor or $147,600,000 a year.[124] The State will contribute 200 million kronor, employers a similar amount, and 340 million will come from member contributions. Members pay 44 percent of the cost, employers 27, and the central government 29. In 1955 the total costs of health insurance were about 815 million kronor, of which the insured paid 437 million, the employer 167 million, and the State 210 million.[125] In 1955 37.4 percent of all social expenditures in Sweden went for health, 36.9 in Norway, 34.9 in Iceland, 30.3 in Denmark, and 17.6 in Finland.[126]

123. SAMORDNAD, *supra* note 23, at 26.
124. TEGNER, *supra* note 88, at 74; MICHANEK, *supra* note 88.
125. GRÖNQVIST, *supra* note 103, at 586.
126. *Id.* at 587.

Those whose assessed income subject to state income tax is less than 1,200 kronor pay no contributions for health insurance. For a married couple this refers to joint taxable income. Persons under 16 do not contribute, nor do persons in receipt of the national pension. In general persons with incomes of 1,200 kronor or more contribute. The combined contribution for daily cash benefits and other health insurance benefits of those in the lowest income brackets may not exceed two percent of the taxable income. If a pensioner has an income from employment of 1,200 kronor or more a year, by virtue of which he is insured for the basic daily benefit, he must contribute for this benefit. Contributions from insured persons cover about 55 percent of the total costs.

For voluntary insurance, contributions are payable by the insured directly to the sickness benefit society, and are higher than the contributions for the ordinary compulsory insurance. Although no contribution is made by the employer, this is offset by a grant from the state.

The employer contributes 1.14 percent of annual wages up to 15,000 kronor a year for health insurance. One percent is for daily cash benefits, 0.1 percent for medical care benefits, and 0.04 percent for maternity benefits. The cost to the employer averages between 1.50 and 2 kronor a week per employee. Employer contributions cover about 25 percent of the costs of the system.

The government contributions cover 50 percent of the benefits paid out for doctor's care, transportation expenses, and basic daily cash benefits, and 75 percent of child allowances. The State also helps finance price reductions on medicines. It pays 1.5 kronor a year per member for medicines. It pays a fixed amount (4 to 5 kronor) per member towards administrative costs of the insurance. The local health insurance funds are reimbursed for the money lost through contribution exemptions and reductions granted persons who have low incomes. State contributions cover 20 percent of the daily cash benefits going to those who are voluntarily insured for such benefits. The government contributions cover about 30 percent of the total costs of the system.

In 1954 in Sweden the average insured person contributed 47.88 kronor, the employer 0.02, and the government 21.90 for a total of 69.80 kronor.[127] The contribution of the average in-

127. SAMORDNAD, *supra* note 23, at 45.

sured person was thus about $9.10 and the total cost to all $13.25. The year 1954 was the last year of the old type of health insurance.

In general, Swedes pay two kinds of premium for this health insurance.[128] One covers medical care, hospitalization, and surgery, and costs about 30 kronor or $5.70 a year. The other supplies daily cash benefits for the minimum cash benefit of three kronor a day, and the insured pays about 28 kronor or $5.32 a year for a total cost of $11.02 a year. This is the normal insurance for self-employed individuals and housewives. Corresponding coverage under the former voluntary scheme cost about 64 kronor or $12.16 a year. Those in the 2,400 to 3,000 kronor income bracket, with a daily cash benefit of five kronor, pay about 73 kronor or $13.87 a year, as compared with 91 kronor or $15.50 a year under the voluntary system. One in the income bracket from 6,800 to 8,400 kronor a year will pay about $20.00 a year; one in the 8,400 to 10,200 kronor bracket receiving a daily cash benefit of 14 kronor, contributes about 127 kronor or $24.13 a year, as compared with 212 kronor or $39.28 under the former voluntary system. For a married couple, combined insurance costs are about 160 to 182 kronor or $30.40 to $34.58, if the wife does not work and the man has an average income. Their children under 16 will also be protected. The cost for one in the top income bracket of 14,000 kronor or more will be about $36.00 a year. Thus in Sweden, as in Denmark and Norway, the contribution amounts to less than a week's wages for an unskilled laborer. The average contribution is about 1.5 percent of income.

V. ORGANIZATION AND ADMINISTRATION

A. *Denmark*

There are about 1,588 sick clubs in Denmark with a total membership of 3,100,000 active members including children, or 73.3 percent of the population. They usually operate within a local area, the commune. There are 16 sickness insurance societies for the more well-to-do with a membership of 430,000 active members including children, or 10.2 percent of the population. There is a special act for the Danish railways. This group has 60,000 members including children, or 1.4 percent of the population.

128. MICHANEK, *supra* note 88.

The Danish sick clubs and societies are mutual, self-governing, non-profit organizations. The two cooperate closely in the county covered. Sick clubs are represented in the management of a sick society to which they jointly elect a member. Both clubs and societies have the decision as to those applying for active and passive membership. Active members are presently insured and pay a real insurance premium and have the right to assistance when sick. Passive members pay only a small contribution and get no sickness aid as long as they remain in a passive status. But they may become active, subject to a six months qualifying period, and then obtain insurance regardless of age and health at the time of transfer. Thus they have an advantage over non-members. In effect the health insurance assures a future not a present risk for passive members.

With respect to the approved supervised sick clubs in Denmark each club elects its own chairman and the members of the executive council. In rural areas the chairman is the business manager. He receives a small remuneration; the others on the council are unpaid. In most clubs there is a paid treasurer. In each county there is a Central Association covering sick clubs of the county. There is also a federation for the whole nation in charge of matters common to all clubs. It carries on negotiations with government authorities and organizations of physicians, dentists, and midwives. The sick clubs, when approved by the Minister of Social Affairs, get the right to receive grants from the State and the communes, care and treatment in public hospitals of members at a reduced rate, and free transportation to and from the physician and the hospital. In return, the clubs engage to pay legal benefits and to submit to the supervision of the Directorate of Sick Clubs. It is a usual prerequisite for state approval that a club have at least 200 members. It must be associated with a certain trade, industry or craft, or must lay down a suitable geographical limit.

The Director of Sick Clubs approves by-laws of the clubs, sees that the clubs are following those rules, and sees to the standardization of administrative procedure. He supervises the financial standing of clubs and audits their accounts. He settles disputes between members and sick clubs, subject to appeal to the Minister of Social Affairs. The Director is Chairman of a council appointed under the Act, the Sick Club Council, consisting of twelve members elected by the sick

clubs. The council meets to discuss problems of a general character. The council may draft rules for transfer from one sick club to another. Consequently transfer is easy, as if there were one large sick club with branch offices. The council may propose to the government agreements with foreign states as to transfer. The Director holds annual meetings with leaders of sick clubs in all counties in Denmark.

The Sickness Insurance Societies or Continuation Sick Clubs for the more well to do are approved by the Minister of Social Affairs. They operate under the direction of the Director of Sick Clubs. He approves their rules and inquires into their financial position. They receive no grants from the central governments or the communes. Their liability rests solely on the mutual responsibility of their members. They are mutual self-governing associations, and elect a chairman and an executive council. The sick clubs in the area jointly elect a member to the council. There are 16 societies. Sometimes they have no agreements with doctors, unlike the sick clubs. The members pay the doctors and are then reimbursed in whole or in part by the society on presentation of itemized and receipted bills. All members of sick clubs whose financial status has improved to a certain point are transferred to the sick societies irrespective of health and age. Members of sick societies whose financial status has declined to a certain point must transfer to the sick clubs. The sick societies admit directly persons between 14 and 40. Children under 15 may be insured under the father's or mother's membership on special request and payment of a fee provided they meet health requirements at the time of admission. Health requirements for direct admission are stricter than those for admission to a club. The applicant must be healthy and not be (or have been) suffering from any incurable conditions or considerable bodily defects.

The costs of administration of the sick clubs average about eleven percent of the total expenditure.[129] Profit earning is not one of the purposes of the Danish sick clubs. The attributes of private insurance have been avoided. There is no competition for club members since, with few exceptions, the clubs have their own local area. There is no canvassing or ad-

129. Gersenov, *Administration and Financing of Sickness Insurance*, (lecture in International Labor Organization Series given in Copenhagen in 1956). See *supra* at n. 16. See also SAMORDNAD, *supra* note 23, at 46.

vertising for members. There is no problem of agent commission. The clubs have no advertising charges to pay. The clubs have been organized geographically and not according to trade. They have, therefore, avoided the difficulties which arose in Sweden and Great Britain where contributions were collected in the same town by many clubs, several of which had only a few members in the town.

The importance of the autonomous administration of local clubs has been reduced a good deal with the passage of time. At least in the towns there is little interest. Statutes have increasingly regulated the work of the clubs. Much negotiation has been taken out of the hands of the individual clubs and placed into the hands of associations of clubs. Yet there continues to be a sentimental attachment to the concept of autonomy.

