

**THE MAIN AGENTS  
IN THE DANISH WELFARE STATE**

Acting Bodies & Structures,  
i.e. authorities and levels of competence

European modules, Social Policy 3)

**by**

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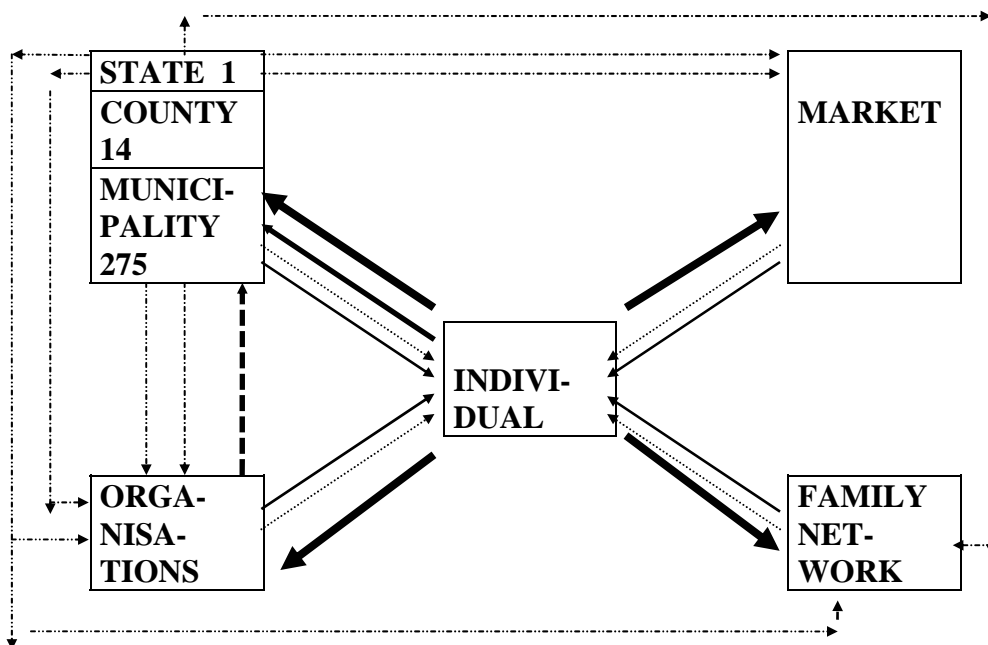
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## Introduction: THE DANISH WELFARE STATE

The concept WELFARE STATE<sup>1</sup> implies a STATE, intervening in the ways *production*, *distribution* and *consumption* of goods and services function in a society, mainly organized in a MARKET way.



The multiplicity of the roles of **the STATE** is illustrated by the several types of "arrows" from **STATE** to individual and to the other 3 "corners" of the **SQUARE**:

- provision, care —————→
- socialisation, education .....→
- regulation, control - - - - -→
- contributions - - - - -→
- political claims - - - - -→
- tax payment —————→
- work, effort —————→

The concept **welfare mix** is often being used in discussions about how to organize the efforts in the 'WELFARE SQUARE':

1. from which of the 4 sectors should **provision** be delivered? What level of sustenance should be provided, to which groups? And: who should be responsible and be paying?
2. from which of the 4 sectors should **care** be delivered? What level of care should be provided, to which groups? And: who should be responsible and be paying?
3. from which of the 4 sectors should **education** and **socialisation** be yielded? What level of **education** and **socialisation** should be provided, to which groups? And: who should be responsible and be paying?

