WOMEN AND THE DANISH NATIONAL HEALTH CARE SYSTEM

Redstockings

$4.00

A NATIONAL HEALTH CARE SYSTEM FOR THE UNITED STATES

Redstockings of the Women's Liberation Movement, the revived and revamped offspring of the first Redstockings of the 1960's, salutes the First National Conference on Devising a National Health Care System for the people of United States.

For the benefit of the conference and of our joint future work, we are contributing this reprint of a pamphlet about health care for women in Denmark, one of the many modern, industrialized countries of the world with a national system of providing free health care to all its citizens -- and a country with a healthy and militant women's liberation movement. In fact, as you will see from an article on the Danish Women's Liberation Movement which we have also included, the name of the whole movement in Denmark -- Redstockings -- was taken from the first Redstockings of the U.S.A.

As Denmark took ideas from the American Women's Liberation Movement, the United States now has to take ideas from Denmark and the many other countries that have national health care systems. We are in a crisis of astronomical health care costs and poor results in terms of a healthy nation of people, and we have to do something very soon.

As the Women's Liberation Movement in the U.S. sparked similar movements around the world, now the great masses of people in the U.S.A. have to learn from the rest of the world. Social progress toward greater equality for all is a world learning process. We can sift through the ideas and experience of many countries to decide which are best for us.

We are printing this pamphlet as a contribution to the beginning of the teach-ins and speak outs and consciousness - raising and political action and MOVEMENT that will be needed for the United States to acquire a national health care system.

A system of free quality health care for all -- paid for out of public funds -- always a necessary part of the program for women's liberation, a much needed step, is now on the agenda in the United States. For a majority of the people, it will bring much needed relief, and for women in particular, a little more of a base, a springboard toward more and more independence, a greater social sharing of the costs of child care, without which the goal of fully equal relations with men cannot be finally achieved.

-- May 15, 1987

REDSTOCKINGS of the WOMEN'S LIBERATION MOVEMENT
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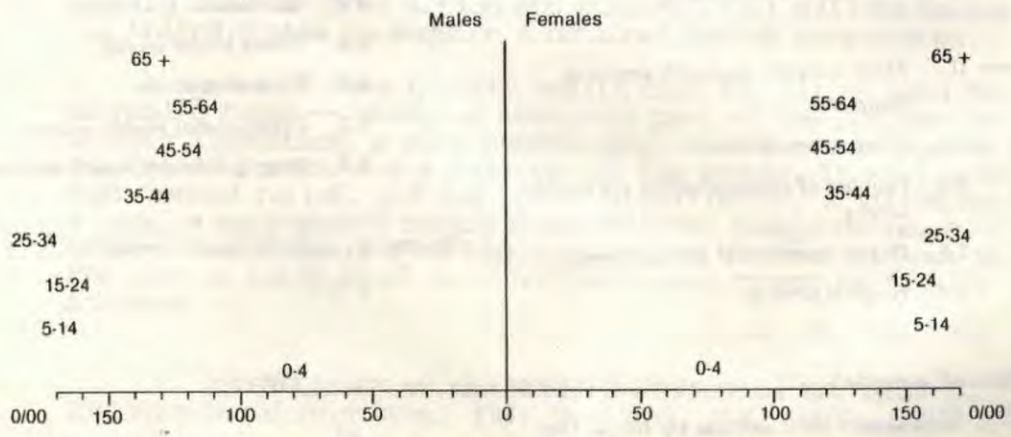
Chapter I
The health status of the Danish population with special reference to women

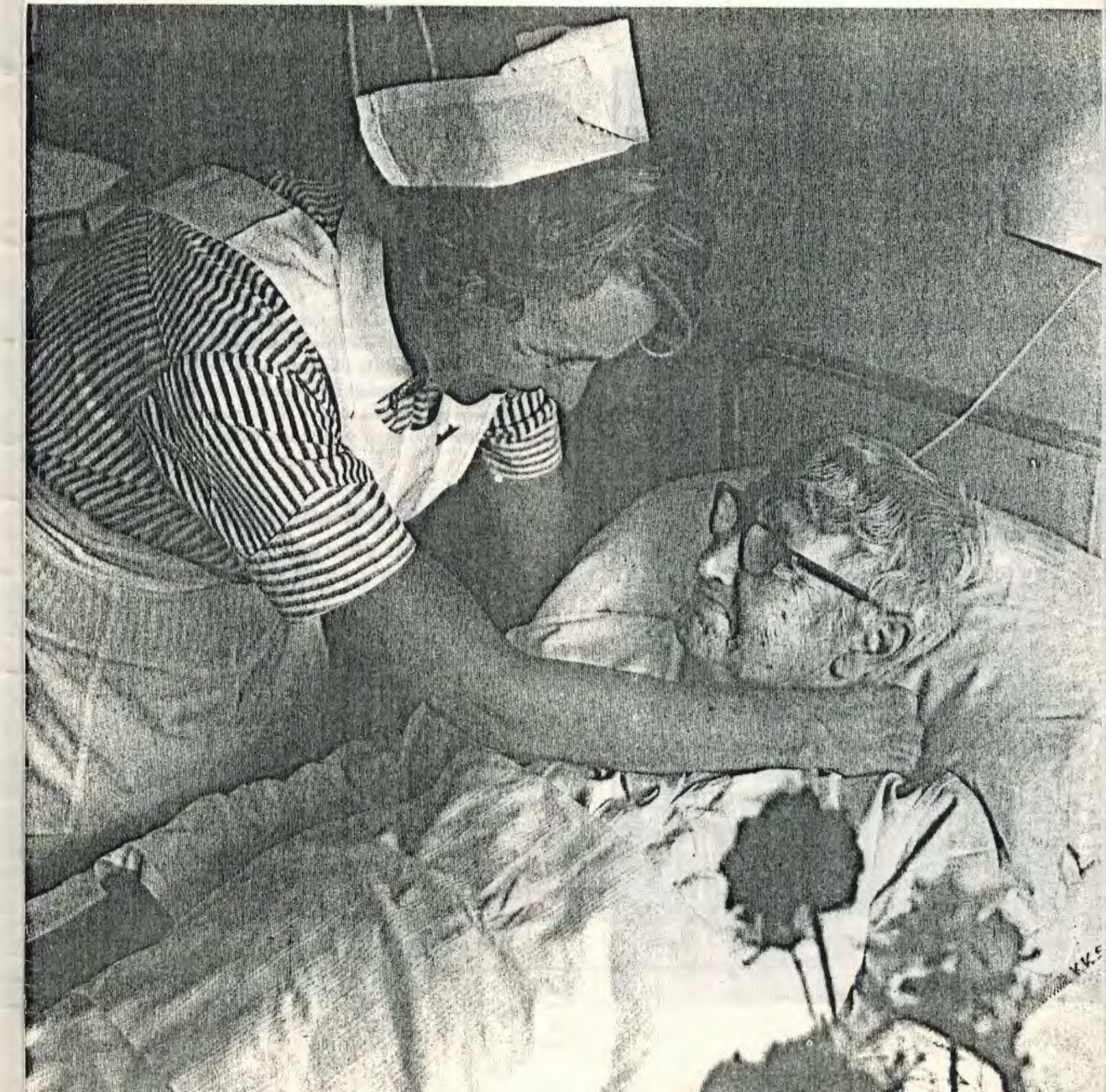
General health and life expectancy have improved, and morbidity of special women's diseases has gone down during the last decades. Even then, new health hazards for women have emerged because of their higher participation in all sorts of work and other ways of life. This refers to for instance a higher risk of traffic accidents, and of diseases caused by tobacco and alcohol consumption.