There is pending a proposal before the Danish Commission on Invalidity to separate the entire system of invalidity insurance from the sick clubs and to turn it over to the state. The existing system of requiring payment of the premium for invalidity with the payment for sickness insurance would be abolished. The contribution for the general folk pension would be increased from one percent to 1.5 percent, and the new contribution would cover both the general folk pension and invalidity insurance. The theory behind the change is that it would be easier to administer the invalidity insurance system and that invalids would receive better care when they are dealt with as a separate group under the new system. Members of the conservative parties are critical of the proposal. There is no need to shift administration in order to obtain full coverage. Revision of the law of health insurance is being discussed by the Commission on Health Insurance. The Commission will consider repeal of the existing requirements of good health for sick club membership. Members of the Commission favor repeal of the provision for termination of sick club membership after 420 days of sickness assistance.

B. *Finland*

Finnish benefit funds are administered by the Ministry of Social Affairs. The Ministry approves their rules and amendments of the rules. When a benefit fund has been founded for the workers of an industrial establishment or other enterprise and receives continuous financial support specified in the rules from the employer, the employer has the right to ap-

point members to its board in proportion to the amount of the employer's contribution, but may never appoint more than half of their members. If a benefit fund it not operated with its rules and the statute, or if a fund is clearly unable to meet the obligations assumed, and after warning fails to correct the abuses, the Ministry may forbid the fund to accept new members and may even carry on its work until satisfactory improvement has been made when the circumstances require it.

While the founding of a fund is voluntary, membership may be made compulsory by the employer if the fund was founded for persons in the service of a specific employer. In most of the benefit funds founded in industrial establishments membership is compulsory.

In 1954 administrative costs, in percentage of health insurance expenditures, were 11 percent in Denmark, 5.5 in Finland, 7.6 in Iceland, 4.4 in Norway, and 14.5 in Sweden.[130] Administrative costs in Finland are low since most of the societies are connected with a specific private corporation whose facilities they may use.

Of the expenditures of the Finnish sick club funds in 1956, 90.3 percent went to members and only 3.7 percent was used for administration. Of the burial funds 68 percent went to members and 14.7 percent for administration. In 1957 expenses for administration of the sick club funds increased to 4.7 percent and the burial funds to 15.3 percent.

C. *Iceland*

The 1946 Act resulted in centralization of the various social insurances. The Social Security Institution was to administer old age insurance, workmen's compensation, disability insurance, survivor's insurance, maternity aid, and health insurance. Under Article 2 of the Social Security Act of 1946, the agency which deals with social security, including health insurance, is to be called the State Social Security Institution. The Institution may be divided into departments, but all the departments are to have joint financing. The entire revenue of the Institution is to accrue to a general fund from which all its disbursements are to be made.

Under Articles 4 and 5 the administration of the Social Security Institution is in the hands of a director appointed by the Minister. Under Article 6 administration is also under a

130. SAMORDNAD, *supra* note 23, at 46, 48.

Social Security Council of five members elected jointly by both houses of the Althing. Under Article 3 the supervision of the Institution is in the hands of the government, that is to say, the Ministry of Social Affairs. Under Article 6 there is also a special committee of three medical experts to advise in medical matters and in the administration of the Health Service. The Director of Public Health is chairman. The other two members are appointed by the government for four-year terms, one of them on the joint nomination of the Medical Association of Iceland and the Reykjavik Medical Association, and the other on the nomination of the Medical Faculty of the University of Iceland.

Under Article 7 if there is a dispute concerning health insurance benefits decision is to be by the Social Security Council. But the medical experts committee is to be consulted before decision is rendered on questions of a medical nature affecting the payment of compensation. The losing party may take an appeal to the law courts.

Under Article 11 the country was to be divided into insurance districts. The Social Security Institution was to maintain officers or representatives in such districts. Each insurance district was to have an insurance committee of five members elected by the local government bodies at joint sittings. The insurance committee was to keep informed of the management of social insurance in the district, offer proposals for administration, protect the interests of the insured, and suggest measures for economy in operation. Under paragraph 11 of Temporary Provisions the executive committees of sick benefit societies were to attend to the duties of the insurance committees until the end of 1947. Under the Act of 1948, amending the 1946 Act, this provision was to continue in effect until 1950. Since 1957 daily cash benefits have been paid by the local sick benefit societies. In 1956 the guarantee of the solvency of social insurance by the central government was terminated. The thought of abolishing the local sick benefit societies has disappeared. As of January, 1958, the situation may be briefly summarized as follows: The Ministry of Social Affairs has general supervision. The sick benefit societies, in which membership is compulsory, administer benefits under the supervision of district clubs and the State Social Security Institution. Iceland is currently governed by a law of 1956.

Under Article 138 of the 1946 Act on recommendation of the Social Security Institution, the Minister shall issue regulations further defining the practical application of the Act. Under Article 139 persons may not accept payment for assistance in collecting compensation, including health insurance, unless the Social Security Institution has refused to pay. Violation is punishable by a fine.

In 1954 of the total expenditures for health insurance only 7.6 percent was for administrative expenses.[131]

D. *Norway*

There are about 750 local insurance offices in Norway, usually one in each commune.[132] There is also a special office for seamen and for government employees abroad. Each local office is much like an independent, self-governing insurance company; directed by national statutes and by rules set up by the National Insurance Institution, but having great leeway to adjust to local conditions. At the top is the National Insurance Institution (*Rikstrygdeverket*) which operates under the Ministry of Social Affairs. Administrative authority of each local office is placed in the hands of a five-man board chosen by the regularly elected governing body of the commune. But the business manager is appointed by the National Insurance Institution from locally named nominees. Thus there is a combination of local and centralized control. It seems fair to say that local self-government as to health insurance is more limited in Norway than in the other Scandinavian countries.[133] The National Insurance Institution sees to it that the local offices function according to law, determines how much they shall collect in premiums, settles disputes appealed from local complaints committees, sends out inspectors and auditors, and gives aid when the local board runs into financial difficulties. Through the giving of financial support the local offices are enabled to charge practically the same rates for premiums. This is helpful to thinly populated areas. Half the local offices have less than a thousand members each, while one-fifth have less than 500. Aside from such support and supervision the local boards have full charge of their own affairs. The local areas are small enough so that frauds may be easily detected.

131. *Id.* at 46.
132. EVANG, *supra* note 62, at 24.
133. FREEDOM AND WELFARE, *supra* note 7, at 411.

Through their elected national and communal representatives, the Norwegian people can assert indirect control over the health insurance program. The Parliament lays down the basic principles in statutes, including what benefits shall be given. A member of Parliament may raise specific questions at any time. The National Insurance Institution operates under the Ministry of Social Affairs and is, therefore, subject to the cabinet which, in turn, is responsible to Parliament. In the commune the board of directors and the complaints committee of each insurance office are appointed by the communal council which is elected by the people.

Under section 177 of the Norwegian Act the Ministry of Social Affairs shall have the power to issue regulations for the administration of the Act.

Every insurance office has a disputes board. Before this board disputes may be brought concerning benefits and contributions arising between the insurance fund and an insured person, or between the insurance fund and the employer, or between an employed person and an employer respecting deductions from wages. This dispute must be submitted within six weeks of notice of the fund's decision. An appeal lies to the National Insurance Institution within six weeks after the decision of the disputes board. When an appeal is taken from the local disputes board to the National Insurance Institution its decision shall be binding upon the insurance fund. But the other party may take the decision to the court of law unless it is purely a matter of opinion.

The employer shall notify the insurance fund at the place of the employment within eight days when a person enters employment. An employer failing to give notice becomes liable to pay up to 300 kroner of the amount disbursed where an illness develops after the person's entry into employment but prior to his being registered. Within eight days, a non-employed member must himself notify the insurance fund in his place of residence when he fulfills the conditions for membership, as for example when a child who is insured as a family member reaches 18 years of age or a marriage is terminated by divorce.

The employer shall notify the insurance fund at the place of employment within eight days when a change occurs in an employed person's income entailing a change of income class. A failure to give such notice makes the employer liable

up to 300 kroner. A non-employed member must himself within eight days notify the fund in his place of residence when a change occurs in his income that may entail a change of insurance class; if he moves to another place within the same commune, he must give notice to the insurance fund at his place of residence within 14 days.

When an employed person terminates his employment relation, the employer shall notify the insurance fund at the place of employment within eight days. For a failure to give such notice the employer becomes liable to pay the member's contribution and his own contribution from termination until the insurance fund learns of the termination. A non-employed member who moves to another insurance fund area must give notice to the insurance fund at the place of his former residence and also to the insurance fund at his new place of residence within 14 days; in the case of a person under age the guardian is responsible for giving notice.

Under section 128 of the Norwegian statute every person who is in a position by virtue of the Act to become acquainted with any other person's private circumstances or with the organization or financial circumstances of an establishment is bound to preserve secrecy, and for failure to do so is subject to criminal prosecution; and he is bound whether or not he is a public official.

