Modern Implementation of Denmark's Tradition of Health Care Delivery

Dr. Johnson is a consultant with the Office of Consumer Education and Information, Health Maintenance Organization Service, Health Services and Mental Health Administration. During a recent visit to Denmark she interviewed key members of the Ministry of Health and the Ministry of Labor and Social Affairs and toured several social and medical institutions in Copenhagen. The paper is also based on information from pertinent documents in the literature.

Tearsheet requests to Dr. Elizabeth F. Johnson, Health Maintenance Organization Service, 13A–03 Parklawn Building, 5600 Fishers Lane, Rockville, Md. 20852.

The beginnings of Denmark's tradition of health care delivery can be traced to the Middle Ages. Its modern cornerstone was the Royal Ordinance of 1806 which decreed uniform hospital service for all. Historically, health services in Denmark have been based on the principle that medical care should be free—a right. Treatment and care were free of charge, and this principle of access to hospital treatment has been maintained. Upon payment of an additional amount, a person could have a single room, rather than being in a ward, but the treatment was the same for everyone.

In the middle of the 19th century, Danish physicians established "sick clubs" with the cooperation of the poor working class and the rural population. Through such an arrangement, however, physicians took an economic risk. The physicians were paid by the members from a fixed enrollment fee and they, the physicians, provided treatment. In 1933 a parliamentary act made membership in a "sick club" compulsory, and the clubs received certain subsidies from the State. This Danish principle, "free medical treatment by the general practitioners—no money between patient and doctor," is still followed. Through the sick clubs, 80 percent of the Danish population was assured equal access to medical treatment.

Recent Legislative Landmarks

Medical aid and other benefits became available to the Danish population through the Health Insurance Act of June 10, 1960; the benefits were amended by an act of March 29, 1968. These acts were based on principles that date from 1892 in Denmark—mutuality, voluntary membership in

ELIZABETH F. JOHNSON, JD

State-supervised sickness funds, autonomy of operation with State supervision, and State grants to the less well-to-do. In other words, they embody the concept of aid toward mutual aid.

Supplementing the medical aid provisions of these two acts was an act of May 19, 1967, setting up cash benefit insurance and other benefits. But a system of tax-supported health care, available to all citizens as a municipal service, was established by the Public Health Security Act of 1971. The new system, unifying health and social services, went into effect April 3, 1973.

Many provisions of the earlier acts will remain in effect under the new system. In subsequent sections of this paper, the framework of the health care system of Denmark before April 1973 will be outlined, and in the final sections the new system will be described.

The Sickness Funds

The health insurance system was administered by State-approved, State-subsidized health insurance funds (sickness funds) open to all persons, irrespective of occupation and income. The funds had two divisions, one for persons whose incomes were below a specified limit, division A; and one for persons whose incomes were above this limit, division B. Only one sickness fund operated in each local district or municipality. The members elected the executive committee, and at least two persons on the committee were elected to represent the local city council or rural district council. The executive committee and the general membership took full responsibility for the operation of the fund within the framework of the law.

Local funds were combined into central associations, each normally covering a county; these central associations then formed a national organization. The national organization, among other functions, negotiated collective agreements with general practitioners, midwives, dentists, and other health workers and approved the agreements entered into in the interest of the funds in relation to the public authorities and other societies. The local funds had to be approved by the Ministry of Social Affairs and were subject to the supervision of the Directorate of Health Insurance. The Directorate approved the rules of the funds, supervised their activities and, subject to an appeal to the Ministry of Social Affairs, settled disputes between funds and members.

Every person who was entitled to join a sick-

ness fund as a division B member could choose instead to join a health insurance society for persons of means. Before 1960, all persons whose incomes were above the income limit were required to join a society. The benefits granted were almost the same as those granted B members of a sickness fund, and the contribution was almost equal to that paid by B members to the funds.

Membership

The income limit for members in the A division was fixed on January 1 each year by the Minister of Social Affairs in accordance with the cost-of-living index. The limit was higher for persons with families or dependents than for single persons and was, moreover, increased by a certain amount for each child under 16 years of age.