Generally the morbidity of women is higher than that of men. Women more often consult general practitioners, they are more often admitted to hospitals and have a bigger consumption of medicine. More elderly women than men become handicapped in a way which reduces their mobility further, and more women than men are absent from work because of illness (this only refers to younger women and especially to women with small children, so perhaps statistics are questionable here).

1.1. The population of Denmark by sex and age. (Fig. 1)



The percentage of people sixty-five years or more is 14.1.



1.2. Life expectancy

Table 1.

	Men		Women	
0 years	1956-60	1976-79	1956-60	1976-79
	70.4	71.2	73.8	77.1
70 years	10.7	10.8	11.5	13.7

The main causes of death now are vascular diseases and cancer. Women mostly die from cancer of the uterus or breast, while men mostly die from pulmonary cancer. The most common diseases for women are disturbances in connection with menstruation or menopause. Next, diseases in the ovaries or uterus apart from cancer.

1.3. Standardized annual incidence rate of certain cancers per 100,000 women (WHO 619/78).

Table 2.

Country	Breast	Uterus body	Uterus Cervix
USA (Conn.)	71,4	17,8	9,8
Denmark	49,1	11,4	31,6
Colombia	27,8	5,1	62,8
India	20,1	?	23,2
Israel (Jews)	55,5	10,8	4,5

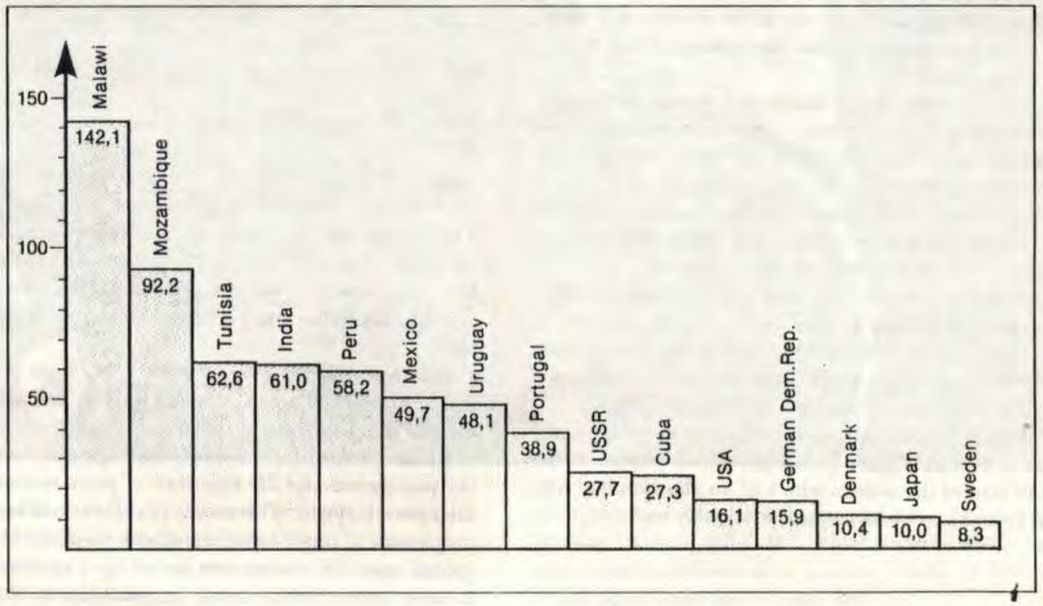
Table 3. *Some diagnoses for patients discharged from general hospitals, distributed by age and sex per 10,000 inhabitants 1972-73.*

	Men			Women		
	0-14 years	15-69 years	70 years	0-14 years	15-69 years	70 years
Vascular diseases ..	4	165	849	3	137	672
Tumors	17	108	574	16	165	346
Total number of discharged patients	1348	1168	2996	1063	1887*	2414

* including 541 patients with hospital stay because of normal deliveries.

Danish women now have fewer children than before. The average is now one or two children (1.7). At the same time the women's age at the first pregnancy has increased, so that the majority of women have their first child between the ages of twenty-five and twenty-nine. 80 per cent of pregnancies are planned, and the majority of the women use some kind of contraceptive, primarily intrauterine devices or pills. There has been a slight decline in the consumption of pills and a rise in the use of IUDs in recent years. Women are entitled to fourteen weeks of maternity leave.

Table 4. *Comparative perinatal mortality rate (deaths per 1,000 live born) ca. 1975.*



1.4. Birth rates and infant mortality rates

Table 5.

	Live-born children per 1,000 inhabitants	Deaths 0-1 year of age in relation to live-born. %
1855	32.4	13.0
1905	28.6	11.1
1950	18.6	3.1
1977	12.2	0.9

70 per cent of all women in the productive age groups now work outside the home. This means new risks for some working under especially straining conditions, and in spite of better domestic facilities and some change in the role of men and women concerning domestic duties, the majority of the women still have the main responsibilities for the upkeep of the home and small children.

For many years there has been a steady decline in breastfeeding. Now a reversal seems to have begun, but the rather short maternity leave has not encouraged extended breastfeeding.

In 1978 special legislation on equal status for men and women was passed. Hence it is illegal to dismiss a woman from her job because of pregnancy.

The risk of disease and death in connection with pregnancy and birth is very small. The death rate is now three per 100,000 births. This is apparently the result of better living conditions, better health screening during pregnancy and better medical care.

The number of legal abortions has dropped in recent years so that the figure is now per 1,000 women 21.6. 40 per cent of the women who had an abortion had not used recognized contraceptive methods.

1.5. Legal abortions 1977

Table 6.