In 1957 it was estimated that the Norwegian health insurance would cost 580 million kroner a year, with 25 millions or four percent for administrative expenses.[134] In 1957 the expenses for administration of the Trondheim health insurance office were 3.92 percent of total expenditures.

E. *Sweden*

Prior to 1955 the Swedish health insurance system was entirely on a voluntary basis.[135] It was organized in independent associations, the so-called "recognized sick funds." The scope of the sick fund was local or connected with a certain industry or occupation. The funds were under the control of the National Insurance Office which made contributions to the funds. In 1954 only 57.4 percent of the population were covered by health insurance. There were about 1,000 local societies, rather similar to the Danish, and 37 central societies some

134. EVANG, *supra* note 62, at 25.
135. FREEDOM AND WELFARE, *supra* note 7, at 410-411; SAMORDNAD, *supra* note 23, at 50.

of which covered large towns while others were organized on a county basis and entrusted with certain important duties on behalf of the local societies.

Administration of Swedish health insurance is largely in the hands of the local sickness societies. In most cases there are the societies which previously handled the voluntary plan. They had to submit to some reorganization to bring them into line with the new compulsory system. They are no longer voluntary, and no longer private. There are two groups: local and central benefit societies. The local societies review and pay all claims for basic medical care, and also pay the basic sickness benefit fees for the first 90 days of illness. The central societies reimburse the local societies for their expenditures and all benefits after the first 90-day period of illness.

There are now 31 central societies covering one county or one city each. There are 631 local societies, each of which serves one or more municipalities. There are no local societies in cities having a central society. The relation between the central and local societies is primarily financial. In order to equalize costs among the local units, the central societies assume considerable responsibility for local liability. A central society has a certain supervisory power over the local societies and takes care of part of their bookkeeping and statistical recording. Each society is an independent corporate entity responsible for its activities and financial solvency. Needed funds beyond contributions from the government and employers must come from member contributions. If there is little illness in a district and good administration, member contribution rates will be low.

Each society has a constitution regulating its activities within the framework of the health insurance legislation. Business matters are handled by a board and a representative body chosen by local authorities. The representative body of the local society in turn elects the representatives for central societies, except in cities which have central societies where the representatives are chosen by city authorities. The board of a central society is composed of members selected by the National Health Insurance Office, the Royal Medical Board, and the County Council. The societies cannot carry out any kind of business other than health insurance, but the national government may impose other duties on them and, in fact, a good deal of the administration of workmen's compensation has been delegated to the societies.

The societies are under the supervision of the National Health Insurance Office (*Riksförsäkringsanstalten*). It oversees the activities of the societies and sends out necessary directives. It follows the economic development of the individual societies and of the system in general; approves the contribution rates which each society decides to charge, as well as the salaries and pensions of all managerial personnel; and apportions the governmental and employer contributions among the societies. If an insured is dissatisfied with a decision his society has made concerning his insurance, he may enter a complaint with the society within one month. The society then comments on the complaint, and sends it to the National Health Insurance Office. Certain cases may be further appealed to higher government authorities.

VI. CO-OPERATION AMONG THE SCANDINAVIAN STATES

In 1911 Danish and Swedish health insurance societies agreed that their members could transfer to a society in the other country without first having to prove their fulfillment of the usual conditions of admission such as waiting periods.[136] In July, 1953, there was an agreement between Denmark, Iceland, Norway, and Sweden under which all persons insured against sickness and taking up residence in one of the other countries are henceforth entitled to full health insurance facilities.[137] Permanent residents became ordinary members of the local health insurance unit, while temporary residents will be entitled to benefits only if they are insured in their home country. Finland is not a party as it has no comprehensive health insurance.

Under the July 20, 1953, convention the Scandinavian who has moved for permanent residence to another Scandinavian country and seeks local health insurance membership must make application within two months after arrival, and must bring with him the certificate of removal from his former health insurance. If the application is made within three weeks after arrival, removal is reckoned from the date of arrival; if later, from the date of application. Local limitations as to age and health and waiting period will not be applied. Students from other Scandinavian states for more than three months may be admitted to a local sick club. But in general persons temporarily present cannot be admitted to a local

136. FREEDOM AND WELFARE, *supra* note 7, at 488.
137. NORDISKE STATSBORGERES SOSIALE RETTIGHETER OPPHOLD I ANNET NORDISK LAND 8-10 (1955); SCANDINAVIAN DEMOCRACY 378 (1958).

sick club. Scandinavians temporarily present but insured in their own country may receive medical care or hospitalization. Application should be made to the local sick club where the aid is given, should be made promptly and at least within 14 days after the help was given. The applicant should bring his sick club book or other proof of his sick club or may make a written declaration on his honor. Help is given only until he can return for treatment to his own country and at the most for 90 days in each temporary sojourn. If the sick person has himself paid the costs, he can be reimbursed on sending in his receipts. He should send in the receipted payment before leaving the country, and at the latest within six weeks after he has paid.

Under a July 20, 1953, convention between all five Scandinavian states, the same care given to local mothers is given to other Scandinavian mothers who live in the country.[138] Under the convention of January 9, 1951, between all five Scandinavian states, general assistance which includes medical care is given to Scandinavians from other states in the same manner as it is given to local residents.[139] Such help is given even to persons not covered by health insurance, and includes medical care and hospitalization. A temporary recipient of such help may not be sent back to his own country unless he is willing. But if the recipient requires permanent help, that is to say help for a year or more, he may be sent back to his own country unless he has lived in the transferee country for at least five years and during that period has not required permanent care and has not received a prison sentence of more than 60 days.

The social-political committee of the Nordic Council has proposed a common work market for medical personnel, pharmacists, nurses, health workers, midwives, etc. The proposal also includes psychiatrists, and it is urged that they receive a common Nordic training.

VII. THE SUCCESS OF SCANDINAVIAN HEALTH INSURANCE

Scandinavian health insurance appears to have worked very well. There has been wide coverage of the population, and an increasing number of benefits conferred. The costs of the systems have not proved impossibly high, and the quality of medical care, hospitals, and drugs has not deteriorated.

138. NORDISKE STATSBORGERES, *supra* note 137, at 20.
139. *Id.* at 20-21.

The health of the people has improved. Scandinavians, moreover, rank high among the nations of the world in health when measured by the usual yardsticks of average life-span, infant mortality, and occurrence of communicable diseases. In 1939-1940 the United States was fifth in life expectancy at birth, ninth at age 20, twelfth at age 40, and thirteenth at age 60.[140] The longest average life spans have been recorded in the Netherlands with 72.5 years, in Sweden with 72 years, and Norway 71 years. The United States ranks behind these two Scandinavian countries.

In 1951 the deaths per thousand born alive during the first year of life were 2.1 in Sweden, 2.6 in Iceland and Norway, 2.9 in Denmark, and 3.5 in Finland.[141] They rank among the lowest in the world. In the same year the rate was 2.3 in New Zealand, 2.9 in the United States, and 3.1 in the United Kingdom. The number of maternal deaths per thousand births is less than one in all five Scandinavian states, thus ranking with England and the United States among the lowest in the world.[142] The Scandinavian states, except Finland, have some of the lowest mortality rates for tuberculosis; Denmark has the lowest in the world. In 1950 the rates per 100,000 population were 14 in Denmark, 20 in Iceland, 22 in Sweden, 29 in Norway, and 91 in Finland. In 1937 Denmark and Sweden had the lowest typhoid mortality in the world.

Brigadier General Hershey pointed out on May 27, 1941, that, of the first million men examined in the draft, 400,000 were found unfit for general military service and that this revealed that "we are physically in a condition of which nationally we should be thoroughly ashamed."[143] A recent U. S. National Health Survey found that 70 million Americans, or 41 percent of the entire population, had not been to a dentist in three or more years. Yet, public opinion researches indicate that almost 90 percent of Americans agree that a dental checkup every six months "is a good thing."

The number of doctors in America per hundred thousand population has decreased in recent decades. In 1910 there

140. Note, 59 YALE L. J. 292, 293 n. 4. A committee of the American Bar Association erroneously asserted that the United States has the best record. 30 A.B. A.J. 275, 276 (1944).
141. FREEDOM AND WELFARE, *supra* note 7, at 256.
142. *Id.* at 248.
143. N. Y. Times, May 28, 1941.

were 164.[144] In 1955 there were 131.9. In 1958, according to President Grayson Kirk of Columbia University, the ratio was 130 to 100,000.[145] The prospects for increasing the ratio of doctors are not very good.[146] On the other hand the number of doctors per hundred thousand population has been increasing in the Scandinavian countries. One must conclude that there is no support in fact for the assertion of many American medical men that the American system encourages entry into the study and practice of medicine while systems of government health insurance discourage such entry.

In the school year 1950-1951, 40 percent of the medical freshmen in American Medical schools had "A" averages in their premedical courses and only 43 percent had "B" averages.[147] In the school year 1956-1957 only 16 percent had "A" averages and 70 percent had "B" averages. On the other hand the quality of students in the Scandinavian medical schools always has been and continues to be of the highest. The claim of many American medical authorities that the American system is the best incentive for securing high quality students seems likewise unwarranted by the facts.

