ance under most systems come from special contributions paid regularly by insured persons and employers, with the government granting an additional subsidy in a number of countries. The United States program is an exception to the usual practice in its reliance only on employer contributions and in determining contribution rates in accordance with the employers' experience with unemployment.

The common qualifying period for a worker is about 6 months of insurance within the year before unemployment began. Workers in nearly all countries are disqualified if they leave their previous employment voluntarily without good cause, or if they are dismissed for misconduct or were participating to a specified extent in a labor dispute that caused a work stoppage. The unemployed worker who without good cause refuses an offer of a suitable job may also have benefits temporarily or permanently suspended.

Most unemployment benefits are commonly fixed at an amount from 50 to 75 percent of average earnings, with a maximum limit—often 26 weeks—on the period benefits can be drawn.

LIKE THE PREVIOUS reports in this series, *Social Security Programs Throughout the World, 1969*, reveals the continuing versatility of the social security mechanism in meeting the diverse needs of people living in vastly different political, economic, and social settings. Between 1967 and 1969 there has been a noticeable slowing in the rapid expansion of social security programs into areas where they were unknown before, and for good reason. With 93 percent of the independent nations having established programs there is little room left in the world for expansion. The 1969 report lists only Laos, Swaziland, and Western Samoa as additions to the 1967 list of independent countries with some kind of social security program. But the 1969 report also makes clear that wherever social security has taken root, the work of refining and adjusting the established programs is accelerating. Since the mechanism has proved so flexible in its adaptations to local conditions, traditions, and needs, it is reasonable to expect that dynamic change will continue to characterize social security systems wherever they exist.

Social Security Abroad

Changes in the Sickness Insurance Program in Sweden*

A series of reforms in the Swedish sickness insurance program became effective January 1, 1970. The most significant of these is the so-called "7-kronor reform" that, by bringing about a simplification in the reimbursement for medical services, seeks to improve social security protection and to lessen the current burden on in-patient facilities. The legislative reforms also provide for improved benefits for patients in part-time hospital care, as well as for pensioners in full-time hospital care. In addition, cash allowances were raised with respect to expenses incurred in overnight travel during visits to doctors outside the patient's immediate geographical area. These measures are expected to add about 250 million kronor[1] to sickness insurance expenses, four-fifths of which will be raised by increasing the employer contribution rate from 2.6 percent of payroll to 2.9 percent. The remaining 50 million kronor are to be covered by government funds. The employee contribution rates are not affected.

Hospital care in Sweden has for over a hundred years been provided almost entirely in public hospitals, which are supported from tax revenue—primarily county taxes with a small Federal grant. A very modest daily charge previously paid by the patient (before the initiation of health insurance) is now paid in almost all cases by the sickness insurance system, so that the individual and his family have no out-of-pocket expenses for in-patient care.

Medical services for ambulatory patients have been provided through hospital out-patient departments, by medical officers employed by the counties, and to a lesser extent by hospital-based

* Prepared by Leif Haanes-Olsen, International Staff, Office of Research and Statistics.

[1] One U.S. dollar equals 5.17 Swedish kronor.

doctors practicing outside the hospital for part of the day or week and by "private doctors" who have no affiliation with the social insurance system. Until the recent reform, patients have paid the full cost of such medical services, and subsequently been reimbursed for 75 percent of the cost by the health insurance system. A fee schedule, negotiated by the Medical Association and the Federation of County Councils, determined the charges for specified services whether they were provided by the hospital out-patient department or outside the hospital. Private doctors were, of course, not bound by this fee schedule and their charges were usually higher—often considerably higher. The social insurance system reimbursed its members for such expenditures but for no more than the maximum allowable under the fee schedule.

This method of reimbursement has imposed a hardship on many patients. Since the approved fee varied depending on the condition, the patient often did not know in advance what a series of visits would cost. He might have to pay a sizable amount out of pocket and only later be reimbursed.

THE 7-KRONOR REFORM

The reform completely changes this arrangement for doctors who work within the insurance system. The patient now pays the doctor a maximum fee of 7 kronor[2] for an office visit, regardless of the type of consultation. This amount is based on the average nonreimbursable portion of fees paid by ambulatory patients during 1968. The 7-kronor fee covers the costs of tests or treatment (X-ray, laboratory tests, etc.), or a consultation with a specialist, when it is recommended by the doctor. If more than one visit to the doctor is necessary for the same illness, the patient pays 7 kronor each time.

Similarly, a maximum charge to the patient of 15 kronor has been established for home calls, with the same tests and services covered. For consultation by telephone, the patient pays a fee of 2 kronor. The social insurance system pays the provider of service directly the equivalent of the reimbursable portion of the agreed-upon fee for the services.

OTHER REFORMS

As part of the same legislation, sickness insurance benefits for pensioners have been improved to the extent that free hospital care is now available for 365 days in a spell of illness instead of the previous 180 days. After this 365-day period, the patient pays a nominal fee of 10 kronor per day that is not covered by health insurance. The charge may be lowered or completely disregarded at the discretion of the hospital, if the economic circumstances of the patient dictate.

Another liberalization relates to pensioners who receive income from work and are thus entitled to cash sickness benefits. They may now receive such benefits for 180 days concurrently with the 365 days of free hospital care.

In an effort to better utilize available hospital resources, part-time in-hospital care has been introduced in a number of places. Patients may spend part of the day or week in the hospital and part outside on a regularly scheduled basis. Under the new reforms, part-time hospital care is now like regular in-patient care with respect to the cost of doctors' care—that is, the sickness insurance fund pays the charges directly and there is no payment by the patient. Traveling expenses between home and hospital are payable by the hospital during the period of part-time care. The sickness insurance fund, on the other hand, covers travel expenses in connection with initial admittance and final release from the hospital for both full-time and part-time patients.

If the patient must consult a doctor far away from home, the insurance fund may in certain cases reimburse him for overnight expenses. The new regulations provide for higher rates and reimbursement for more trips.

THE MEDICAL CARE DILEMMA

Historically, the physician-to-population ratio in Sweden has been low in comparison to many

[2] This sum is equal to 62.3 percent of average hourly earnings for wage-earners in mining and manufacturing, January 1970, based on earnings data in *Statistiska Meddelanden* (Statistical Reports), Am 1970:17. The charge may be lowered or dropped altogether at the discretion of the county council, if warranted by the financial position of the patient.

other countries, while the ratio of hospital beds to population has been high.

Drastic increases in the cost of health care in Sweden as in most other countries have been viewed with considerable concern. It is hoped that by encouraging ambulatory care it may be possible to reduce or contain such costs in the future. The "7-kronor reform" should make ambulatory care more attractive, and contemplated plans for training additional doctors will make possible expanded services.

Three steps have been suggested in an effort to expand the supply of doctors. First, the need for more medical schools has been stressed. Secondly, the Department of Social Affairs has designated the ambulatory care sector as one of three priority areas (together with psychiatry and long-term illnesses) in the distribution of doctors during the period 1969–75. Finally, a compulsory 6-month service period within the public sickness insurance program as part of the educational requirements is expected to have the residual effect of interesting more doctors in working permanently within this sector.

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