	Total number	per 1,000 women
Under 15 years	127	
15-19 years	4,502	25.5
20-24 years	5,541	30.4
25-29 years	5,283	28.0
30-34 years	5,355	26.5
35-39 years	3,231	21.4
40-44 years	1,379	9.8
45-49 years	144	1.0
Total number	25,662	21.6

1.6. Number of sterilizations 1977

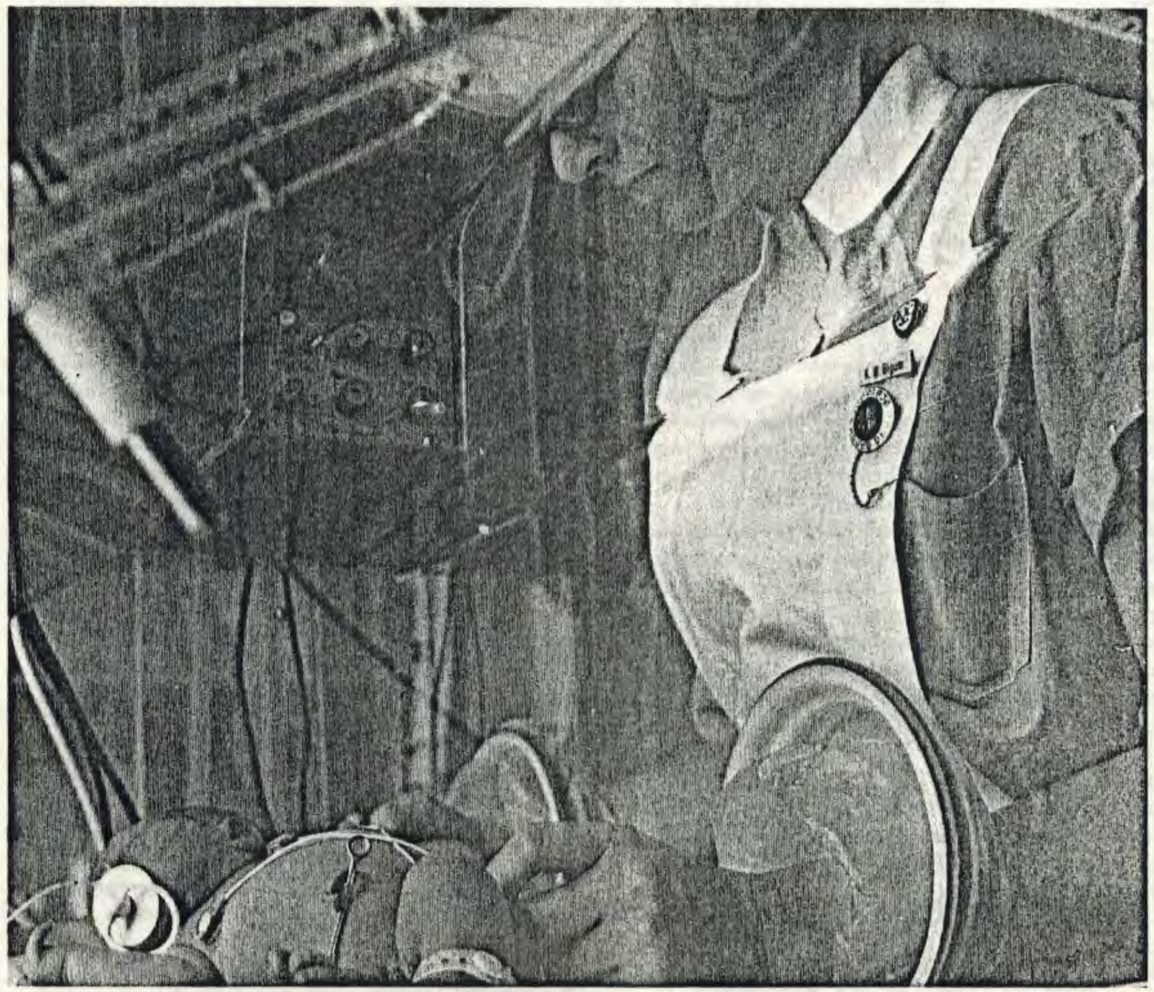
Table 7.

Male	8,538
Female	5,695
Total	14,233

The suicide rate in Denmark has always been higher for males than for females. The suicide rate for women has gone up during the last decades so that now (1976) it is 30.2 for males and 17.7 for females per 100,000 inhabitants.

Venereal diseases, mostly gonorrhea, have dropped in recent years. Women morbidity is only half of that of men in this field (about 5,000 for men).

As can be seen from the tables of age distribution of the population and life expectancy, more women than men grow very old. This means that there will be a high proportion of single women and widows in the high age groups and that the percentage of aged women in the nursing homes (which must be provided by the local



government for all invalid and/or aged persons) is higher than that of the male inhabitants (about 7 per cent of the population of more than 65 years live in nursing homes) while the majority of the aged live in their own home supported by social services, i.e. home nursing services and home helper services which local governments are bound to provide. About 15 per cent of the aged have home helper services.

Chapter II
Main principle of health services in Denmark

The main principle is that personal health services comprising treatment and prevention are free of charge regardless of personal income as all health services are paid for by the general tax system. Drugs, adult dental care and physiotherapy are to a certain extent paid for by the patient himself.

Danish health services include both prevention and treatment. The responsibility for both the primary health service and hospital services lies with the regional authorities, i.e. at county level. Nearly all services are run by public authorities. The public cost of the total health service amounts to almost 6 per cent of GNP. About 11 per cent of public expenditure is allocated to the health sector.

The National Board of Health – a unit under the Ministry of the Interior – has advisory functions on health matters vis-a-vis all ministries and carries out certain planning functions in the health field as well. The National Board of Health supervises all medical personnel in the country.

2.1. Primary health care

The family doctor remains the main figure in these services. Orginally, family doctors were fully established in independent practice outside hospitals. General practitioners still work only outside hospitals. They used to represent 50 per cent of the medical profession but with the development of more specialized hospital services the percentage has dropped to about 25.

In 1973, a national health scheme was introduced. It was a consequence of the fact that public funds had to pay for the majority of health service costs.

The principle of the family doctor, however, remains as does the principle of the general practitioner as a member of the liberal professions.

General practitioners still work out of privately-owned premises but are paid by the health insurance authorities according to agreements between the medical association and the association of county councils. About one half of the general practitioners work in a solo practice while the other half work in group practice or other forms of joint practice.

When a doctor is licensed to work independently (after having completed postgraduate services) he may take over a practice from a colleague who wishes to retire, or he may set himself up in practice under an agreement with the local committee of the representatives of the county council and the local doctors. Some overall plan does exist, however.

National health insurance also covers some of the costs of adult dental treatment, physiotherapy and of prescription medicine.