<sup>1</sup> This text draws heavily on my preceding paper: "The WELFARE STATE - SOCIAL WORK - The INDIVIDUAL and her autonomy"

A glance on the history of Danish *economic development* and *social policy* shows a large and varied interplay between public and private actors about different types of production and distribution of goods and services, including transfers, care and education:

- ordinary **consumer goods** are produced and distributed largely in and by the private sector and on market conditions. Since 1857 Danish industrial policy has been ultra liberalistic (except for war periods). Yet, the state in many ways law-regulates the functioning of the market: on-the-job safety, work conditions, ‘proper marketing behaviour’, Road Traffic Act, building construction law, etc.
- **income transfer** have been carried out by STATE institutions: poor relief, old age pensions (state/municipality); by ORGANISATIONS: unemployment insurance (unemployment benefits), health insurance (sickness benefits, medicine cost subsidy); and in FAMILY: mutual support duty between spouses, and between parents and children <18, support of youngsters in education. The organisations' income transfer activity has been regulated by STATE, by contributions and control, and in the 1970'es social reform sickness benefit and (part of) medicine cost subsidies have been re-organised from an ORGANISATION-function to a STATE-function. As a speciality should be mentioned a set of formally ‘private’ old age insurance (saving) schemes, formally organized as private saving (MARKET) but regulated by law and with tax reduction as a main source of finance (STATE).
- **care** in case of disease during the 1800- and 1900 years has been **produced** and **delivered** partly by general practitioners and pharmacists, and to a very limited extent by private hospitals (MARKET), partly by municipal- and county-run hospitals (STATE). **Financing** has been mixed private/organisation/state organized, with a growing part being financed from tax.
- **care** also includes handicap compensating services, which in the same period have been **produced** and **delivered** by MARKET, ORGANISATIONS, FAMILY (especially women), and STATE. These services have been **financed** by STATE, ORGANISATION, and to a very little extent by the individual client.
- during the 1800- and 1900 years **basic education** and **professional training** in Denmark has mainly been **provided** by local authorities, organisations and state, and **financed** mainly through tax. **Socialisation** mainly is carried out in the family but since World War II also to a growing extent in public institutions (kindergartens), and in financially tax-supported leisure organisations, with limited local authority control.

Four of the *welfare functions* in which the *welfare state* are intervening, are:

1. **provision** (maintenance) of persons, who a) cannot themselves sell (or should not sell) their work-power, and b) are not by law provided for by wife/husband or children/parents,
2. **care** in case of disease, and **compensation** in case of disablement, and **shelter/asylum** for those in need thereof
3. **education - socialisation** for all (children), including childcare, and including socialisation of adolescents and rehabilitation of criminal offenders.
4. **housing** Mostly people buy/rent housing, but in Denmark quite some state intervention takes place with regards to quality and price of housing. It will be dealt with at limited length below, since this article is mainly orientated towards the connection: Social policy <-> Social work.