A person was free to decide whether to take an active membership; before April 1973, 96.7 percent of the population was actively insured against sickness. Those who were not active members were obliged to become associate members with the right to transfer to active membership at any time—regardless of age or health status. If the member failed to pay the membership fee, the amount was paid by the municipality, which recovered the arrears in accordance with the rules applying to the collection of taxes.

Husband and wife took out membership separately. Children under age 16 were covered by their parents' membership. When a child reached the age of 16 he was given the option of active or associate membership in the fund and, as the community was interested in having as many members of the population as possible insured against sickness, the funds made an effort to encourage young persons to join as active members.

Everything was done to make benefits in the two divisions equal so that the effect of transfer from one division to the other would be felt as little as possible. Members of both divisions had the right to the same categories of benefits, but owing to special circumstances, the way in which some of the benefits were provided differed. All benefits—except those in cash—were unlimited as to time; as long as treatment was needed, the fund would pay. Most benefits were automatic; some less important ones were optional.

Automatic Benefits

Medical care by a general practitioner. A major difference in the A and B divisions was in the provision for medical care by a general practitioner; members of the A division were covered by agreements between the funds and the Danish Medical Association; members of the B division were not so covered. There were two agreements, one for Copenhagen and one for the remainder of the country. Both agreements were built on the family physician system.

In Copenhagen, general practitioners were appointed by the sickness fund. The city was divided into districts, and several physicians were appointed in each district. The members were free to choose their physician from those appointed to the district for that year. Ordinarily a general practitioner was allowed to list a maximum of 2,200 members, but on the average, there was one general practitioner for each 1,500 members.

Outside Copenhagen, members chose their physician for the next year from among physicians who had declared themselves willing to undertake practice for sickness funds, subject of course to certain geographic limits. The physician received about one-half of his yearly income as a fixed per capita fee; in addition, the fund paid the physician for each visit according to fees specified in the agreement. These agreements between sickness funds and participating physicians were of the greatest importance for the Danish public health insurance system, not only because the fees were somewhat lower than for private patients, but because many matters in connection with the physicians' practice were fixed in the agreement.

Members of the B division had to pay the physician's bill out of their pockets as private patients. The rules of the funds provided that B members recovered part of the bill. The amount reimbursed was equal to what the fund should have paid for a member of division A.

Specialist services. Specialist services for A members and B members also differed. Generally a number of agreements on behalf of A members covered almost all specialities and provided for a limited number of free consultations and treatment visits every year. However, there was no limitation for patients with eye diseases or ear, nose, and throat diseases. No aid was granted towards the cost of specialist treatment unless the A member patient had been referred by his family physician. Only if the family physician could not cope with the diagnosis and treatment, was the member entitled to apply to a specialist at the expense of the fund. In the referral, the family physician needed to state whether the patient re-

quired diagnosis, supervision over a period, or treatment by the specialist.

B members, treated by specialists who had an agreement with A members, received a refund equal to the amount the fund paid for an A member. B members needed no referral from a general practitioner. For certain special examinations and treatments, an extra fee was paid for both A and B members. If a specialist had no agreement with the sickness fund, his patients—A members as well as B members—were reimbursed for four-fifths of their expenses up to a certain limit.

Hospitalization. The funds provided free treatment and care of A and B members in the common wards of public hospitals and in certain hospitals for special diseases. The funds paid only a part of the actual cost of hospitalization; the greater part was borne by the local authorities and the State. Hospital benefits were unlimited as to time, except for treatment of more than 2 years in mental hospitals.

Medication. A and B members received identical benefits for medication. They received three-fourths of the cost of medication prescribed by a physician, provided that the medicine had been approved by the Ministry of Social Affairs, thereby qualifying as an automatic benefit. This provision applied to medicines that were especially important in the treatment of the patient. The remaining fourth of the cost was borne by the member himself or, in certain cases, by the Invalidity Insurance Fund.

Home nursing. Since 1957, home nursing had been provided through the local municipalities. All members of a health insurance fund were entitled to free home nursing by a trained nurse.