Sickness benefits have now been introduced which correspond to 90 per cent of the average weekly wages of workers in trade and industry.

General practitioners handle both preventive and curative medicine.

The general practitioner, i.e. the family doctor, is usually the first contact point between patient and health system. As a matter of principle the family doctor must always see the patient before referring him for further examination or treatment either by a practising specialist at primary care level or to secondary health care service, i.e. hospital care. The general practitioner must submit full information on his referral of a patient to a hospital and hospital physicians on the other hand must provide the family doctor with information on their findings and therapy during a patient's stay in hospital after the patient has been discharged.

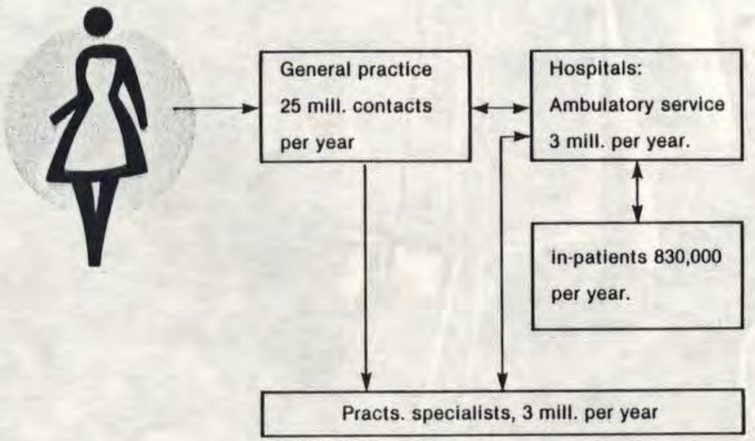
Danish hospital physicians are full-time, salaried staff members. They do not collect any fees from hospitalized patients in their respective departments. It has been discussed whether this system of total separation between primary and secondary health care system ensures the best cooperation between primary and secondary level.

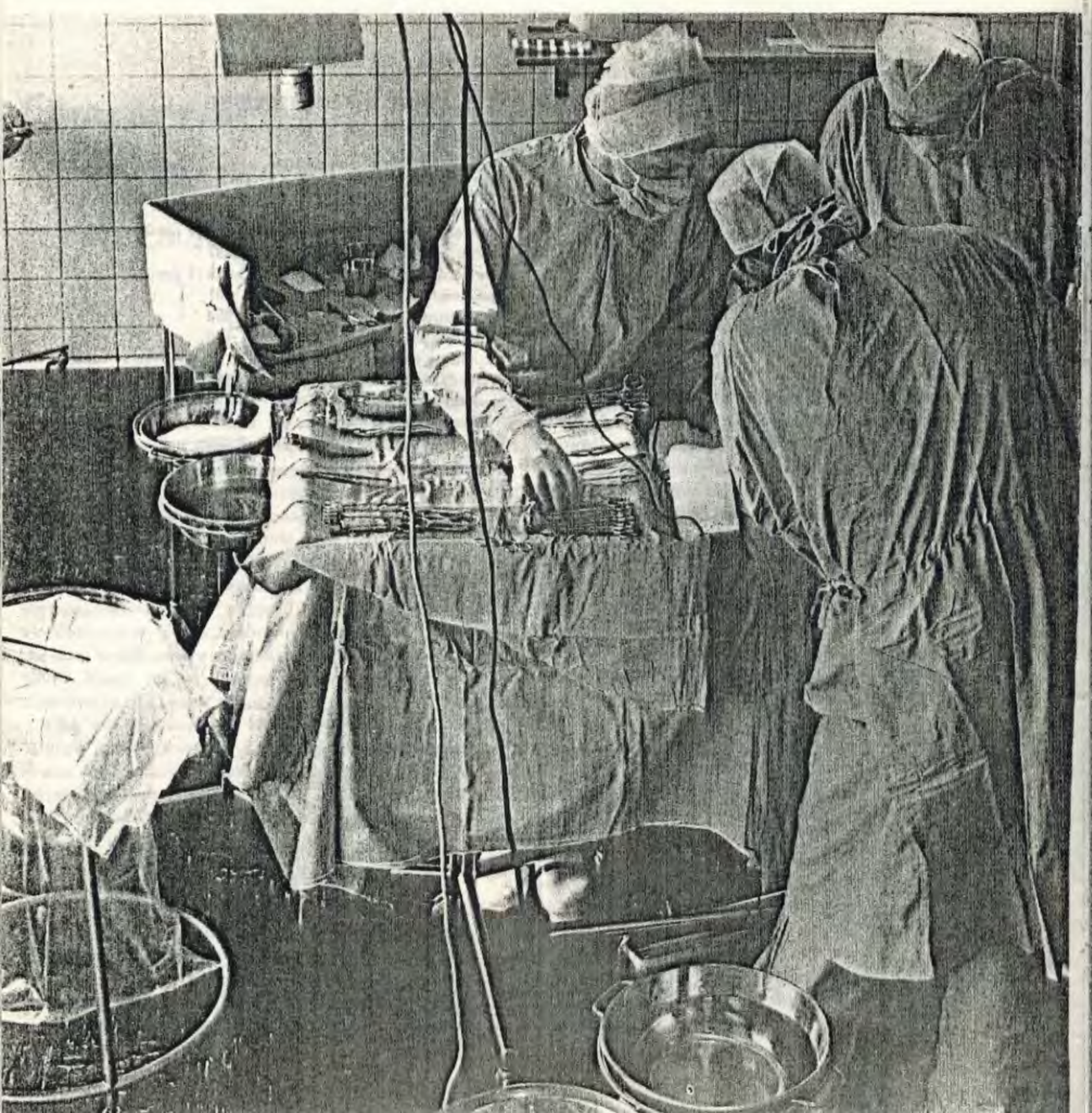
2.3. Health resources at primary level 1979

Table 8.

Number of	
General practitioners	2,789 (1 per 1835 inhab)
Practis. specialists	1,887
Practis. dentists	3,028 (1 per 1690 inhab)
Midwives	661
Home nurses	2,354
Infant health visitors	1,150
Dispensing chemists (State licensed) pharmacies	330 + 14 in hospitals
Nursing home beds (Homes for the aged) app.	50,000
Physiotherapists	2,771

2.2. Fig. 2. Number of contacts within the health service in late 1970s.





2.4. Hospital services

Modern hospital services were first introduced in the second half of the nineteenth century. The first hospitals were built in the capital. In the years up till the Second World War the bigger cities and some of the bigger towns had hospitals. In the years after the Second World War the development has shown a tendency towards concentration of hospitals in the larger cities. A number of hospitals in the smaller towns have been abolished or changed into special hospitals.

