Basic Features of Sickness Insurance in European Socialist Countries

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SOCIAL SECURITY has become an integral part of the economic policy of highly industrialised countries and many studies have been carried out on its role in economic development. But whereas long-term schemes, on the one hand, and medical care, on the other hand, have engaged the interest of many scholars, schemes providing cash benefits in respect of short-term contingencies have received scant attention. Yet these schemes have developed from measures of limited scope into important instruments of social policy playing a significant role in contemporary society.

The following article attempts to highlight some of the more important changes that have taken place during the evolution of sickness insurance in European socialist countries and the main features of the present schemes. A follow-up of two other articles published in the *International Labour Review* in 1960 and 1962 [2], it covers the sickness insurance schemes in Bulgaria, Czechoslovakia, the German Democratic Republic, Hungary, Poland, Rumania and the U.S.S.R.

Points of departure

At the close of the Second World War Bulgaria, Czechoslovakia, the German Democratic Republic, Hungary, Poland and Rumania inherited sickness insurance schemes with a rather comprehensive scope of coverage which included practically all permanently employed manual workers and salaried employees in non-agricultural occupations and at

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[2] " Social security protection for members of farmers' co-operatives in Eastern Europe ", Vol. LXXXI, No. 4, Apr. 1960, pp. 319-334, and " Coverage of employment injuries under general social security schemes in Eastern European countries ", Vol. LXXXV, No. 5, May 1962, pp. 478-499.

least important categories, if not all, of employed persons in agriculture. Moreover, sickness insurance had a long tradition: the countries and territories of Central Europe (Czechoslovakia, Hungary and parts of Poland and Rumania), attached before the First World War to Germany or to the Austro-Hungarian Empire, had had sickness insurance for well over half a century. The Kingdom of Rumania introduced sickness insurance of limited scope in 1912, and Bulgaria in 1918.

Except in the U.S.S.R., where the limited sickness insurance established by the Russian Empire in 1912 was superseded by a new system more adequate to new needs, most of these schemes were originally based on the German model (1883).

In the inter-war period the countries concerned had to solve the problems raised by the existence of various schemes in different parts of their territory, a consequence of political arrangements in Central, Southern and Eastern Europe after 1918, and by the economic crisis of the 1930s. This was among the important reasons behind the trend towards unification and the search for financial equilibrium reflected in the sickness insurance reforms prior to the Second World War.

However, a period of 20 years was not long enough nor the tendencies strong enough to allow complete unification of the sickness schemes; differential treatment, among others of salaried employees and manual workers and of agricultural and non-agricultural workers, was as a rule maintained.

The organisation of social security differed greatly. The sickness insurance schemes including both benefits in cash and in kind were often tied up, in one way or another, with pension schemes and were separate from accident insurance. Only in Bulgaria and Hungary was the administration of accident insurance linked from the start with sickness insurance. Finally, by 1945 the evolution of the economic situation during the Second World War had undermined the financial basis of the existing sickness insurance schemes.

These circumstances demanded immediate action on the part of the new governments. Hence the first legislative measures adopted in the period 1945-48 often aimed at remedying the most pressing needs only.

New problems and new approaches

Social structure and economic distribution

The changes which resulted in the establishment of the present political and economic systems in the European socialist countries led to important changes in social structure and in the system of economic distribution; this in turn gave rise to new problems that had to be faced by the sickness insurance schemes.

Generally speaking, nationalisation of the economy and limitation of private enterprise led to important changes in the structure of the economically active population. Apart from natural growth due to demographic increases, both the absolute and relative numbers of employed persons increased as a result of the shift of self-employed persons into paid employment, the establishment of state farms and the nationalisation of the liberal professions. Even in a highly industrialised country with a high employment rate, such as Czechoslovakia, out of all economically active persons the proportion in paid employment rose from 65 per cent. in 1948 to 84 in 1964. In Poland the relevant percentage rose from 42 in the 1950s to 54 in the 1960s.

A second important change in the social structure was the grouping of self-employed persons into co-operatives and their gradual transformation into a new social group styled " co-operative members ", who have become an important force in agriculture in Bulgaria, Czechoslovakia, the German Democratic Republic, Rumania and the U.S.S.R.[1] In Czechoslovakia co-operative members represent 7 per cent. of all economically active persons; 84 per cent. of them are members of farmers' co-operatives. They represent an even larger proportion in Bulgaria and Rumania. Only in Hungary and Poland have self-employed persons remained a significant economic factor in agriculture.