In 1958 Denmark had 3,175 nurses per million people, Norway in 1958 had 2,499, Finland in 1955 had 2,435, Sweden in 1955 had 2,254, and Iceland in 1951 had 1,177. The United States had 2,602 in 1955. Scandinavians contend that there is a shortage of trained nurses in all five Scandinavian states largely due to nurses' long hours and low pay. Yet on the whole the Scandinavian countries are about as well supplied with nurses as the United States.

In 1955 Sweden had 14,569 beds per million people, Denmark 10,157, Iceland 10,032, Norway 9,648, and Finland 7,937. The United States had 9,708. There is thought by the Scandinavians to be a shortage of beds, particularly in the

144. Loevinger, *Professional Income: Why Doctors Make More Money than Lawyers*, 44 A.B.A.F. 615, 617 (1958). The American Medical Association has not always been helpful in increasing the supply of doctors. 63 YALE L. J. 938, 971 (1954).

145. N. Y. Times, Mar. 27, 1958, p. 29.

146. M. Clark, *Nation-Wide Physicians to Meet Population Rise*, N. Y. Times, March 3, 1958, p. 1; *Shortage of Doctors?*, U. S. News and World Report, May 9, 1958, p. 66. On the other hand in England which has health insurance the number of physicians may be excessive. TITMUSS, *supra* not 29, at 140.

147. *Shortage of Doctors?*, *supra* note 146, at 69. See also BLOOMGARDEN, BEFORE WE SLEEP 22, 32 (1958). In England on the other hand since the adoption of health insurance in 1948 the number of applicants to study medicine has increased tremendously. TITMUSS, *supra* note 29, at 161-162.

last three nations. One reason for the shortage is the increasing number of beds occupied for longer periods by aged patients. Yet the number of beds compares favorably with that in the United States, and the number has substantially increased. In 1949 Sweden had 10,500 beds per million people, Denmark 9,400, Iceland 8,400, Norway 8,500, and Finland 6,800.[148]

The Scandinavian system of regionalization of hospitals has been very successful and worthy of American notice.[149] Regionalization has not worked well in the United States because of the lack of a regional administrative authority and a regionl financial system. Both these difficulties have been overcome in the Scandinavian countries, and their outlying areas are assured of a high standard of medical and hospital care.

The staffing of Scandinavian hospitals with full-time medical personnel who are usually specialists has resulted in a lower ratio of specialists to the total number of physicians. The group practice which occurs makes for less need of a large number of specialists.

While in 1951 the American Medical Association asserted broadly that government health insurance necessarily involves "second-rate medical care", it should be recalled that in 1916 the Social Insurance Committee of the Association concluded that wherever compulsory insurance had been introduced, the result had been improvement in the general health and prolonged life to the workers. The Committee stated: "The advantages of these systems are so great that the disadvantages while it is necessary to combat them, cannot be mentioned in comparison."

Dr. Gunnar Gundersen, President of the American Medical Association, in a letter of July 2, 1958, to the author expressed the oponion that the introduction of government health insurance "tends in time to downgrade the quality of medical care such as was the result in Germany after Bismarck introduced the scheme of government medicine over 70 years ago. Prior to that time medicine in Germany stood very high, something which cannot be said about the system during

148. FREEDOM AND WELFARE, *supra* note 7, at 337. It is asserted in 59 YALE L. J. 292, 299, (1950) that the United States has too few hospitals and that only half the need is met.
149. WEINERMAN, *The Quality of Medical Care*, 273 ANNALS 185, 188-189 (Jan. 1951).

the last 40 years." He conceded, however, that the Scandinavian "physicians with whom you will meet will probably be satisfied with it." The late Bryn J. Hovde has pointed out that American critics of the Scandinavian systems say "in contravention of plain fact, that they exemplify the deterioration of medical science when it gets into public hands."[150] This unfair criticism "has not prevented great American foundations such as the Rockefeller Foundation from investing American money to promote medical science in Sweden or dentistry in Norway." When the author was in Norway in September, 1958, he met a representative of the Rockefeller Foundation, who had nothing but praise for the Norwegian system. It is fair to say the the Scandinavians "today enjoy standards of hospital and medical care probably unequalled anywhere else."[151] Some years ago an American professor of botany from Kansas visited Norway for some months. While there he became sick and went to a Norwegian hospital. His wife was quoted in a newspaper as saying: "Thank God he got sick in Norway. He received the best of care and at a very reasonable rate." An American cultural attache in Copenhagen got sick and went to a Danish hospital. She informed the author of this study that she got wonderfully fine care and paid an extremely low amount.

The argument made that the quality of medical care under health insurance abroad is poor in quality whereas American medical care is high in quality is to a large extent fallacious because, as Dr. Michael M. Davis has pointed out: *"The facts are incontrovertible that a considerable proportion of our population receives no medical services when it needs it* and the quality of medical service which you do not get is a matter not susceptible to statistical analysis."[152] Compulsory insurance at least makes some care accessible.

The Scandinavians have had great physicians both prior to and after the adoption of government health insurance. One of the first to attain world renown was Niels Stensen (1638-1686), often referred to as Steno of Denmark, who was the discoverer of the duct of the parotid gland (called after him Stensen's duct), and who did valuable work in the physiology of the muscles.[153] In 1873 the Norwegian, Armauer Hansen,

150. FRIIS, SCANDINAVIA BETWEEN EAST AND WEST 341 (1950).
151. FREEDOM AND WELFARE, *supra* note 7, at 504.
152. SOCIAL SECURITY IN THE UNITED STATES 78 (1935).
153. SIGERIST, THE GREAT DOCTORS 151 (1958).

discovered the exciting cause of leprosy.[154] In 1907, the Norwegians Axel Holst and Theodor Frølich established that scurvy was caused by dietary deficiency in what we now call Vitamin C. The Norwegian Owren made notable investigations into blood coagulation. In Iceland Dr. Gudmundur Magnusson (born 1863) was world renowned for his work on hydatid disease. The work of the Swede Linnaeus in classifying plants prompted many physicians to classify diseases.[155]

During the days of health insurance, Scandinavians have had several winners of the Nobel Prize in medicine. Niels R. Finsen (1860-1904) of Denmark pioneered in light treatment and won the Nobel Prize in 1904.[156] Angust Krogh (born 1874), also of Denmark, was a great physiologist who demonstrated the fact that the bloodfilling of the muscles is variable and entirely dependent on the work of the muscles, and received the 1920 Nobel Prize for his work. In 1926 Johames Fibiger (1867-1928) received the Nobel Prize for his research in cancer, particularly for his development of transplanting live cancer cultures on rats. In 1944 Henrik Dam (born 1895) won the Nobel Prize for the discovery of vitamin K. Thus Denmark which has had comprehensive health insurance for the longest period has had four winners of the Nobel Prize. The Danish State Serum Institute in Copenhagen has for several decades been a leader in the production of serums and research in epidemic diseases. The Danish Finsen Institute in Copenhagen is world famous for x-ray and radium treatments of diseases, particularly cancer. The Finnish biochemist, Artturi Virtanen (born 1895), won the Nobel Prize in chemistry in 1945. He was famous for his studies of albumin production and biologic nitrogen engagement. Savonen was world renowned for his work in tuberculosis and Yllpő for his work with premature infants. The Danish Nobel Prize winner, Finsen, referred to previously, was of Icelandic origin.

The Swedes have had two Nobel Prize winners in medicine: Allvar Gullstrand in 1911 and Hugo Theorell in 1955. They have had five winners of the Nobel Prize in chemistry: Svente Arrhenius in 1903, The Svedberg in 1926, Hans von Euler-Chelpin in 1926, George Hevesy in 1944, and Arne Tiselius in 1948. The Nobel Prize in physics was awarded to Gustof

154. *Id.* at 353; LARSEN, A HISTORY OF NORWAY 480 (1948).
155. SIGERIST, *supra* note 153, at 262.
156. CALDER, MEDICINE AND MAN 80 (1958).

Dalén in 1912. "Famous Swedish contributions include the inquiries of Fahraeus into the sedimentation of red blood corpuscles, the production by Lehmann of PAS (paraaminosalicylic acid) for the treatment of tuberculosis, and by Ingelman and Grőnwall of dextran, a blood substitute; in the fields of brain and heart surgery the names of Olivecrona and Crafoord are known all over the world."[157] The Swedish Radiumhemmet is world famous for x-ray and radium treatments of diseases, particularly cancer.

Programs for tuberculosis vaccination were initiated in Denmark in 1947, and in Norway and Sweden in 1948. Subsequently the World Health Organization extended such a program to 21 countries.