The common (somatic) hospital service has always in Denmark been the obligation of the county councils, while earlier the state was in charge of special hospitals, for instance for psychiatric patients. Now both the psychiatric hospitals and other special hospitals are run by the county councils integrated into the ordinary hospital service. The state now runs only the big university hospital, Rigshospitalet, in Copenhagen. There have always been only a few private hospitals in Denmark. They operate only under special agreements with the county councils.

As of January 1979 there was a total of 132 hospitals with 42,955 beds. In the somatic hospitals there were 6.6 beds per 1,000 inhabitants.

2.5. Hospital resources 1979

Table 9.

Number of:	
Hospitals (of these 10 mental hospitals)	132
Number of beds	42,955
Total staff	108,099
Staff persons per bed	1.8
Doctors (full time)	6,187
Nurses	17,505
Other nursing staff	27,698

Number of admissions per 100 inhab. in general somatic hospitals: 17.7.

There are different types of hospitals. On the basis of the hospitals' size and tasks they are divided into hospitals with at least three clinical departments and at least 800 beds, and hospitals with at least three clinical departments but under 800 beds, the so-called divided hospitals, which have surgical and medical departments. Furthermore there are certain so-called mixed hospitals which are not divided into special departments; special hospitals for special somatic diseases, and psychiatric hospitals.

2.6. Hospitals divided by type and size 1979

Table 10.

	Number	Number of beds
Hospitals with at least 3 clinical departments over 800 beds	9	25,091
Hospitals with at least 3 clinical departments under 800 beds	33	
Divided hospitals	30	4,402
Mixed hospitals	24	1,665
Somatic special hospitals	20	2,355
Psychiatric special hospitals	16	9,442
Total	132	42,955

Mixed hospitals are small local hospitals, typically with 75-100 beds which are not divided into special departments and where the chief consultant is a surgeon. These hospitals have traditionally concentrated on surgical treatment, but they also accept patients for medical treatment. To undertake this task these hospitals are provided with assistance on a consultancy basis from a bigger hospital within the same county. Consultancy service in other fields is provided in the same way. Some of these small hospitals serve island communities.

The divided hospitals usually have 100 - 150 beds with a surgical and a medical department. Furthermore, they have a varying degree of X-ray and anaesthesiological functions, usually with a consultant for each of these functions.

In the group of big and larger hospitals with at least 3 clinical departments we have the central hospitals and the regional hospitals. To this group belong the hospitals which provide the main hospital service within a county. The main hospital is chosen within the total hospital planning of the county to provide all categories of specialities and expert service which must normally be available within the county. The most common hospitals are those with 300 - 500 beds. They provide services within the usual specialities for the whole county but at the same time function as hospitals for their local city and the surrounding area.

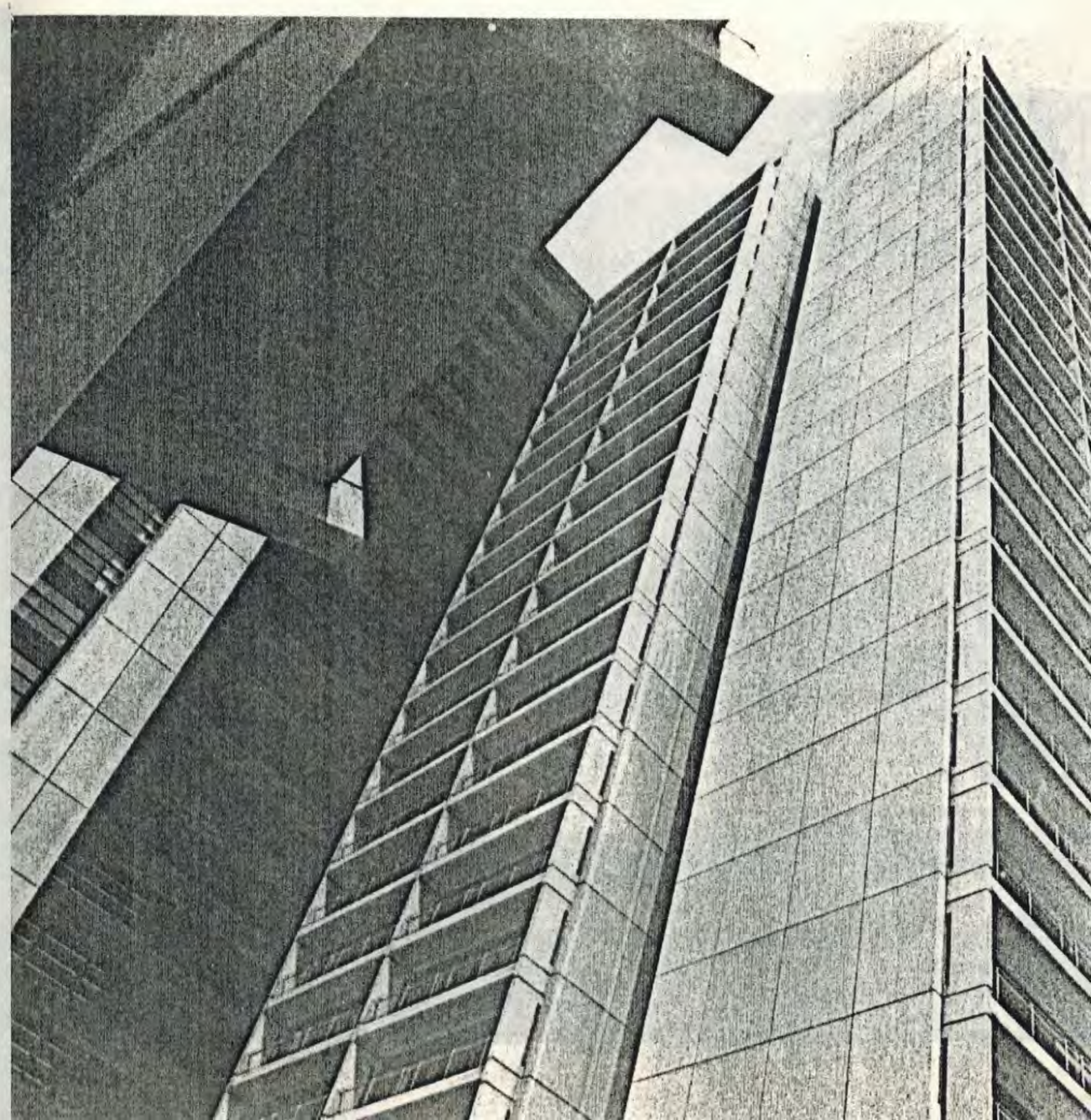
Supplementing these hospitals are big, very specialized hospitals in certain larger cities. They have ordinary hospital functions but also those special functions which it is only necessary to provide in a few places in the country, the so-called national or regional functions.