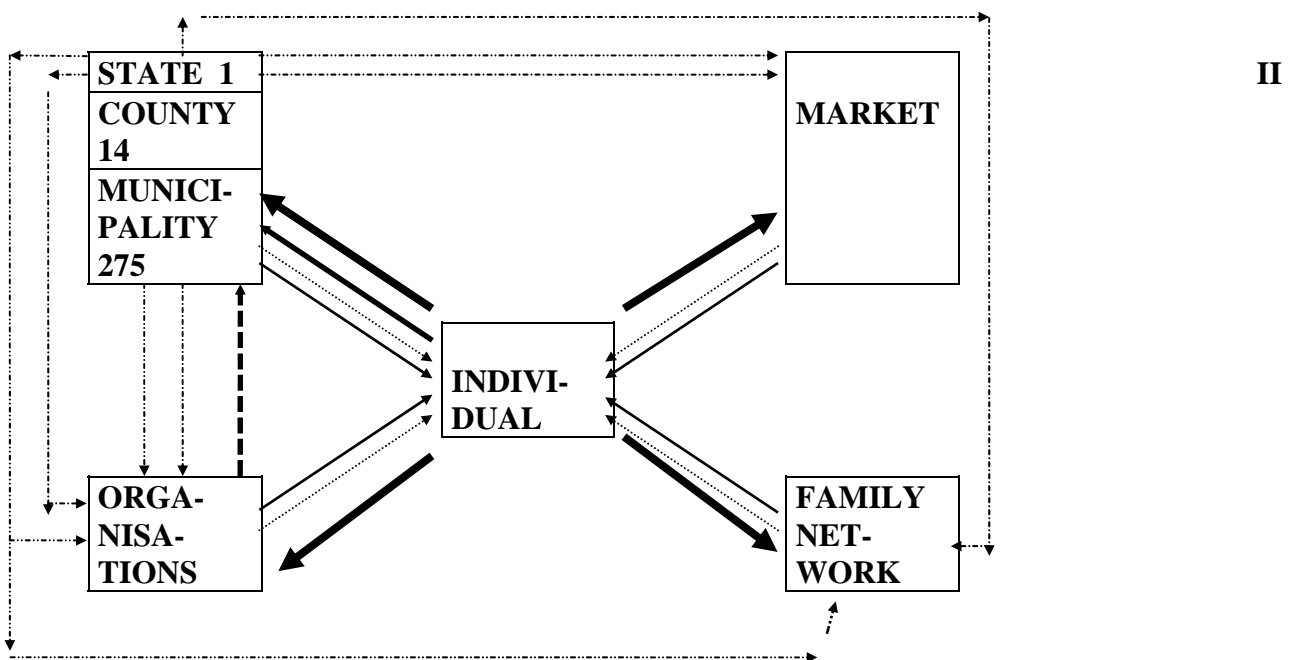
## THE AGENTS - MORE SPECIFICALLY

As a beginning of the description of the acting bodies in the Danish Welfare State some figures will be listed:

<b>Population and employment 2003</b>				
Population, total			5383508	%
Population 16-66 years				
Labour force 16-66			2860636	76,8
	men			80,2
	women			73,3
Employed			2741386	73,5
	men			76,9
	women			70,1
Unemployed		(+118735)	119250	(8,3) 4,2
Private sector			1776135	64,8
Public services			965251	35,2
<b>Revenue and its use 2003</b>				
			Mill. DDK.	%
Gross factor income 2003			1193400	
Private sector			919400	77,0
Public sector			274000	21,0
			Mill. DDK.	%
Total consumption 2003			1030100	
Private consumption			660900	64,2
Public consumption			369200	35,8
Transfers to households			252784	
Source: Statistical 10 year review 2004				

The Dane who has a baby gets a visit from the child-nurse. When the baby grows older, she will apply for a position in at kindergarten. Later the child will attend school. When grown up having come into job, sickness benefit after the 'employers period' is being paid to the sick employee. When we need care in private home in case of disease, up turns the home-nurse. If unemployment insurances runs out, where do we get some economic help? Who would deliver means for the handicapped? Which institution will provide a sheltered house for the elderly. From where does the elderly get the old age pension?

The answer to all of these questions is: from the *Municipality* you will be given the service and the benefit mentioned. More than that: if your child misbehaves badly enough, or if you want a permit to build a house, or if you want to complain the colour or taste of the water in the tap, the municipality is to intervene.



The multiplicity of the roles of **the STATE** is illustrated by the several types of "arrows" from **STATE** to individual and to the other 3 "corners" of the **SQUARE**:

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The 'STATE' corner of 'The welfare square' thus is sub-divided in the three levels: 1 *state*, 14 *counties*, and 275 *municipalities*. Both *county* and *municipality* have a *council*, which decides about *taxation* (income tax, real estate tax) and *expenditure*: activities to be performed and financed. Some of the activities of county and municipality are *compulsory* (law-bidden), some are *facultative*: the *council* decides freely, whether or not it will yield that service to the inhabitants and tax them to finance it.

As for some of the compulsory functions the *level of service* is open to local/regional decision. In Danish politics the concept *municipal self-government* is quite important, stated in the constitution since 1849. Quite many conflicts have been run between local self-government in social politics and central authorities, in which central authority has claimed that local authority has under-fulfilled the legal entitlement of a person to some social benefit or service.