It is sometimes asserted that government health insurance necessarily involves less interest and activity in research.[158] But this has certainly not been true in the Scandinavian states, for, as has been seen, their citizens have won many Nobel Prizes in medicine and related fields. Their medical schools and larger hospitals, like their American counterparts, carry on vast research programs. Scandinavian authorities vigorously insisted to the author that research is not neglected. Although they do not have the enormously wealthy foundations such as exist in the United States, they make full use of such financial and other resources as they have. In Norway, the author learned that income from government lotteries was being made available for medical research.

While many American physicians assert that under the American system medical research is encouraged and stimulated, former Secretary of Health Education and Welfare, Marion B. Folsom, stated in the Saturday Review for January 17, 1959: "In spite of the demonstrated benefits of medical research for human welfare, only three and a third percent of our total research expenditures are for health and medical problems. Surely the health of the people deserves a larger portion of our investment!"

As of 1955 America was spending $16,000,000 a year on research as to heart disease, although ten million Americans

157. FREEDOM AND WELFARE, *supra* note 7, at 345.

158. A committee of the American Bar Association asserted that the center of medical progress had moved from Germany, Austria and England to the United States because of their adoption of health insurance. 40 A.B.A.J. 275, 276 (1944).

It has been concluded that since 1948 when England adopted health insurance more research has been carried on. TITMUSS, *supra* note 29, at 150.

suffered from it. Only $25,000,000 is spent on cancer research, although one out of seven is a victim of cancer.[159] Only $11,000,000 is spent on research in mental diseases. About one cent per person is spent for research on arthritis and rheumatism, though ten million persons suffer from those diseases. If the United States is spending adequate amounts for medical research, it is only recently that it has done so. In 1957 it spent $400,000,000, an amount seven times as much as in 1947.[160]

Several factors facilitated the development of health insurance in the Scandinavian countries. Well organized public health services were in operation. There was a highly developed system of public hospitals, and well trained and highly qualified personnel in medical service. In Denmark, the first country to develop health insurance on a wide scale, there was the additional element of almost uniform density of population with no mountainous areas.

One particular aspect of Scandinavian society has made health insurance easier to obtain. In the eighteenth century public hospitals were erected in most of them. The result has been that the hospital system in all five states has become predominantly public. Hospitalization has been available to all with very modest charges or none at all. Since hospitals in the United States have usually been private, compulsory health insurance would be very expensive.

The United States is geographically much larger than any Scandinavian country. The people of the United States are not as homogeneous; there are many races and colors and religions. The rate of literacy is not as high in the United States as it is in Scandinavia. The American birth rate is higher, hence health insurance for the family would be more costly. The American crime rate is higher, hence more fraud and abuse of health insurance could be anticipated. The existence of both a federal government and 50 states with broad powers would make administration complicated and difficult.

Critics of Denmark and Sweden have pointed to the high rates of suicide, one in 4,431 people in Denmark and one in 4,460 in Sweden. Some have asserted that this is due altogether or largely to the welfare state which allegedly kills the

159. N. Y. Times, June 3, 1955, p. 12. The inadequacy of research is pointed out in BLOOMGARDEN, *supra* note 147, at 73-77, 103-104, 115-142, 147, 171, 174, 177-179, 191.

160. Somers and Somers, *Private Health Insurance*, 46 CALIF. L. REV. 376, 397 at n. 65 (1958).

instinct of self-preservation, arguing that because people are cared for from the moment of birth, they have nothing more to fight for. But many Danes have assigned other reasons such as the monotony of the Danish landscape, too much reason in the Danish mentality, and the decline of religion. Others point out that the Danes keep more accurate statistics on suicide. It would seem that there is a burden on the critics of health insurance to show that the suicide rate was considerably lower before the adoption of health insurance in Denmark and Sweden. It might also be pointed out that 58 nations now have health insurance and that in many such nations the rate of suicide is low. On the other hand, Finland, which has no nation-wide system of health insurance, has a rather high suicide rate.

Attacks on the welfare state are sometimes made by Scandinavian writers. It is alleged that it produces mental discontent, increasing loss of self-control and self-mastery, lessened personal responsibility, and more a sense of meaninglessness resulting from less control and influence over one's life. The cultural and political disadvantages are said to be even more serious than the economic. While those who defend the welfare state usually do so on economic grounds,[161] its opponents rely principally on psychological and political grounds. In the welfare state there is no proper relation between rights and duties, between power and responsibility, between taxation and enjoyment. Why is more and more welfare sought? Is it because there are more people who cannot take care of themselves? A Swedish writer, in a book entitled *Revolt Against the Welfare State,*[162] points out that the average national income in Sweden has risen from 1500 kronor in 1900 to 5170 kronor in 1954. The real earnings per hour of industrial workers quadrupled in that period, not including the social benefits given to workers. The real earnings of an industrial worker are as great as those of a teacher or office manager 50 years ago. Yet, a teacher of 50 years ago, in addition to maintaining his standing as a person of high status, took care of many expenses for himself. He paid his house rent without any state assistance. He paid all the expenses of raising and training his children. He paid all the costs of hospitalization, medical care, and medicine, and put aside the

161. For a defense of the welfare state see a book by a Danish professor: ZEUTHEN, VIDENSKAB OG VELFAERD. [SCIENCE AND WELFARE] (1958).
162. REVOLT MOT VÄLFÄRDSTATEN (1958).

money needed for his old age. He never thought of expecting help from the community. But the worker of today with the same real earnings cannot cope with any of these problems. Twenty times as much for social welfare is spent in 1958 as was spent in 1900. It does not seem reasonable to conclude that in fact there are more Swedes today who cannot care for themselves. Hence there must be other grounds, such as equalization of income. Yet equalization has not been brought about; since the end of the war only two percent of the income of those with more than average income has been carried over to those with less income. Thus, those who receive social benefits have usually paid for them too. The money has simply gone through numerous offices and paid an army of officials whose greatest desire is to make life as difficult as possible for the rest of the people. The welfare state has finally become a macabre farce. But if the welfare state is not based on the Good Samaritan principle or on the principle of equality, it must be that it is based on envy and jealousy.

The proponents of the welfare state assert that a primary object is to confer rights on recipients of welfare. Such recipients should not receive welfare as a matter of charity or poor relief, nor have to prove need. But the opponents insist that if that argument is honorably voiced, over the years fewer persons ought to receive social walfare as the income of workers goes up. Today, however, almost two million Swedes receive social welfare payments, and from 1946 to 1957 the number of Swedes who received state aid for rent increased from 100,000 to 700,000.

Social welfare also results in inhumanity to some. The minorities in real need, such as the insane, alcoholics, and unmarried mothers, are overlooked because they have but few votes. The concept of solidarity in the welfare state, which lies close to Marxism, is not as humane as some think. Instead, it breeds strife since the solidarity is only for certain groups, and there is a violent aggressiveness towards those who stand outside these groups. Competition is not so fierce in the *laissez faire* or liberal society which leaves more elbow room for the individual who does not need to cultivate bureaucracy. In a liberal society there is a separation between economic and political power; in a welfare state these two powers are merged. The separation of these two powers is the basis for the existence of democracy.

Poul Bjerre, a Swedish psychiatrist, tells of some of his experiences in connection with applicants for health insurance. More and more people apply for several months recreation because of nervous difficulties. When the patient has gotten his sickness certificate, he later asks for a certificate to the effect that he is not too sick to work so that he can take a temporary job during his resting period and thus receive pay at two places at the same time. The applicant sees nothing immoral in this procedure. When society has made such arrangements possible, why not take advantage of the opportunities? A parasitical attitude emerges, with a corresponding risk of demoralization. The moment that one fails to see the connection between taxes and benefits there arises a tendency for neurotic patients not to try to recover, but rather to give up and to become even less fitted to survive.

To sum up for the opponents of the welfare state in Sweden, they feel that with respect to law and morality and with respect to economic considerations as well there is the same tendency to free the individual from any personal responsibility for his actions and his fate. A murderer, a cheat, a thief, a vagrant is not at fault in the old sense. He is a victim of his surroundings, unfortunate circumstances, overwhelming temptations, all of which are the faults of society. It follows that punishment must not be deterrent or preventive, but suitable for the individual criminal. If that does not work it is the fault of the community. Yet the same "progressive" viewpoint is not applied to other crimes against the welfare state, such as tax evasion, which on the contrary is severely punished. We are entering into a period of dangerous underevaluation of the individual's capacity to bear the risks for his acts. Every person is born as an individual and as a social being. At the present time a renascence of individualism is needed.

What are the reasons for setting up a governmental system of health insurance? Dr. Karl Evang of Norway has pointed out that practically every one gets sick at sometime or other, and cannot work for a shorter or longer period.[163] The sick person is withdrawn from his normal place in society and is unable to carry out the dual responsibility of performing his work and supporting his family. And all this not through any fault of his own. Medical science has greatly improved in the twentieth century so that it can now cure many

163. EVANG, *supra* note 62, at 13.

more illnesses than formerly, and can do so more speedily. On the other hand, medical care has become much more expensive than formerly. Most people do not have personal economic resources to meet the expenses of illness without difficulty. If the illness continues a long time, or requires an operation or other expensive treatment, the family may undergo economic disaster. Fear of the costs may keep a person from calling the doctor early enough or taking the proper treatment which in turn may result in longer confinement or in a relapse. The lack of medical care may occasionally produce such bitterness that it is followed by parasitic dependency, mental unbalance, criminality, and even suicide.