These average about 8 per cent of the total hospital consumption in the country.

The special somatic hospitals are those that only treat certain special diseases as for example rheumatic diseases; this category also includes the so-called rehabilitation or after-treatment hospitals.

The psychiatric special hospitals are those hospitals which were formerly run by the state for psychiatric patients but are now integrated into the ordinary system of hospitals run by the counties.

The hospital service within a county thus consists of a number of hospitals of different size and type. Generally the hospital service in a county must provide departments for all common medical specialities.



Chapter III
Planning of the health care system

All counties and districts have an obligation to make five-year plans for their social and some of their health services. These plans must be revised every year and sent to the appropriate ministries for comments. The responsibility for most hospital services in each county lies with a special hospital committee. Since 1973 the responsibility for maintaining a primary health service also has devolved to the county councils.

The majority of social services and some of the preventive services are the responsibility of the local governments.

Chapter IV
Preventive health services

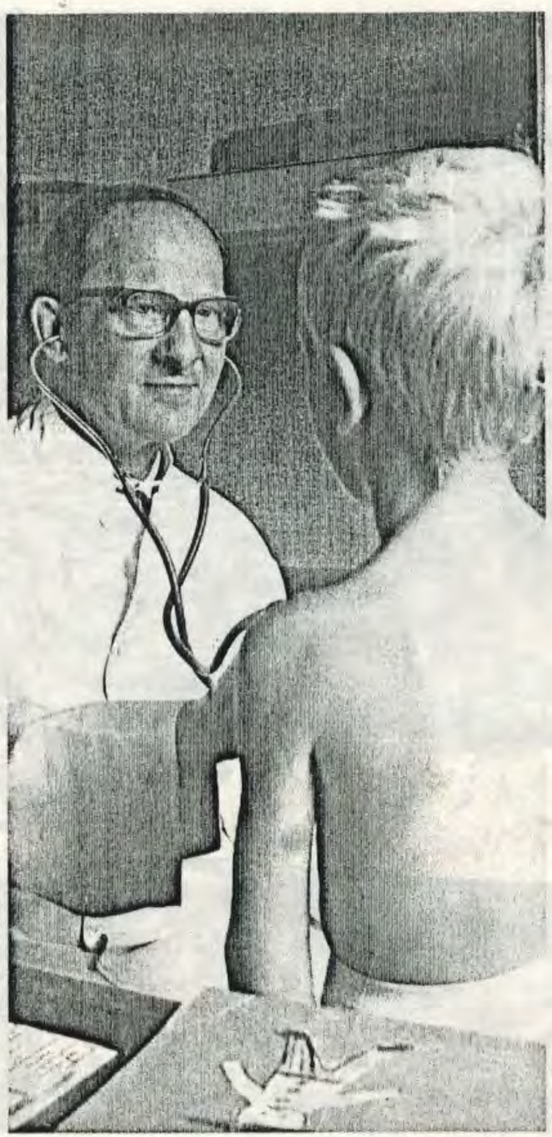
Preventive health services are available to the population, free of charge, in the following fields:

4.1. Prenatal examination and guidance

A pregnant woman can choose to have her prenatal care with her family doctor or she can go to her family doctor and a midwife at her local midwives centre. She can have at least seven check-ups by a midwife before and immediately after delivery, and three by her doctor. In the event of higher-risk pregnancy the patient will usually be referred to further examinations at a local hospital. A woman may choose to give birth at home or in a hospital. The vast majority of births take place in hospital departments; only 0,5 per cent takes place at home. All Danish midwives have received special training at colleges and are licensed. All are attached to public midwives centres, usually in affiliation with the local department of obstetrics. After birth, the child is examined for phenylketonuria and malformations, and the local infant health visitor is notified.

4.2. The service of infant health visitors

The service of infant health visitors was started in 1937 and is now compulsory in all local government districts.



The public health nurse presents herself in the homes of newborns early in the post-parturition period to offer her assistance to the family in the care of the new baby. Nearly all families in Denmark accept the service of the health visitor, and during the first year after birth she pays visits to the homes at regular intervals in order to control the health of the child and assist the mother with different kinds of problems. After the first living year of the child she reduces her visits to well-functioning families and concentrates her efforts on risk-prone families or those already having trouble. She may continue to visit family and child throughout the preschool age.

The public health nurse is supposed to refer patients with more complicated health problems to the general practitioner and, as a member of the crew, she can draw directly upon the local social services.

4.3. Preventive health examinations

Every child is entitled to 9 preventive health examinations by a doctor at the ages of 5 weeks, 4 months, 10 months, 15 months, and afterwards once a year up till school age. The National Board of Health has laid down special guidelines for the general practitioner on what to concentrate on at the various ages of the child.