Maternity benefits. A woman who gave birth at home received the free services of a midwife. Unlike the agreements with physicians, this agreement covered A as well as B members. The A member also received free medical service including anesthesia. The B member recovered the portion of the bill that the fund should have paid if she had been an A member. Both A and B members who gave birth in a public hospital stayed there free of charge. In the towns there are a number of private maternity homes, and an A member going to such a home received a certain amount per day towards the cost of care in the home, as well as payment of her midwife and physician, according to the rules applying to confinements at home.

Funeral benefits. These benefits were adjusted according to the ordinary cost-of-living index.

Necessary transportation. Necessary conveyance of A members to and from the hospital, physician's office, or midwife was paid by the local authority. Similarly, physicians and midwives were reimbursed by the municipality for conveyance within certain limits fixed by the act. Only physicians practicing in rural areas were entitled to payment for conveyance.

Optional Benefits

The funds could grant aid towards certain optional benefits.

Stays in convalescent homes. Patients could stay free of charge in convalescent homes that were approved by the Minister of Social Affairs. The fund paid expenses, however, only during the final stage of treatment and for 4 to 6 weeks at the maximum.

Medication. In addition to the medicine covered under automatic benefits, a fund could pay for medicine for patients suffering from prolonged and serious illnesses. These medicines, such as analgesics, were not especially important for treatment, but were important to the patient.

Dental benefits. Almost all health insurance funds provided aid for dental care. An agreement between dentists and the funds provided that A members receive preservative care, such as fillings, and members born in 1945 or later could get preventive dental examinations as well. Rates for various services were fixed in the agreement. B members paid the dentist directly but were reimbursed by the fund for the same amount granted to A members.

Special benefits. In practice, all funds paid part of the cost of glasses and small bandages. Large bandages, artificial limbs, hearing aids, and other appliances were paid for by the Invalidity Insurance Fund. Many funds granted aid for the services of a physiotherapist, either for treatment at home or in an approved clinic.

Travelers' health insurance. Until May 1967 health insurance funds had been entitled to grant benefits only in Denmark. By amendment to the act of May 19, 1967, the funds were empowered to grant medical aid to members falling ill during a temporary stay abroad. Aid could be granted during journeys in Europe, the Mediterranean countries, the Canaries, and Madeira. Some of the benefits granted were full reimbursement of medical expenses and expenses for treatment in hospitals, prescribed medicine, transportation home if prescribed by a physician because of illness, and

transportation home in case of death. For dental treatment, a limited reimbursement could be granted.

Business trips and the part of a journey in excess of 2 months were excluded from coverage under the act, and reimbursement could be granted only for expenses not covered by agreements between Denmark and the countries listed previously. The travelers' insurance was administered by a private insurance company, and a premium was paid for each active member of the funds who had become a party to the agreement with the private firm.

The Act of May 19, 1967

Preventive examinations and cash benefits were added to the health insurance system by an act of Parliament passed May 19, 1967. Before May 1967 medical aid was granted only in the event of illness. The funds were empowered to grant aid for preventive health examinations, cancer check-ups, for example. An agreement had to be entered into by the funds and the physicians before the benefit could be granted.

The act provided for two categories of cash benefits, compulsory insurance for wage earners and voluntary insurance for self-employed persons, housewives, and others. The duration of the benefits was identical and, for reasons of administration, an attempt was made to keep the rules the same as far as possible for the two categories, but on certain important points they differed.

Cash benefits for wage earners. Workers receiving no wages during sickness were in a very difficult situation, and the obligatory cash benefits had been designed to help them. A wage earner receiving wages during illness was not entitled to this cash benefit and, for practical reasons, persons whose work was of short duration or who worked only occasionally were also excluded. Connection with the labor market was the decisive factor, and employment for at least 40 hours during the 4 weeks immediately preceding illness was the condition for eligibility. Sick pay benefits replaced unemployment benefits for the unemployed person who became ill.

Cash benefits were paid at three rates—for head of families, for single persons, and for young workers. These fixed sums were paid to all wage earners who had notified their sick fund, regardless of the size of the earnings. No allowances for children were paid. Benefits were payable for 156 days in the course of 12 consecutive months and for a total of 468 days during 36 consecutive months.