One of the advantages of the Scandinavian systems is that they protect the people from having to go into debt for health services. According to a report published in the New York Times for January 24, 1924, illness in the United States puts 8,000,000 families, or 16 percent of all families, into debt each year for medical, hospital, and dental services. In July, 1953, the debt amounted to $1,100,000,000.

Among the weaknesses of voluntary insurance is that workers are unwilling to pay for adequate and comprehensive insurance. They will pay only when required by the government. Another weakness is that workers in the lowest brackets are not covered, and do not have the money to be covered. It is possible to cover the lowest brackets only when there are contributions from the government, the employer, and other workers with more means. This is doubtless the major reason for compulsory insurance. Voluntary insurance means that poor relief must take care of much of the costs of illness. Where there is only partial coverage those not covered not only do not share in the costs of health insurance but actually benefit to the extent that expenditures for public assistance or poor relief are reduced.[164] Compulsory insurance means that poor relief for illness is reduced to a very minor proportion. Compulsory insurance gives the whole population a legal right to assistance. Voluntary insurance confers it on merely the fortunate group who are able and willing to pay for voluntary insurance. Workmen's compensation has worked well largely because it is compulsory. Voluntary systems tend to exclude those who are sick or old or poorly paid.

Why is the system of individual contributions retained in the Scandinavian states when coverage becomes universal?

164. FREEDOM AND WELFARE 399.

There are several reasons.[165] Historically, the concept of social insurance is tied to the payment of contributions. Health insurance is to a considerable degree administered by local authorities or self-governing insurance institutions; hence because of this independence economic responsibility is also entailed. Psychologically, the payment of contributions conveys to many people a feeling of self-respect. Finally, general taxes need not be increased, and many feel that general taxes are already too high. While contributions from employers, in effect, are paid by the consumers of goods, politically this is less difficult than raising the money by ordinary taxation. It should, therefore, be borne in mind that Scandinavian health insurance is quite different from "socialized medicine." Socialized medicine involves payment of the costs by general taxation and the physicians are state employees on a salaried basis. The Scandinavian systems now involve and have always involved substantial contribtutions from the insured population made for the specific purpose of paying for health insurance. The physicians are not state employees and are not paid on a salary basis. They are paid on a fee-for-service basis although in Denmark they are also paid on a panel or per capita basis.

Scandinavian patients like health insurance for a number of reasons. They obtain health protection as a matter of legal right, and not as charity. Relief costs for medical care are kept to a low figure. Even the most expensive treatments are available to all. Serious illness is no longer a financial catastrophe. The service is complete and comprehensive. The contributions paid by the insured are small compared with the benefits received. A few years ago an American from Utah polled a thousand Norwegians in the streets of Oslo as to whether they liked government health insurance. All replied in the affirmative. The American was amazed and proceeded to poll another thousand. Again all replied in the affirmative.

Scandinavian physicians like health insurance because all the people are covered and because they receive comprehensive benefits. Physicians can disregard costs in prescribing treatment and visiting patients. There is better distribution of specialists throughout the country. More and better hospitals are provided. Physicians are assured of larger incomes and easy collection of fees. Physicians are not obliged, as in

165. *Id.* at 400.

America, to engage in Robin Hood justice by over-charging the well-to-do to make up for free services to the indigent. The conscience of the Scandinavian physician is clear. Unlike many American physicians, the typical Scandinavian physician has not become too proud or too arrogant. He does not feel that the great accomplishments of Scandinavian medicine has given him the right to be sole judge in matters of profound social need. There seems to be no general impression in the Scandinavian medical associations that health insurance has unduly increased the number of malpractice suits. While some English writers have asserted that English health insurance has increased malpractice suits, an American observer has stated: "Malpractice insurance is even more necessary in the United States than in England, as the general public is extremely litigious."[166] Very few general practitioners in the Scandinavian countries feel that health insurance has unduly increased the amount of work they have to do or that the population makes too frequent use of their services for trivial reasons.[167]

The adoption of government health insurance does not mean that individual rights will be ignored and that liberty and energy will disappear. Julius Bomholt, Minister of Social Affairs for Denmark, stated in an article in the Copenhagen newspaper, *Politiken*, on November 17, 1958: "The Danish democratic system — and here I have in mind Conservatives, Liberals and Socialists — share in a common tendency to place the individual before the community and the community before the state." As John Stuart Mill remarked in his *Essay on Liberty*: "Energy and self-dependence are as likely to be impaired by the absence of help as by its excess."

Joshuah Liebman, well known American writer, in his book *Peace of Mind* insisted that the highest goal was peace of mind, rather than health, wealth or fame. But one of the most spiritual of modern men, Aldous Huxley, has pointed out that "without health the steady persistence of effort required by the spiritual life is very difficult of achievement."[168]

Article 25 of the Universal Declaration of Human Rights, adopted by the General Assembly of the United Nations in

166. BRIT. MED. J., 1956, ii. 596.
167. The English experience has been that the quantity of work of physicians has not increased, but, if anything, it has decreased. TITMUSS, *supra* note 29, at 173-175, 203-214.
168. HUXLEY, THE PERENNIAL PHILOSOPHY 109 (1946).

1948, provides: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." The Constitution of the World Health Organization provides: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." In 1952, the President's Commission on the Health Needs of the Nation issued a group of guiding principles the first of which stated: "Access to the means for the attainment and preservation of health is a basic human right." And an "increasing number of Americans appear to have adopted the view that 'adequate medical care' is as much implicit in the right to 'life, liberty and the pursuit of happiness' as, for example, public education."[169]

VIII. The American Alternatives to Compulsory Health Insurance

According to the United States Public Health Service, 20 days for each American were lost because of illness and injuries during the year preceding July 1, 1958. About 12.4 percent of the time lost was due to injuries, the balance due to illnesses. "It is, however, one thing for a society to agree on the importance of good health and good medical care; quite another for it to agree on how good health may be achieved by organizing and distributing its medical resources in alternative ways."[170]

Group practice has not offered a completely satisfactory alternative to compulsory health insurance. State and local medical societies object to plans which are not controlled by the societies themselves. In about half the states lay-controlled prepayment groups are treated as illegal.[171] Moreover, a considerable number of workers are suspicious of such plans

169. Somers and Somers *supra* note 160, at 376, 383 (1958). In 1937 Dr. John Kingsbury, former Secretary of the Milbank Memorial Fund, stated: "I think that the time will come when one will feel that medical care must be brought to the people just as education is brought to them." Social Security in the United States 171 (1937).

170. Titmuss, *supra* note 29, at 135.

171. Hansen, *Group Health Plans — A Twenty Year Legal Review*, 42 Minn. L. Rev. 527, 531 (1958).

because they think that the quality of medical care will not be as high as desirable.

Unions began to bargain for hospital and medical care about 1946.[172] But the system of securing medical care through labor union welfare funds has not always worked with entire satisfaction. The labor unions insist that they must have a voice with respect to doctors' fees and quality of service, or go broke. The physicians on the other hand contend that this violates the patient's right to choice of doctor, and that the medical profession can be relied on to prevent overcharging or questionable medical practices. Dr. Warren Draper, Executive Medical Director of the United Mine Workers welfare and retirement fund, says that his experience during a decade of buying medical services has been that there has been no adequate policing.

Health insurance obtained through collective bargaining has several other disadvantages. Increasingly the trend is for the employer to assume all costs. This means that the consumer foots the bill. Many workers do not have the benefit of such contracts. Even if there is a contract covering the worker, it may not cover his dependents. Most plans do not provide for preventive care, such as general physical examinations. Most plans do not cover catastrophic illness. Most plans do not cover unemployed, partially employed, or retired employees. The welfare fund insurance often fails to cover doctors' bills for office or home visits. This was true in three-fifths of the cases in New York. Hospital bills were paid for only 86 percent of the hospital costs. Only half the costs of medical care were paid even in cases involving hospitalization. The welfare insurance plans make no provision for dental care. It was not until 1958 that any plan embodied such a provision; a union in New York obtained such a plan. The employer pays a premium of $1.65 a month. All expenses are covered when the dentist is a participant in the plan and the employer's income is $5,000 or less.

Labor unions may use the insurance funds to obtain low-grade medical care.[173] This was the finding of a joint labor-management foundation which studied the situation in the state of New York. Many union members went to non-ac-

172. In 1954 eleven million workers were covered for health insurance under collective bargaining agreements. In 1956, 85 percent of union workmen were covered. THE EMPLOYMENT RELATION AND THE LAW 799-80. (1957).
173. N. Y. Times, Jan. 17, 1959, p. 56.

credited hospitals for surgery, obstetrics, and other medical services. Many of the physicians and specialists consulted were of low standing. In many cases the plan is administered only by the employer or by the union so that decisions may be arbitrary.