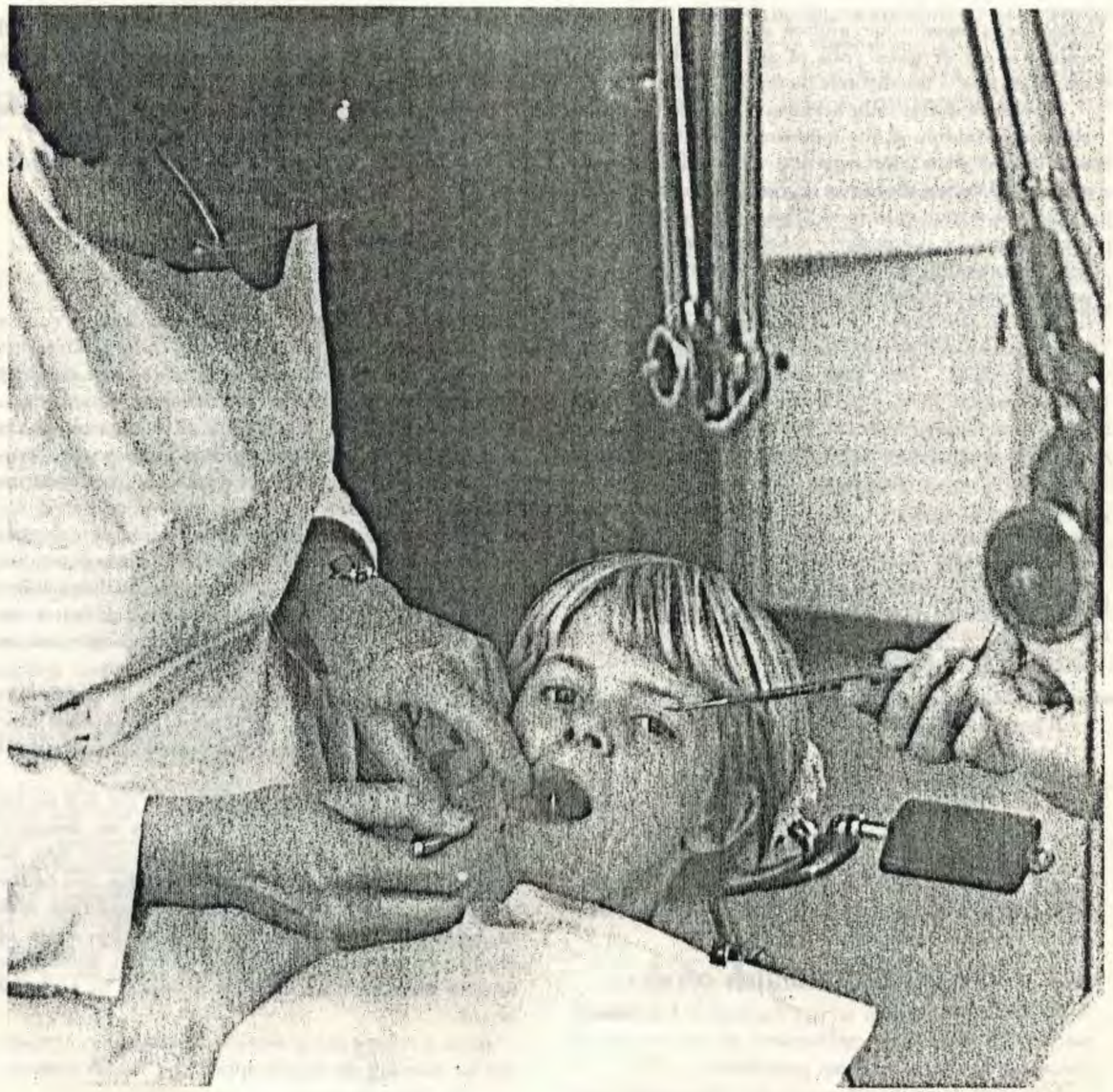
4.4. Vaccination of children

All children are offered free vaccinations by their own doctors against diphtheria, polio, tetanus, whooping cough. Some children are vaccinated against tuberculosis while smallpox inoculations have been abolished.

4.5. School health service

The school health service was established in 1946.

It is the only point in the total health care system where a compulsory check-up of the whole population is done. All schools, private or public, must provide a



school health service for children at the time of entry – usually at six or seven years of age – to the time of school leaving – usually nine or ten years later.

The school doctor must perform routine screening of all school children at the following levels: in the first and second years after entering school, in the fifth grade, and during the last year of school. Furthermore, the school doctor examines children who may have a special need, i.e. where there are special problems or a risk of unhealthy development, whether for social, psychological or somatic reasons. The school nurse participates in the health education and checks height, weight, visual and hearing capacities each year on each child in school. Other tests are done at fixed times. School doctors do not treat illness but always refer them to the family physician. School health service also checks that children receive the usual immunizations and whenever a tuberculin skin test is negative Calmette vaccination is offered. Furthermore, school physicians supervise the school environment with the school principal and evaluate heating, ventilation, lighting, class rooms, and toilet facilities as well as overall hygienic conditions.

4.6. Child dental care

Since 1972 child dental care has been compulsory in all local government districts.

Compulsory child dental care now includes all children of compulsory school age and will by 1985 include all children under and of compulsory school age, i.e. children from two to about sixteen years of age.

All children have access to free dental service at public clinics for both routine check-ups and treatment. A preventive programme is in work in schools and in day-care institutions.

4.7. Occupational health services

An occupational health service legislation has existed since 1913. Since then employment of children below the age of fourteen has been prohibited.

At present, legislation has extended the occupational health service so that all employees will now be covered by a special service and health/safety committees are compulsory everywhere.

Special health examinations are required before entering certain specified apprenticeships or jobs.

Special health certificates are needed before a driving licence may be obtained.

4.8. Other preventive health measures

Every county must have a *child guidance* clinic run by the county where psychologists and child psychiatrists examine children and advise families with children having emotional or other psychological disturbances. Many districts have *screening* of all women in certain age groups for uterine cancer, and some local governments conduct screening for cancer of the breast as well.

All schools have *sex education* in their curriculum at various levels. Under the general health insurance system everyone is entitled to free counselling, either with own doctor or at a special county clinic, to examinations and advice concerning *contraceptive methods.*

Every adult above twenty-five years is entitled to *sterilization* on demand. All sterilizations must take place in hospitals and must be reported to the National Board of Health.

Since 1973 every woman may within the first twelve weeks of pregnancy have an *abortion* on demand. Legislation provides that the woman must first be counselled as to the nature of the operation and on the social benefits to which she is entitled should she wish to have the baby. After the first twelve weeks of pregnancy a woman may get an abortion, should she wish it, after her case has been reviewed by a special board.

In each county one or more *rehabilitation centres* exists for assisting the handicapped and, where possible, to train them for work.

Chapter V
Public health service

The public health sector is the responsibility of various authorities and ministries. Many of the tasks involved are highly technical and go far beyond what a medical system can provide. Within the medical system there is control with the morbidity and mortality in the population, and the medical system is involved in special preventive measures, screening examinations, control of various kinds of institutions, while hygiene, drinking water, pollution, control of foods and drugs, and control of the environment as a whole involve both local and state authorities. Special legislation regulates working conditions and the environment of employees in factories and other places of work while special regulations apply to dwellings and buildings.

Likewise, we have town planning and planning of traffic, and special regulations and legislation in these fields influence the health of the individual and of the whole population as much as medical examinations and treatment. However, there is still far to go and many problems within the health field remain. A better health education is necessary for all age groups with the ultimate aim that everyone should be more responsible for his or her own health.

5.4. National health service

Denmark's national health-service scheme applies to everyone resident in the country, irrespective of state of health, age or occupational status; married women without work outside the home are thus covered by the national health service in their own right. Immigrants arriving from abroad, however, have a qualifying period of six weeks before entitlement under the scheme commences.

Almost all expenses arising in connection with illness are covered by the national health service. All hospitals admit and treat patients free of charge; they are owned and run by the state. Medical help outside the hospital service is also free of charge to everyone registering with a medical practitioner who has agreed to serve under the scheme; patients are also required to apply to specialists only on referral from their regular doctor.

If the patient reserves the right to choose any doctor and specialist at any time, the state contributes a fixed amount for each consultation. The doctor fixes his own fee, and the patient pays the difference. Patients are also refunded part of the cost of treatment by a dentist or physiotherapist.

The state pays part of the cost of vital medicines.

In certain cases the state pays for transport to and from a doctor or hospital. A fixed amount of death grant is payable toward the cost of funeral expenses.