As a result of these changes in the social structure, citizens in most of these countries in effect rely for their maintenance on income from work either for an employing organisation or for a co-operative of which they are members. This is, in fact, an aim of the prevailing policy, which requires that economic distribution should be based on work performed. Gradual implementation of the principle of " remuneration according to work " necessitated adjustments in certain respects. By its very nature such a principle applies only to distribution among the economically active population, thus entailing the need for methods of distributing income among those who, for valid reasons, cannot work; and these methods become, in effect, an integral part of the prevailing system of economic distribution. This increases the dependency of persons incapable of work on social solidarity. In addition, the needs of different people are not the same, because of their cultural standards, family responsibilities, and so forth, and this leads to inequality of consumption which, unless tempered from resources other than wages, may reduce the effectiveness of distribution according to work performed and weaken the incentive of employed persons to produce.

The necessity for government intervention to meet such needs from public funds leads, among other things, to the development of public services providing education, medical care and economic security and

[1] For detailed discussion see " Social security protection for members of farmers' co-operatives in Eastern Europe ", loc. cit.

welfare. This development had been foreshadowed as early as 1912 in a resolution of the Conference of the Social Democratic Workers' Party of Russia, which laid down the principle that social insurance should provide, for all persons working under a contract of service and for members of their families, benefits in all cases of loss of earnings due to incapacity for work, at a rate ensuring full compensation for such loss of earnings, the cost of the insurance being borne by the employer and the government.

Sickness insurance schemes had to meet the new circumstances as regards the need for medical care and economic support in case of temporary incapacity for work due to illness. The first sickness insurance reforms (in the late 1940s and early 1950s) in most of the countries concerned attempted to unify the quality and scope of protection provided by sickness insurance funds by removing privileges based on occupational status. Existing differences in sickness benefits in favour of certain categories of employees were inconsistent with the new system of economic distribution, as they were not based on merit but on traditional professional privileges and were in conflict with the ideology of the new governments based on support of the proletariat.

The second aim common to these reforms was the extension of coverage to practically all employed persons and the abolition of the great majority of existing exceptions and limitations in the scope of coverage. These reforms were part and parcel of the organisational and financial unification of social security in the German Democratic Republic (1947 and 1957), Czechoslovakia (1948), Bulgaria and Rumania (1949) and Hungary (1951); only Poland maintained in principle its legislation of 1933. The U.S.S.R. established its sickness insurance in 1918 and by 1927 had extended its application to all employed persons.

Since then the scope of persons protected by the sickness insurance schemes has been further extended to cover certain categories of economically active or inactive persons whose status is for some reason considered to be similar to that of employed persons. These categories usually include free-lance writers, composers, artists, etc. (e.g. in Bulgaria, Czechoslovakia, the German Democratic Republic and the U.S.S.R.), lawyers organised in professional associations (Czechoslovakia, U.S.S.R.), students and post-graduate students (Bulgaria, Czechoslovakia, German Democratic Republic, U.S.S.R.), and clergymen (Czechoslovakia, Hungary, U.S.S.R.). In some circumstances they include certain categories of self-employed persons like drivers working with their own vehicles, provided they are members of an appropriate organisation (Bulgaria).

There are special health insurance schemes for self-employed persons in the German Democratic Republic and for craftsmen in Poland. Separate sickness insurance schemes sometimes exist for special categories, e.g. for military personnel (Czechoslovakia), railway workers (Hungary), and so forth.

Once all employed persons have been covered, the next step is usually the extension of sickness insurance to co-operative members. Here a distinction is made between craftsmen's co-operatives and farmers' co-operatives. In the former, the co-operative members' income depends mainly on their active participation in the production or services of the co-operative; their share of the profits is generally not large. Consequently their social situation differs very little from that of employed persons. In the U.S.S.R. craftsmen's artels (co-operatives) have recently been integrated into the communal economy, operated by the local soviets. In most of the other countries concerned they enjoy the same sickness insurance protection as employed persons.