At the beginning of 1958, 71 percent of Americans were insured for hospital insurance, 64 for surgical insurance, and 42 for non-surgical medical insurance.[174] The last category of non-surgical medical insurance is limited in character as it covers only doctor's care in the hospital and not outpatient services. None of these voluntary insurance systems provides for daily cash benefits to take the place of earnings lost during illness. Yet, in most of the 59 nations of the world which have government health insurance systems such benefits are paid.[175]

About 29 percent of the population, some 49 million, have no health insurance of any sort.[176] Over half of those protected by health insurance are limited to hospital and surgical protection. Only about five percent of the population are enrolled in plans providing comprehensive physicians' services.

Those with low income are not likely to be covered. In 1953 families with incomes over $5,000 were twice as likely to have some form of health insurance as families under $3,000, 80 percent and 41 percent respectively. According to the October, 1958 issue of the Social Security Bulletin "about 6 million families with insufficient income to meet subsistence received payments under public assistance" during the year 1957. In other words about 24 million persons were aided. Mr. Leon H. Keyserling, former Chairman of the President's Council of Economic Advisers, stated recently that there are "almost 17 million American families above $1,000 but below $4,000 most of whom certainly live in poverty by current U. S. standards." This failure of voluntary health insurance to cover the low income groups is surely one of the gravest defects in voluntary health insurance and at the same time one of the most powerful arguments for compulsory health insurance.

Rural areas are not likely to have full coverage. In urban areas 70 percent have some protection. In rual nonfarm groups the percentage is 57, and among farm groups only 45.

174. Somers and Somers, *supra* note 160.
175. SOCIAL SECURITY PROGRAMS THROUGHOUT THE WORLD, No. XV, (1958).
176. Somers and Somers, *supra* note 160, at 518.

Voluntary health insurance plans often charge lower premiums to young employees. This means that older employees pay higher rates. This violates one of the tenets of compulsory insurance systems that the good risks help pay for the poor risks. This weakness exists not only in commercial insurance plans but also in many non-profit plans. The non-profit plans are under pressure to adopt this system to meet the competition of commercial insurance companies; otherwise they would be left with too big a proportion of poor risks.

The old are not likely to be covered in voluntary systems. After 65 coverage declines to about half the national average. In 1956 only 37 percent of those over 65 had some insurance. In 1958 about 43 percent of Americans over 65 carried hospital insurance. But the costs are very high at a time of life when income is very low. The largest American company charges $8.50 a month.[177] Upper limits in fixed dollars and limited time periods are provided as to hospitalization, convalescent home nursing care, and surgery. No provision is made for payment for physicians' care outside the hospital nor for medicines and drugs.

In December, 1958, the American Medical Association indorsed a program for cheap voluntary health insurance for elderly persons with low incomes and modest resources. But low income was not defined, and hospital care was not to be included. The program would not cover either charity patients or persons who can afford insurance at present prices. The Federal Department of Health, Welfare, and Education will provide Congress with a report in 1959 on possible ways to provide health insurance under the Social Security system for persons over 65, such as contracts with private insurance groups, and grants-in-aid to the States. Congressman A. J. Forand of Rhode Island has again introduced his bill to levy additional Social Security taxes to provide the aged with hospital, surgical, and nursing home insurance. There would be a 0.5 percent tax on wages, 0.5 percent on employers' payrolls, and 0.75 percent on revenue of self-employed. The American Medical Association has attacked the Forand proposal as opening the door to national compulsory health insurance.[178] On the other hand a recent official report in England has recommended more welfare provisions for old people.[179]

177. N. Y. Times, Mar. 8, 1959.
178. BLOOMGARDEN, BEFORE WE SLEEP, *supra* note 147, at 39; N. Y. Times, Mar. 11, 1959, p. 22.
179. TITMUSS, ESSAYS ON THE WELFARE STATE 149 (1959).

Voluntary health insurance is likely to be taken out almost exclusively by the employed. In 1953, 77 percent of all families who had any health insurance got it originally through their employer, union, or other group enrollment.[180] Even the fact of having been an employee may not insure coverage. If employment is lost due to old age, retirement, serious disability, or business shutdown, the health insurance is automatically cancelled. Blue Cross and Blue Shield are primarily geared to group insurance. There may be conversion to individual insurance, but the premium is increased by about twenty percent.[181] One who is covered by group insurance taken out with a commercial health insurance company will often find that conversion to individual coverage is not permitted or is almost prohibitive in price.[182] Group insurance is aimed at rather large groups, usually requiring 25 or 50, and 75 percent participation.

For those not covered by voluntary health insurance, such as persons with small incomes, the aged, and the seriously disabled, the growth of health insurance has meant that they pay higher prices for health care and obtain none of the advantages of health insurance. Compulsory health insurance distributes the costs over the whole population. It makes it possible to cover those who are economically weak, those who are in poor health, those who are in their older years, those who are not employed by others, and those who do not have the benefit of contracts and agreements for health insurance between employers and employees, and those who for various reasons are excluded from voluntary health insurance groups.[183] It makes it possible to protect the entire population without employing mean tests which are humiliating and difficult to administer.[184] It makes it unnecessary to stretch workmen's compensation laws to cover non-occupational diseases.[185]

Governor Nelson Rockefeller in his message to the New York Legislature of January 7, 1959, referred to the gaps in coverage in voluntary health insurance. It does not cover costs of doctors' and nursing care outside the hospital, or diagnostic and preventive services, or mental illnesses.

180. Somers and Somers, *supra* note 160, at 519.
181. *Id.* at 510-511.
182. *Id.* at 511.
183. Willcox, *Patterns of Social Legislation: Reflections on the Welfare State*, 6 J. PUBLIC LAW 3, 23 (1957).
184. 59 YALE L. J. 292, 307 (1950).
185. THE EMPLOYMENT RELATION AND THE LAW 270 (1957).

About two-thirds of the annual charges for all personal health services to insured families are incurred for services not covered under health insurance.[186]. Among the services not covered are physicians' home and office calls. Yet, of private expenditures in 1956 for medical care and voluntary health insurance, 33.9 percent was for hospital services, 29.9 for physicians' services, 20.7 for medicines and appliances, 8.8 for dentists, and 6.7 for others.[187] Mental diseases and tuberculosis are not covered.

How inadequate voluntary insurance is in paying for doctors' fees in America is shown by the fact that only about ten percent of the average physician's gross earnings come from Blue Shield and other health insurance plans.[188] About 90 percent of physicians' services are provided outside of hospitals.[189]

A recent survey in New York showed that the average family spent $18 for medicines, vitamins, and other drugs in a three-month period. This represented two-fifths of all that such persons paid out of their own funds for medical care.

Governor Nelson Rockefeller in his message to the New York Legislature of January 7, 1959, pointed out that in New York only 10.1 percent of employees in New York had protection against serious and long-term illness. Only state employees and employees of some private firms had "major medical" insurance. Yet catastrophic illnesses account for about half of the nation's total medical bill.[190] Eleven percent of the families in any given year have medical expenses of $500 or more.[191] In 1956 only three percent of the American people had comprehensive protection.[192] Yet six million families had medical expenses totaling 10 to 19 percent of their income. Three million families had expenses totaling 20 to 99 percent of their income. Half a million families had expenses equaling or exceeding their income. Eight million families had medical debts totaling $1,100,000,000. It has been estimated that three-fourths of the population cannot meet the costs of serious illness.[193]

186. Somers and Somers, *supra* note 160, at 524.
187. *Id.* at 377.
188. *Doctor's Income From Health Insurance Plans*, 33 MEDICAL ECONOMICS 110 (1956).
189. N. Y. Times, January 8, 1957, p. 32.
190. Drucker, *The Medical Insurance We Need Most*, Harper's Magazine, May 1953, pp. 50, 51.
191. N. Y. Times, January 7, 1957, p. 18.
192. N. Y. Times, October 9, 1956, p. 24.
193. 59 YALE L. J. 292, 301 (1950).

Even the comprehensive voluntary systems leave much of the costs to the insured. It has been estimated that only about half of the average family's medical costs are covered.[194] Critics of comprehensive insurance point out that it usually has a deductible feature to keep premiums low.[195] The deductible amount often runs from $100 to $500. Furthermore the insured is usually responsible for a fourth or so of expenses incurred after the period of deductibility. These features make it too expensive for low income families. They need protection against small and moderate losses. Physicians' charges are likely to spiral. Costs of such insurance would be exorbitant except in group plans. The aged are not covered. There is no provision for periodic health examinations and preventive medicine.