Of the publicly employed labour force, 54% work in *municipal* institutions (schools, day-care, elder-care, roads, libraries etc), 19% in *county* institutions (hospitals, high schools, handicap-institutions etc) and 23% in *state* institutions (teaching, administration, police etc.). The remaining 4% are in "privatised" state institutions such as Post offices.

As mentioned above, very many of the public services to the individual citizens are being delivered by the *municipality*. When the public administrations and institutions in Denmark were reformed in the 1970'es, the basic principle of the reform was that of *proximity*: the municipalities were reduced in number so as to be increased in size, in order to be able to yield a professional service in a number of fields, and in the same reform a number of functions hitherto carried out by different regional and organisational, semi-public institutions were transferred to the municipalities. The *counties* were given tasks which would normally need a larger number of persons to be served, such as somatic and psychiatric hospitals, high schools, specialised institutions in rehabilitation, labour market institutions, specialized environment protection, highways. And, since the size and population of the municipalities vary quite much, the counties were given an *advisory* and a *controlling* function in some of the fields of *municipal* action. The *state* kept the task of policing, high-speed roads, military forces, professional education, tax collection (but not income taxing) and company taxing. A few of the most specialised social and health services were retained on state level.

In the 1970 reform of public administration the *Sickness Insurance Associations* became integrated into a public, tax-financed scheme. The S.I.A. originated as a voluntary organisation in the 1860'es, and since 1933 membership was made legally compulsory for Danish citizens. The organized members of the associations were asked in a survey, whether they preferred to go on paying their contribution separately to the association, or they preferred to pay it as part of ordinary municipal tax. The latter solution had the majority. So for purely practical reasons the organisation was dissolved, and its functions were integrated in the municipal administration.

*Voluntary organizations* play a limited role in the volume of the Danish welfare services.

## HOW TO USE MODEL II - some examples.

When a woman finds out that she is pregnant, she is entitled to free medical examination and midwife service, financed by the COUNTY. These services can be regarded as both **care** and **socialisation**, since one of the purposes is to teach her about the (new) role as a mother. Later on, when the baby is born, the family will be offered a number of visits by the MUNICIPALITY's *child-nurse*, whose role is to control the development of the child and advise the parents how to deal with the bringing up the child. In this there is an element of **socialisation** as well as an element of **control**. Further on, the family will be entitled to *General Family Allowance*, paid to all child-families by the Department of Inland Revenue (STATE), and possibly to *Child Allowance*, payable to single-parent families by the MUNICIPALITY. Later the parents will be sending their

child to *school* which the MUNICIPALITY is obliged to offer free of charge in a 9 year curriculum from the child is 7 years old. —————> If the parents prefer so, they may teach the child themselves or send him to a privately organized but partly publicly financed —————> school, the curriculum of which is controlled to be able to provide the same level of qualifications as the *municipal* school system.

When the nice little child becomes a roaring teenager, the COUNTY will *offer* a seat in an upper secondary school. —————> And if she misbehaves too much, the STATE may intervene in case of criminality. —————> Supporting the effort of the STATE'S police- and prison authorities, the MUNICIPALITY counsel the youngster to correct him or her. —————>

In a Social Policy context it must be underlined that the distribution of roles between STATE, COUNTY and MUNICIPALITY in the 1970's administration reform was based on a thoroughgoing idea: the MUNICIPALITY was intended to act as a *welfare service delivering* body with an obligation to *reach out* for the citizen in case of chance of her *social deroute*. The *proximity* was intended to facilitate the MUNICIPALITY in being aware of situations in which it ought to offer *counselling* to the citizen. This obligation can be exemplified in the law of *social assistance*: if a person has received *cash assistance* for more than eight weeks, the municipal social worker is obliged to interview the client more in detail in order to disclose whether there be reason to yield a more intensive effort than the mere cash assistance in order to help the client overcome temporary difficulties. It is open to debate whether or not this *outreaching* role of the MUNICIPALITY tends toward a totalitarian society. But in Danish Social Policy discussion it has never been questioned. On the contrary: quite often criticism is forwarded about MUNICIPALITY having not intervened in time or sufficiently towards persons in distress.