Sickness insurance has not yet, as a rule, been extended to members of farmers' co-operatives. They are generally covered by government health care measures (e.g. in Bulgaria, Czechoslovakia and the U.S.S.R.) or health insurance concluded by the co-operatives with local administrations (Hungary). Sickness cash benefits are more often paid by the co-operative out of its own funds and in conformity with rules approved by the members. In Czechoslovakia a special compulsory sickness insurance scheme administered by the local public administration (people's committees) has recently been introduced for members of farmers' co-operatives with a high-level economy.[1] In such co-operatives the income of the members depends on their work and thus resembles to a large extent remuneration from employment. This measure is considered as a step towards the extension of sickness cash benefit schemes to the whole economically active population.

Health care

While sickness cash benefits are, as a matter of principle, reserved to persons who depend for their maintenance on remuneration and are thus in economic need if they have to stop working, health care was from the start considered a public obligation. In the first years after the Revolution in the U.S.S.R., lack of medical facilities and great epidemics during the civil war made development of an efficient national health service, with a reasonable geographic distribution of facilities, essential. Preventive health measures were needed to combat epidemics and to reduce the workload on existing medical facilities.

Thus the concept of close co-ordination of preventive and curative medical services was gradually developed. The manpower shortage experienced throughout the implementation of industrialisation pro-

[1] As determined by the regional people's committee in accordance with rules approved by the Government. See the Act respecting a social security scheme for co-operative farmers (I.L.O.: *Legislative Series*, 1964—Cz.2B).

grammes increased the importance attached to health protection as a means of keeping as large a portion as possible of the existing labour force healthy and productive. Finally, prevention and thorough health protection, although initially expensive, are on the whole more rewarding than cure and rehabilitation, taking account of the economic and social consequences of disease; and, apart from its economic value, prevention also reduces the hardship associated with disease.

Nationalisation of the existing health facilities and development of a national health service were, moreover, part of the political programme, the ultimate aim of which was the establishment of a free, comprehensive health service providing both preventive and curative care to all citizens as a right.

In the U.S.S.R. medical care was developed from the start as a national service distinct from sickness insurance, which primarily provided cash benefits. In other countries under consideration one of the earliest and most important changes after the Second World War was the removal of medical care from the scope of sickness insurance and the establishment of national health services operated by the Ministry of Health.

In Bulgaria and Czechoslovakia medical care developed into a national service, totally separate from social insurance, provided to the whole population practically free of charge. In the other countries a similar national health service has also developed, but the scope of persons to whom it is available free of charge or with minor cost-sharing is linked in some way or another to the scope of sickness insurance; generally speaking, everyone other than employed persons, pensioners and members of their families is required to share to some extent in the cost of medical care. The precise arrangements differ from country to country. For example in Poland members of co-operatives receive free treatment and bear only the cost of drugs; medical care is generally provided free to all schoolchildren and to adults in case of contagious diseases, accidents, maternity, and other contingencies. In Hungary a voluntary health insurance scheme to cover the cost of medical care was recently established for persons not covered by compulsory sickness insurance or by the medical care contracts concluded by farmers' co-operatives for the benefit of their members.

Towards a broader definition of "sickness"

The main reason for the award of cash sickness benefits remains loss of earnings due to incapacity to work in current employment as a result of illness or accident. As a matter of principle, no partial sickness cash benefits are provided in the countries under consideration. However, in Bulgaria a differential benefit is paid in cases where a person suffering

from tuberculosis temporarily takes up alternative employment with lower remuneration, provided he does not receive a pension. In the U.S.S.R. such benefit is granted in respect of transfers within the employing establishment, on health grounds (tuberculosis or an occupational disease), to lower-paid work. In Rumania the benefit is granted in respect of all transfers to lower-paid employment for reasons of health. These measures were designed to meet new circumstances. As public health measures succeed in reducing the frequency of infectious and endemic diseases, the degenerative diseases and functional disorders, whether external or internal in origin, became more common. Some of these diseases do not require total absence from work, and total idleness may even psychologically harm rather than help the person concerned. The *raison d'être* of these differential benefits lies in the attempt to maintain the social integration of a sick person in special cases which do not require full-time absence from work, without causing him any economic hardship.

The development of the medical sciences, the health-consciousness of the people and the stress on prevention had the effect of broadening the contingency of sickness in two major ways. Firstly, medical examinations for diagnostic purposes and preventive treatment have been generally recognised as valid reasons for the payment of cash benefits; similarly, benefits are payable during spa treatment of a preventive nature, provided the person concerned cannot, for a valid reason, receive holidays with pay in respect of that period (Bulgaria, Czechoslovakia). Secondly, total or partial isolation of healthy persons required as a preventive measure in the control of infectious disease in a community has been generally recognised as a contingency in which sickness cash benefits are payable (Bulgaria, Czechoslovakia, Hungary, U.S.S.R.). The fact that in this case a healthy person capable of work, or a person only liable to fall ill, may qualify for a sickness benefit has extended the contingency in which sickness cash benefits are payable to " loss of earnings due to absence from current employment on health grounds ". In legal terms, it has introduced the concept of a legal fiction of incapacity for work in cases of preventive examination and treatment and of quarantine.