In 1956 voluntary health insurance paid for only 24.9 percent of private expenditures for medical care.[196] The total expenditures were $12,091,000,000, and the insurance benefits $3,015,000,000. As of 1955, 50 percent of hospital bills were paid by insurance, 13 percent of doctors' bills, less than one percent of dental bills, less than one percent of bills for medicine and appliances, and one percent of bills for opticians, private nurses, chiropractors, and laboratory tests. Health insurance in America now pays 50 percent of all general hospital bills, 40 percent of all surgeon fees, and about 20 percent of all doctor bills.[197] In 1957 insurance paid only 25 percent of private medical expenditures for medical care. For general hospital care, insurance is now paying about 50 percent of the total private expenditures incurred by all families, and 75-80 percent for the insured; for surgery, 40-45 percent for all and 76 percent for the insured; for all physicians' services, 13-28 percent for all families.

Commercial insurance policies do not give full protection as they usually provide for indemnity benefits rather than services. Thus the insured may often find that he must pay considerable sums out of his own pocket. The number of dollars paid per day may be inadequate and the number of days of protection given also inadequate.

Voluntary insurance is becoming more and more expensive. During the year ending July, 1958, 34 plans in 28 states raised

194. Somers and Somers, *supra* note 160, at 525.
195. N. Y. Times, January 8, 1957, p. 32, See Silverman *The Post Reports on Health Insurance*, Sat. Even. Post, June 21, 1958, p. 30.
196. Somers and Somers, *supra* note 160, at 377.
197. *Id.* at 547-548.

premiums as much as 60 percent.[198] The costs of American voluntary health insurance are increasing at the rate of 5 percent a year.[199] Much of such increases are due to abuses by patients, doctors, hospitals, labor unions and management. In 1956 a state commission was appointed in Michigan to look into the causes of six raises in health insurance rates since the end of the war. Standard group — hospitalization that cost $24 a year in New York and Philadelphia in 1946, now costs $64 in New York and $81 in Philadelphia. The District of Columbia and four states, Michigan, New Jersey, New York, and Pennsylvania, have started official studies of soaring medical expenses.[200] In Massachusetts a privately financed study of hospital costs is underway.

Where health plans are administered by labor union officials, the funds are sometimes plundered by the officials.

The concentration in America on hospital insurance has resulted in an abuse of hospital use.[201] The absence of other types of health insurance means that people try to use their hospital insurance to cover part of their uninsured costs. The insured enters hospitals more often and stays there longer than the uninsured. On the other hand persons with comprehensive health insurance use the hospitals less.

Hospital costs are rising at the rate of five to ten percent a year.[202] The daily cost at the Massachusetts General Hospital went from $10.60 in 1946 to $35.47 in 1957. The average cost of a day in a hospital in Indiana increased six percent, from $22.60 on October 1, 1957, to $23.97 on October 1, 1958.

At the present time the average person spends five percent of his income for medical care.[203] In 1948 he spent only four percent. Thus, he now spends twenty percent more than he formerly did.

Data collected by the Federal Bureau of Labor Statistics in 1958 reveal that while overall living costs have risen in the last decade by 23.5 percent, the medical care category has risen

198. *Id.* at 531.
199. Silverman, *supra* note 195, at 25, 128.
200. *The High Cost of Being Sick,* U. S. News and World Report, p. 73, Mar. 16, 1959.
201. Somers and Somers, *supra* note 160, at 390-395; Clark, *Why It Costs So Much To Go To The Hospital,* U. S. News and World Report, Mar. 16, 1959, pp. 77, 78.
202. *The High Cost of Being Sick, supra* note 200, at 73, 76.
203. *Id.* at 74. At the same time English expenditures have gone down. The proportion of total national resources paid for by public authorities fell from 3.75 percent in 1949-1950 to 3.23 percent in 1955-1956. TITMUSS, *supra* note 179, at 149.

nearly 43 percent, or more than any other item. The medical care category, broken down, shows that in the last ten years hospital room rates have increased by 96 percent, doctors' fees 36 percent, dentists 30, eye examinations and glasses 16.5, and prescriptions and drugs 20 percent. Professor Seymour Harris of Harvard University states that the cost of hospital treatment has jumped ahead of general inflationary price levels by almost one-third since 1947. Partly to blame are the medical insurance plans, covering only a part of the population, since such plans stimulate excessive use of hospital and doctor services. Those under the plans are protected at the cost of those not covered.

Dr. Karl Evang, Director General of Health Services in Norway, who visited the United States recently found many complaints about the high costs of medical care in the United States.[204] He tells of an American businessman who figured that the hospital bill he had received after a stomach operation was so large that if he had taken an airplane trip first class to and from Norway and entered a Norwegian hospital and paid the usual charges he could have saved $250.00.

Voluntary insurance has frequently resulted in bill padding by physicians. Their bills are often apparently based on the ability of the insurance fund to pay, rather than on the patient's.[205]

The Scandinavian countries have been able to make use of medical men as employees of hospitals without encountering the legal difficulties which have recently arisen in America. The American Medical Association urges that hospital radiologists, anesthesiologists and pathologists be paid directly by the patient on a fee-for-service basis rather than by the hospital on salary which they refer to as the "corporate practice of medicine."[206] The recent legal rulings have tended to favor the position of the American Medical Association rather than that of the hospitals.

There can be little doubt that government health insurance makes for standardization of doctors' fees. That has certainly been the experience in the Scandinavian countries. In the United States on the whole there is little standardization of

204. EVANG, *Syketrygd — Et brennende Spørsmal i U.S.A.*, [*Health Insurance — A Burning Question in the United States.*] SOCIAL TRYGD, July 1958, pp. 234-236.
205. Silverman, *supra* note 195, at 25.
206. WILCOX, HOSPITALS AND THE CORPORATE PRACTICE OF MEDICINE (1957).

fees though there are plans in California, Iowa, and Kansas. The District of Columbia Medical Association is studying the problem, apparently with the purpose of combatting the movement for government health insurance.

In 1953 the average annual cost of personal health services was $65.[207] In 1957 the average American family spent $280 a year for medical care, or five percent of family expenditures.[208] It has been estimated that a family can be insured against 50 to 70 percent of all its medical costs for $180 a year.[209] In practice in the past a family has been insured for 25 percent of medical costs for $100 to $114 a year. Former Secretary of Health, Education and Welfare, Marion B. Folsom, has pointed out that "the financial problems of health insurance have generally been met" in the nations which have health insurance.[210]

In 1956, 21.4 percent of all expenses for personal health services were paid for by the government, compared with 18.9 percent for private health insurance.[211] Nearly 44 percent of all hospital income came from tax sources.

Administrative costs for voluntary health insurance in America amounted to 17 percent of premiums in 1956.[212] But they amount to 47.2 percent as to commercial non-group policies. On the other hand administrative costs have been kept very low in the Scandinavian countries. In 1954, of the average expenditures per adult insured, the percentage for administration was 14.5 in Sweden, 11.1 in Denmark, 7.6 in Iceland, 5.5 in Finland, and 4.4 in Norway.[213] Thus charges of some American physicians that compulsory health insurance necessarily involves expensive bureaucratic costs are wholly without foundation.

The American alternatives to compulsory health insurance have been far from adequate and even then they have been fought bitterly by many groups. As one writer has concluded: "The organized medical profession as represented by the American Medical Association and many of its state and county units has fought all such experiments with undiscriminating opposition; it has never been smart enough to concoct

207. ANDERSON AND FELDMAN, FAMILY MEDICAL COSTS AND VOLUNTARY INSURANCE, 30-35 (1956).
208. Somers and Somers, *supra* note 160, at 388, 389.
209. *Id.* at 508, 536.
210. SOCIAL SECURITY IN THE UNITED STATES 226, 233 (1938).
211. Somers and Somers, *supra* note 160, at 508, 550.
212. *Id.* at 529 n. 73.
213. SAMORDNAD, *supra* note 23, at 46.

a plan of its own that caught the public imagination; and now that the tide is rising in favor of federal insurance the A.M.A. begins to advocate the same sort of voluntary prepayment plans as it was lately opposing. A large part of the thinking public has become convinced that the organized profession is simply fighting a rear-guard action against the advance of a necessary social reform."[214]

Possibly it will take the impact of a war felt directly by civilians on American soil as through atom bombs and missiles to make the American people see the need for compulsory health insurance. This seems to have been the case in Great Britain. Victory in the Second World War "depended not on the efforts of a fraction of the population but on virtually the efforts of all citizens."[215] It "was necessary to take positive steps in all spheres of the national economy to safeguard the physical health of the people; it was also an imperative for war strategy for the authorities to concern themselves with that elusive concept 'civilian morale'." The war could not have been won "unless millions of ordinary people, in Britain and overseas, were convinced that we had something better to offer than had our enemies — not only during but after the war." The ancient Greeks believed that physical health was an absolute good largely because they were involved in continuous wars. Our civilization faces the same prospect.

214. CORNER, ANATOMIST AT LARGE (1958), quoted in the Saturday Review, Mar. 7, 1959, p. 57. The cost of the propaganda campaign to "alert the American people to the danger of socialized medicine launched by the American Medical Association in 1950 was $19,000,000.00." New York Times, September 17, 1950.

215. TITMUSS, *supra* note 179, at 81-82.

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