When women took action

The new women's movement broke away from traditional goals and resorted to new methods - and became a factor to reckon with in Denmark in the 1970s.

By Hanne Dam

Recently, when Minister for Social Affairs Ritt Bjerregaard was asked what she considered the most important development in Denmark in the 1970s she replied, "The women's movement". What she meant was the "new" women's movement which started out with provocative actions in 1970 and like the new radical American women's movement assumed the name of "Redstockings".

Perhaps the Minister for Social Affairs did not think only of the organised members of the movement but equally much of all the women around the country who have adopted the ideas of the Redstockings and who have begun the battle for their emancipation as women in their own individual contexts: in the home, in their relationships with husband, children, grandparents, at work, in trade unions, vis-a-vis authorities.

The Minister is in tune with the times for it is a fact that there isn't a Dane above six years of age who does not know the word "Redstocking" and who does not have some idea of what it means. For some it has become an insult. "I am not a Redstocking but..." is what some of the women participating in the sex role debate may say. They do not want to be labelled although they are often working as an extended arm of the new women's movement.

A weariness that exploded

But how did it all begin? We were faced with a situation in which the labour market throughout the 1960s had absorbed many of the women who had formerly stayed at home. The women had joined the workforce and become financially independent if that is indeed the correct choice of words considering that it takes two incomes to provide for a family with two children.

Women had gone "out" but there were still the chores to be done at home. Now they had to do double work and they felt - like the women in many other countries undergoing the same development as Denmark - increasingly humiliated and weary. Their humiliation and weariness exploded and were superseded by the Redstocking movement.

A series of colourful actions marked the start of the radical impact on Danish society. While the traditional women's movement continued its work on councils and commissions, on which it had waged battle to be seated, the Redstockings took to the streets and demonstrated. In April 1970 a flock of women marched through Copenhagen to Town Hall Square where they tore off stuffed brassieres, artificial eylashes and other female paraphernalia and dumped it all in a trash bag carrying the word "Keep Denmark Clean". They dissociated themselves from the traditional female ideal and made a symbolic show of discarding their inferiority complex together with the artificial props.

They cropped their hair short, distributed handbills, made speeches around the country, changed the stat-

First demonstration by Redstockings, April 1970

Bra and girdle are hurled into the trash can during Redstocking demonstration in Town Hall Square in Copenhagen

ues of the city, and refused to pay full fare on buses as long as the pay of women was so much lower than that of men.

Personal means political

The women of the Redstocking movement stuck to the anti-authoritarian and anti-bureaucratic ideas of the so-called youth revolt. The basic unit of the movement would be the base group or the chatting group whose aim is to develop the strength of the individual woman. Each group consists of 5-10 women who decide themselves what they want to work with. As a point of departure the women must tell about themselves, in turn, so that all get an equal opportunity to have their say.

Through discussions in the base groups the women have found out that individual problems are actually shared by many women. Also that the problems of the individual are not caused by personal insufficiency or perhaps an unsympathetic husband but rather by the existing social structure. Out of this conclusion came the slogan "Personal Means Political".

Another slogan was coined: "Private and Public are Complementary". It was prompted by a demand that everything dominating a woman's everyday life must be considered in the political battle.

Over the years the Redstockings have helped move the ideological and sexual repression onto the political list of priorities. Political left-wing parties have formed women's groups whose work is converging more and more towards that of the Redstockings. The "new" women's movement is nevertheless regularly criticised by traditional left-wing political groups for being an isolated protest movement without social effectiveness and without a firm hold on the conditions offered women on the labour market. The movement is charged with being individualist and narcissistic and for not having the declared goal that the work of the women's movement should always be a springboard for participation in the class struggle.

"Women's problems can never be self-contained," say some of the left-wing critics.

Still, the principal motto of the Redstockings is "No women's struggle without class struggle - no class struggle without women's struggle". As a matter of fact, in addition to striving for individual liberation from the "old" sex role the movement has become increasingly active in traditional political work. It is heard in the political debate, supports women in labour conflicts, even cooperates with the elected politicians of the Folketing. Thus the Joan Sisters, a counselling group within the movement which assists women who have been raped, have been invited by the Parliamentary legal committee to contribute to preparations for new legislation on the victims of rape.

Until 1973 the new women's movement was among those advocating legislation on free abortion and equal pay. And the movement makes more and more traditional political demands: Six-hour workday, maternity leave for men, de facto equal pay. As long as women in industry are given special women's jobs which pay less than men's jobs we have no equal pay system, they say.

The movement has tackled the serious problems of female unemployment in Denmark during campaign weeks and in the publication »Kvinder« (Women) whose readership goes far beyond the membership of the movement and whose editorial policy reflects the concerns of the movement.

To establish contact with other women the movement organises annual women's camps which are open to all women and children, and women's festivals on specific topics to which also men are admitted.

New actions

The numerous actions undertaken by the movement over the years to acquire a building to work in are a chapter by themselves. The women would select condemned, empty buildings, move in and then negotiate with the owners. The present women's house was made available by the authorities of the City of Copenhagen. It is not very large which is why the Redstockings jointly with 23 other women's groups in Copenhagen organised an action which has commanded the attention of large parts of the Danish population: the occupation and subsequent purchase of a building more than one hundred years old, the so-called Countess Danner Foundation.

The plans of the women's groups include an emergency centre for women who have been exposed to battery and assault, and the gathering under one roof of conference rooms, workshops, a book café. When the original board of the Foundation was about to sell the building to a private firm for office premises, the women who had not been consulted in the matter broke into the house and settled there. This took place in the early morning of November 2, 1979.

The Ministry of Justice; however, approved the sale of the building to the private firm so the women launched a nationwide drive to collect funds for the price asked by the firm. Only a few believed it possible to raise the three million kroner asked but the people backed the women morally and financially so that today the house belongs to the women and in about a year it will be fully established as a women's centre and as an emergency centre.

From the very beginning the women's groups asserted their right to take over the building without payment; they see themselves as a modern response to the ideas of Countess Danner, the founder of the house. Of modest origins, born out of wedlock to a Copenhagen mangling woman, she climbed socially (without ever being recognised by the genteel bourgeoisie) when she married the Danish king.

The new women's movement is rooted in socialism and has discarded the goals of the "old" women's movement, viz. equality between the sexes. It does not want a society built on the terms of men but on more human terms. It does not want the right to share in the psychosomatic ulcers of men, say the feminists.

Their points of departure vary but the battle for the Foundation of Countess Danner proves that Danish women's groups, however disparate, and whatever their parties, movements and trade unions, are capable of pooling their energies in order to achieve a specific goal.

Redstockings

of the

Women's Liberation Movement

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