The special position of women

One of the features of economic development in the European socialist countries is the widespread employment of women due to manpower shortages, especially in countries with a low rate of population growth and an aging population. Increased participation by women in economic activity is also encouraged by the fact that every extra wage in the family unit has a substantial effect on its living standards. In many of the countries under review women represent 40 per cent. and more of the total economically active population.

The higher participation of women in employment presents new problems and new needs, such as the care of children while both parents are at work. While looking after healthy children is the responsibility of the pre-educational and educational systems, the care of sick children is the responsibility of the health services and the parents.

To meet this responsibility in the case of a sick child who is not hospitalised and both of whose parents are at work, sickness insurance schemes in all the countries under consideration have extended the contingency in which cash benefits are payable to include loss of earnings due to absence from current employment on grounds of attending a dependent family member for whose care no other suitable arrangements can be made. The provisions of the schemes differ in detail as regards the definition of the dependent family member and the conditions of entitlement. As a rule, the benefit is payable at the same rate as the cash benefit in respect of sickness. The maximum benefit period for which it is payable differs—depending on the country concerned—according to the age and family situation of the sick member and the family situation of the insured person (e.g. mothers living alone in Czechoslovakia receive benefits for a longer period).

Conditions for entitlement

Legal conditions for entitlement to sickness cash benefits have been gradually modified to meet the current economic and social needs and possibilities.

Generally, the award of sickness cash benefits is conditional only upon performance of insured employment and certification of the contingency; all waiting periods and qualifying periods of affiliation have been abolished.

The claimant's affiliation to the scheme at the time of the claim is not necessary as the scheme applies *ex lege* to all persons in covered employment. As the ultimate aim is coverage of all economically active persons, the condition of formal affiliation to the scheme (designed to limit the benefits of the scheme to specified categories of persons who have contributed to it) is not essential. Moreover, as the sickness insurance schemes are generally operated in close co-operation with the management of the employing establishment, the element of abuse is, in effect, limited to a strict minimum and does not require any special administrative practices to avoid it. Finally, with some exceptions, the possibility of abuse is also diminished by the fact that sickness cash benefits are earnings-related and the earnings taken into account are averaged over a reasonable and adequate period.

Except in Bulgaria and Poland, no specified qualifying period of work in covered employment is required for entitlement. In Bulgaria entitlement is conditional—to some extent—on three months' unin-

terrupted employment, which is intended to stabilise manpower rather than to protect the sickness insurance scheme from abuse. In Poland the qualifying condition offers alternatives: either four weeks of uninterrupted employment immediately preceding incapacity, or 26 weeks of employment during the previous 12 months. It is waived in cases of employment injuries or infectious diseases. In some of the countries where no qualifying period is generally required, exceptions may be found in respect of seasonal employment (Rumania and the U.S.S.R.), of employed pensioners (Czechoslovakia) and of discharge for disciplinary reasons (U.S.S.R.).

Since, in the prevailing system of economic relations, social security is intended to free the employed person from the need to save part of his earnings in case of future want, he should also be protected during the period between leaving one job and starting a new one. Sickness insurance protection is extended to such cases by the provision, subject to certain conditions, of a period of free coverage of two months in Bulgaria, up to 42 days in Czechoslovakia, three weeks in the German Democratic Republic, 90 days in Rumania, etc.

No waiting period is required in any of the countries under consideration with one exception: in Rumania an insured person with more than two days of unjustified absence from work in the 30 days preceding incapacity does not receive cash benefits for an initial period of incapacity, the length of which depends on the case.

Protection may be refused in certain cases as a penalty for intentional abuse of the scheme, for a criminal act or gross negligence causing harm to the scheme, etc. These provisions are of the type commonly encountered in sickness insurance schemes throughout the world. Nevertheless, in most of these cases a proportion of the cash benefit is paid to dependent family members. Cash benefits are sometimes not payable during periods of unpaid leave (Hungary, Rumania, U.S.S.R.), as in these cases illness does not cause any loss of earnings.