The examples of STATE/COUNTY/MUNICIPALITY intervention in the life cycle of man shall not be extended much here. Though, a few words have to be added concerning the role of the voluntary organizations.

The biggest role is played by the *Unemployment Insurance Associations*, the origin of which is in the Trade Unions in the 1880'es. Since 1907 the *U.I.A.s* have been entitled to state contributions, provided their statutes and their administration are made in accordance with the *Law of Unemployment Insurance and Job Provision*, and they subject themselves to government control. The U.I.A. in 2003 delivered transfers of 22 bill. DDK, out of a total social transfer of 253 bill. DDK (see tab. p. 5). 15 bill. (68%) of the 22 bill. DDK was tax subsidy. 2,1 mill. members (78% of the labour force) are in the *UIA's*.

The functions of the *Unemployment Insurance Association* can be described as follows:

It delivers **provision** to unemployed member —————>

It does so under **regulation, control** from the STATE, and —————>

It does so partly financed by STATE **contribution** —————>

and it does so, provided that the member is 'active' in retaining his labour qualifications and applying for jobs —————>

The *Housing Associations* are non-profit, user-owned organisations, with some public contributions, but mainly rent financed. The origin of the public support for these organisations is the political aim, formulated in the 1930'es, to contribute to especially the less well off people's health standard by providing healthy and relatively cheap housing. It should be noted, that *market intervention: governmental control of rent* in privately supplied housing, and *governmental subsidies to rent*

payment have been instituted to achieve the same political goals. The *Housing Associations* are under some municipal control with regard to accounting, and they are entitled to accept a number of occupants instated by the municipality for social reasons: Newly divorced parents, homeless, handicapped persons. By now some social action is undertaken in some of the larger *Housing Association* owned areas, so as to improve environments physically and empowermentally, this action having been initiated and financed by parliament and by local government.

Using the model II (p. 6), the functions of the *Housing Association* can be described as follows:

It sells **housing** to the member - —————→  
 at reduced price, partly financed by STATE/MUNICIPALITY **contributions** -----→  
 and subject to **control** from the MUNICIPALITY -----→

The case of *Housing Association* illustrates, that one can chose to analyse the same phenomenon both as a market agent and as a voluntary organisation.

A number of *Religious Associations* (mostly Christian) are undertaking care for alcohol and drug addicts and homeless people, most of them supported by *municipal* authorities either by ad hoc economic contributions or on a long term contractual basis. In some municipalities and counties the very same functions are being carried out by local governmental institutions.

Using the model II (p. 6), the functions of the *Religious Association* can be described as follows:

It provides **care** and/or **housing** to the addict/homeless, and —————→  
 though it may be called weak, there is an element of social control or **socialisation** in the charity workers' relation to the client -----→

The *Religious Association* often gets some economic **contribution** from MUNICIPALITY or COUNTY -----→

In Denmark few ORGANISATIONS play an important budgetary role in delivering *welfare services*. But very many ORGANISATIONS play a role in 2 respects:

the *organisations of disabled* give much advice to members as to what services they are entitled to from MUNICIPALITY and COUNTY, thus often working to expand quantity and quality of service (and budget burden), and

the *organisations* participate in *policy making*, both by claiming how laws and regulations ought to be modified -----→ and by developing caring techniques in ORGANISATION owned institutions, and henceforth claiming that these techniques should be applied in (often COUNTY owned) public hospitals or other care institutions.

### Finally – the uncertain future:

In 2004 the government has initiated a total reform of public administration and service, merging municipalities into larger units, and doing away with the counties. Much uncertainty remains as to which will be the consequences especially for social and educative work with handicapped. The overall idea is that the (merged and bigger) municipalities shall be induced to arrange cross-municipal units for such work. But details have not been described, and law-proposals have not yet been forwarded

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