Persons with protracted illnesses could obtain invalidism pensions in suitable cases; in others, the municipality could step in. In protracted illness, attention was, of course, given to the potential for rehabilitation, and the cash benefits could be extended until the rehabilitation measures had been instituted by the proper authorities. A member who had received cash benefits for the maximum period was not barred from receiving more benefits later. If after some time—240 days—he could prove that he had performed work for at least 90 days during the preceding year, he was again eligible for cash benefits.

Female wage earners who were expectant mothers were entitled to the same cash benefits as persons who were ill. Maternity cash benefits were paid for a maximum of 14 weeks, and at the earliest, 8 weeks before confinement.

To obtain cash benefits the member had to make a solemn declaration stating the nature of his illness and give particulars about his earnings, employment, and whether he was a head of family, but the fund could, when necessary, require the applicant to produce a medical certificate, and the employer or the unemployment fund would have to send a written declaration.

The funds had nothing to do with the financing of cash benefits; five-sixths of the benefit was provided by equal contributions from employers and workers and one-sixth by the National Treasury. The workers' contributions were deducted from their wages, and the employers turned over both amounts to the fund.

Various legal remedies were laid down in the act to deal with the employer who failed to pay. He could be fined and could himself be required to pay the cash benefits to his sick worker. To have cash benefits paid under this scheme, the worker was required to be an active member of the fund, either as an A or a B member. Active insurance fund membership was voluntary, and a worker who had not joined as an active member could find that contributions were being deducted from his wages by his employer for cash benefits he was not eligible to receive.

Voluntary cash benefits. The rules of the voluntary scheme were as far as possible the same as those governing wage earners' cash benefits. With no employer to help finance this benefit, the member had to pay to the fund a contribution in proportion to the amount of cash benefits he was

insured for. The State, however, paid a grant of one-fourth of the expenditure.

The only passage in the act setting conditions as to age and health status were for voluntary cash benefits. The age limit was 45 years, although there could be exemptions in special cases. Also, no person could insure for, or increase the amount of, cash benefits he was insured for during his illness. A member wishing to insure for unemployment and sick pay benefits (including maternity) could do so. In maternity cases, cash benefits were paid for 2 weeks following confinement, to the same amount as the member had insured for in the event of sickness.

Financing the Health Insurance System

Contributions from workers, employers, and the National Treasury financed the cash benefits to wage earners. All other benefits of the health insurance funds were largely financed through members' contributions. These contributions supplied 75 percent of the financing, and the State the remaining 25 percent. Thus, subsidies were granted primarily to the less well-to-do A members. Considerable subsidy was given to the health insurance funds in the form of low hospital rates.

A Unified Delivery System

The Labor Party came into power in October 1971 and, with the passage of the Public Health Security Act of 1971, put the finishing touches on a health care delivery system that had been developing for 150 years. This new unified system, which became effective April 3, 1973, coordinates health and social services. The legislation makes health insurance benefits a municipal service to all inhabitants.

Previously, such a system had been impossible. Denmark was divided into 1,400 municipalities, most of which were too poor and too small to provide services to their inhabitants. The area surrounding Copenhagen was the exception. Under the Labor Party's rule, these jurisdictions have been combined into 277 municipalities and 14 counties. No decision has been made about the Copenhagen area, where 2 million people live.

Many of the earlier laws dealing with health and social services overlapped and were complicated. With the new system, a "medical supermarket" will be developed to assure high-quality medical service.

In keeping with the philosophy that every citizen has a right to good health care, the Danish parliament abolished sick clubs as of April 3, 1973. Personal contributions will cease, and the counties (now locally governed districts, each with approximately 250,000 inhabitants) will administer the Public Health Security Act. Since 1970, the local districts have been responsible for operation of the hospitals; effective April 3, 1973, they will finance not only the operation of the hospitals but also the public health services through general taxes.

Taxes are levied by both the Central and local governments. Sources of public revenue are personal income, capital, and land taxes and excise and customs duties. The budget of the Central Government amounts to 30 percent of the total national income. The biggest item in the budget in recent years has been the cost of social and public health services.