Rate and duration of benefit

In all the countries under consideration the cash benefit is earnings-related. A flat-rate benefit is rare; it is reserved, for example, for agricultural workers in Hungary.

Two basic approaches may be noted as regards the benefit rates: they may be uniform or proportionate to length of employment. In the German Democratic Republic and Poland the rate is uniform, 50 and 70 per cent. of reference earnings respectively.[1] In Bulgaria, Czechoslovakia, Hungary, Rumania and the U.S.S.R. the rate differs according to length of employment and depending on certain special circumstances.

[1] In Poland it is 100 per cent. of earnings as from the sixth day of incapacity for underground miners who suffer an employment injury.

Although in Hungary there are only two rates (65 and 75 per cent. in respect of less than and more than two years of uninterrupted employment), the rates in countries of the second group generally range from 50 to 90 per cent. of earnings, 100 per cent. being payable for employment injuries in the U.S.S.R.

There seem to be two major reasons for grading rates according to length of employment, namely to reward older workers who have contributed for longer periods to the national economy, and to discourage undesirable labour turnover. For these reasons the period of employment taken into consideration is the length of uninterrupted employment with the last employer in Bulgaria, Hungary, Rumania and the U.S.S.R.; periods of previous employment and other periods (e.g. military service) are credited only under special conditions, among others that the last change of employment took place for one of the reasons enumerated in the legislation (e.g. in the interests of society, for important family reasons, etc.). This principle was partly abandoned in the U.S.S.R. by the recent adoption of a provision to the effect that all employment will be regarded as uninterrupted if the new employment was taken up within one month from the termination of the old one.

The length of uninterrupted employment required for the highest rate is two years in Hungary, eight years in Rumania, 12 years in the U.S.S.R. and 15 years in Bulgaria.

Czechoslovakia has recently liberalised its sickness insurance provisions as one of the measures to facilitate implementation of the new model of economic management. The present rates depend on the length of total employment irrespective of the organisation for which it was performed and including periods credited (e.g. preparation for employment, military service, etc.). Thus, very generally speaking, sickness cash benefit rates are indirectly related to age, as the large majority of protected persons are either in preparation for employment or actually in employment.

The rates do not take account of family responsibilities, since family allowances are payable to employed persons regardless of whether they are working or are ill. Other considerations that may be reflected in the benefit rates are, in Bulgaria, length of incapacity, the rates being increased from the sixteenth day of incapacity, and, in the U.S.S.R., trade union membership, the rates being lower for persons who are not trade union members. In Czechoslovakia benefit rates are paid at a reduced rate for the first three days of incapacity; in some of the countries a recognised minimum is guaranteed by provisions concerning the minimum cash benefit (Czechoslovakia, Rumania, U.S.S.R.).

The earnings taken into account are, with some exceptions, averaged, e.g. for the last month in Bulgaria and the U.S.S.R., for the calendar year preceding the year in which the contingency occurred in Czechoslovakia and the German Democratic Republic and for the last three months in

Hungary. The earnings are generally the actual or taxable earnings of the person concerned, subject to a maximum in Bulgaria, Czechoslovakia and Hungary; in the German Democratic Republic only earnings in respect of which insurance contributions are payable are taken into account, and in Rumania the tariff wage is considered. In the U.S.S.R. there is a ceiling on cash benefits which, in practice, has the same effects as limiting the earnings taken into account.

A reduction of the cash sickness benefit during periods of hospitalisation or maintenance in other, similar health institutions (e.g. sanatoria, spas) is provided for in Czechoslovakia, the German Democratic Republic, Hungary and Poland. Where the person concerned has family responsibilities, there is either no such reduction (Czechoslovakia) or the reduction is smaller (German Democratic Republic, Hungary, Poland). There is no reduction in Bulgaria, and in the U.S.S.R. cash sickness benefit is reduced only in respect of treatment in sanatoria, provided the person concerned has no right to holidays with pay.

The amount of temporary cash benefit is defined not only in terms of rates and monetary values but also in terms of time. Given that sickness insurance is part and parcel of the system of economic distribution in the broad sense of the term, it is logical to pay cash sickness benefit throughout the contingency. This is done in Bulgaria, Rumania and the U.S.S.R. Nevertheless, to maintain the " temporary " or " transitional " nature of cash sickness benefits, inherent in the contingency, and to distinguish it from invalidity, close co-operation of sickness benefit and pension schemes is required; in Rumania the authorities automatically investigate whether a sick person has become invalid after six months of certified incapacity for work.

The duration of the benefit is limited to a maximum of 26 weeks in the German Democratic Republic and Poland, and of one year in Czechoslovakia and Hungary; it is reduced by any earlier benefit period awarded in the course of the last year, provided the incapacity was not due to an employment injury. There is also a limited benefit period in special cases, e.g. for seasonal workers in Czechoslovakia and the U.S.S.R., for employed invalids and/or old-age pensioners in Bulgaria, Czechoslovakia and the U.S.S.R., for persons with a fixed-term contract in Bulgaria and Rumania, etc.

In special cases, as a measure of co-ordination with invalidity pension schemes, the benefit period may be prolonged. Commonly it is prolonged in cases of tuberculosis (German Democratic Republic, Hungary, Poland) and employment injuries (German Democratic Republic). In Czechoslovakia, the German Democratic Republic and Poland it is also extended if there is a chance that the person concerned may recover within the prolonged period.

Individual employers are not, as a rule, liable to provide sick pay under the labour legislation, as it is considered the responsibility of the

pooled funds to ensure economic security to the person concerned. There are, however, several exceptions. Firstly, the German Democratic Republic and Poland have retained their traditional labour law provisions concerning the right of salaried employees to sick pay for an initial period of sickness and to cash benefits only thereafter. Secondly, in the German Democratic Republic a worker is paid by the employer, for a period of up to six weeks, the difference between the cash sickness benefit and 90 per cent of his previous wage; in the U.S.S.R. such a provision applies only to persons employed in the northern regions. Thirdly, in most of the countries the sickness insurance administration has the right to recover expenses of cash benefits from the employer, if the incapacity resulted from an employment injury caused by a fault on his part; the purpose of these provisions is to encourage safety measures.

Contributions

Although employed persons are exempt from contributing to sickness insurance, the cost of the scheme is not charged to the whole of society, but to the employing organisations as part of labour costs. This is both a principle of the political programme and an expedient in administering the scheme. The financial system is in effect based on equalisation of sickness insurance charges among employing establishments; it keeps administration close to the place of employment and facilitates cheap and efficient control. Generally speaking, the contribution is related to total payroll; the countries under consideration either require a single uniform rate of contribution, e.g. 10 per cent. in Czechoslovakia, or a graded contribution, varying from 4.4 to 9 per cent., depending on the degree of risk of injury in the branch of industry concerned, in the U.S.S.R. for example. (Contributions generally serve to cover expenditure on short-term cash benefits only.)

Conclusion

To sum up, it is more than obvious that sickness insurance plays an important part in social security and in the system of economic distribution. For example in Czechoslovakia and Hungary there were, in 1964, 96 and 169.8 cases of incapacity for work per 100 insured persons, lasting on the average 15.3 and 11.2 days respectively; this indicates that each employed person, on the average, relied on sickness cash benefits for 14.7 days in the year in Czechoslovakia and 19.2 days in Hungary; these are definitely not negligible periods. The total sickness cash benefit expenditure is constantly rising (e.g. in 1965 it represented 330 per cent. in Czechoslovakia, 857 per cent. in Hungary and 371 per cent. in the U.S.S.R. of that for 1950); it also represents an important part of the total expenditure on social security and medical care (e.g. 8 per cent. in

Bulgaria and the U.S.S.R. and 9 per cent. in Czechoslovakia). These illustrative data indicate to some extent the actual role sickness cash benefit schemes play in the economic life of the individual employed person, on the one hand, and of the national economy, on the other, in the countries under consideration.

It would thus appear that the lack of interest of scholars in the development and present problems of sickness insurance schemes is somewhat unjustified. This branch of social security is often considered uninteresting and more or less " non-problematic ". The foregoing pages may have demonstrated the contrary. Changes in the economic and social life as well as in the political structures and prevailing doctrines of the countries under consideration have introduced new factors with important repercussions on all existing social institutions. For lack of scientific research we do not yet know the full impact the new developments have had on sickness insurance, but it is evident that sickness insurance schemes have had to be adapted to meet the new economic and social needs and that this has involved introducing quite important modifications into previous concepts and approaches. There is no doubt that sickness insurance is closely linked with the economic and social life of modern society and that it has to be constantly adapted if it is to serve its purpose fully.