One percent of the tax on individual gross income is allocated for health services. The revenue is divided among the municipalities to meet expenses, except for a percentage kept by the Central Government. In addition to this form of revenue sharing, the local municipality gets from the Central Government a percentage of money for the health services it offers. The percentage had not been determined when this paper was prepared.

The municipality is responsible for teaching the population how to use the health services. The Central Government is responsible for policy setting and interpretation. Municipalities are expected to cooperate with the Central Government, and they can request assistance from it. A field staff will be available to assist the municipalities to implement the law.

The total population, regardless of income, is entitled to free cradle-to-grave treatment through general practitioners and in hospitals, as well as to a contribution for funeral expenses. General practitioners, dentists, and other medical professionals will negotiate their fee-for-service contracts with the local governments rather than with a private corporation.

The Danish system is based on two levels of care.

1. Primary health services given by the family physician, who is the central figure.

2. Secondary health services from specialized, centralized task-oriented hospitals and other institutions.

The primary health services will be directly administered by the 277 municipalities, and the hospitals by the counties. The unified hospital system

will provide all types of services, and the system will also focus on prevention. Services will be regrouped among a number of hospitals so that a single institution will treat patients with mental illness, tuberculosis, and other diagnoses. There will be fewer hospitals caring for special types of patients. Physicians will have a variety of patients, thus enhancing their knowledge and the quality and effectiveness of their services. Six regional hospitals will concentrate on special procedures such as kidney and heart transplants.

It is anticipated that the lone practitioner will disappear and group practice will become the trend. The intent of the system is to encourage the patient to deal as much as possible with the practitioner and home nurse before going to a hospital. The focus of the health care system will be on primary medical services, as a means of saving money.

Pending Legislation

The ombudsman system throughout Denmark responds to all concerns of the citizenry. However, the Ministries of Health and Social Affairs have a bill before Parliament that would establish a mechanism to deal with complaints about those services under their jurisdiction. The bill was still pending at the time this paper was prepared.

The bill would establish eight boards. Each board will respond to those citizen complaints that deal with their assigned administrative units—welfare, special assistance, health, rehabilitation, old age, and so forth.

Each board will be composed of two lawyers, selected and appointed by the Minister of Social Affairs, and two ordinary citizens, selected by various organizations such as the Association of Old Age Pensioners, trade unions, and others. Citizens can present complaints to the board in person or by mail. The board is expected to investigate the complaint and resolve it in a manner that is mutually satisfactory to all parties, with the complainant having the edge. It is felt that such legislation is vital for successful implementation of the Public Health Security Act.

HMO Concept and the Danish System

In the United States, a new method for delivering health services has achieved growing respect. It brings together a comprehensive range of medical services in a single organization so that a patient is assured of convenient access to all of them. The general term applied to this method is health maintenance organizations (HMOs). To some extent, the HMO concept parallels the new unified system established by Denmark's Public Health Security Act.

Characteristics of the two are compared in the box.

In Denmark, the necessity for the Government to intervene and assume responsibility for the delivery of total health care to all people is recognized today. The implementation of the principle that quality medical care is a right is on the threshold of realization. The modernization of the Danish tradition in health care delivery is another cornerstone toward achieving a decent life for all members of the community.

Comparision of the health maintenance organization concept of the U.S. Department of Health, Education, and Welfare and the Public Health Security Act of 1971 of Denmark's Ministry of Health and Social Affairs

HMO CONCEPT	PUBLIC HEALTH SECURITY ACT OF 1971
1. Voluntary participation by enrollees	1. Participation a right based on citizenship
2. Financed by prepayment by enrollees	2. Financed by taxation of all citizens
3. Comprehensive coverage	3. Total and complete coverage
4. Administered by a private corporation and monitored in the planning and developmental phases by the Department's Regional Offices	4. Administered by the Central and local governments; no monitoring as in the HMO concept
5. Serves a target population within a geographic boundary	5. Serves all citizens; each local municipality is responsible for the health of its inhabitants
6. Does not include funeral benefits	6. Includes funeral benefits
7. Role relationship between Regional Offices and headquarters not clearly defined	7. Central Government sets and interprets policies for municipalities

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