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Spanish Website

The Madrid hub of the Observatory has created a Spanish website: www.isciii.es/publico/drvisapi.dll?MIval=cw_usr_view_Folder&ID=2071

This is a summarised version of the Observatory's main website. It also contains recent and downloadable files of work in Spanish, such as the HIT report on Spain.

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Structural reforms for Germany's health care system?

Markus Wörz and Reinhard Busse

The governing coalition in Germany between the Social Democrats and the Green Party managed to regain a slim majority in the federal general elections on 22nd September 2002. However, Chancellor Schröder must now govern with a parliamentary majority of only four, compared to ten during the previous legislature. During its new term in office, the government has set its sights on fighting unemployment, consolidating the public budget and decreasing ancillary wage costs in order to promote employment and strengthen German industry's international competitiveness. Therefore, the first important measure to be implemented has been the creation of two 'super ministries' - one for the economy and labour and the other for health and social security – out of the former three ministries for economy and technology, labour and social security, and health. Primarily, this bundling of competencies aims to promote concerted reforms in labour market and economic regulation. It also means more responsibilities for Ulla Schmidt, Minister for Health and Social Security, whose competencies will cover health care, as well as social insurance and assistance, pensions, disease prevention and rehabilitation, and disabled people.

On 16th October 2002, the Social Democratic and Green parties endorsed their coalition agreement which sets out the government's plans for the new legislative period. The coalition agreement announced the introduction of preliminary legislation (*Vorschaltgesetz*) aimed at preparing for structural reform in the health sector, and motivated by the desire to avoid increases in statutory health insurance (SHI) contribution rates. Indeed, the stability of contribution rates may be in danger as the SHI recorded a deficit of €2.8 billion in 2001 (corresponding to 1.3% of total public expenditure on health and 2.3% of total SHI expenditure in 2000) and also posted a deficit during the first half of 2002. Since the statutory sickness funds are prohibited from incurring long-term debts, the only way to avoid increasing contribution rates is to contain costs.

The government moved quickly and introduced it's first two bills on statutory health insurance into Parliament in the first week of November 2002. They contain the following measures:

- Raising the income threshold for mandatory insurance from a gross monthly salary of €3375 to €3825. This increase was one of the main health policy issues discussed during the electoral campaign.[1] Thus, people with high earnings up to the new threshold* will be forced to remain within the SHI and will not be allowed to opt-out in favour of private health insurance;
- A one-year freeze in remuneration rates within the hospital sector and for the ambulatory and dental sectors;

* According to government estimates, this change affects 50 000 to 60 000 people (approximately 0.09% of all people insured in the SHI) while the Association of Private Health Insurance Funds puts this figure at 750 000 people (1.1% of SHI insured).

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– Inclusion of patented pharmaceuticals into the reference pricing system, the introduction of higher discounts on pharmaceuticals for sickness funds, and reductions on prices for orthodontic services;
– Cuts (approximately 50%) in the funeral allowance benefits per insured;
– A freeze in contribution rates to the statutory sickness fund until 31st of December 2003.

With these immediate measures the government hopes to save the statutory health insurance funds a total of approximately €3 billion.

The coalition agreement includes several other demanding reform measures. Currently, statutory sickness funds have an obligation to contract with all SHI accredited physicians who also have a monopoly for the provision of outpatient medical services. The government envisions a modification of this obligation whereby hospitals will also be allowed to provide outpatient services. In addition to collective contracting with health care providers, the statutory sickness funds will be allowed to make 'selective contracts with defined quality standards'. The agreement does not elaborate further but it is probable that these additional contracts will be based on higher prices for quality. In addition, the coalition agreement states that sickness funds will be given the opportunity to compete on incentive and bonus systems but again, does not give further details.

Improved quality will be promoted by continuing with disease management programmes (DMPs) for chronic illnesses. DMPs are an innovation in German health care policy and were legally established in November 2001. The intention is that statutory sickness funds will be allowed to offer DMPs to their insured with chronic illnesses. Since subscription of a sickness fund member to a DMP is linked to the risk adjustment scheme between statutory sickness funds (by ascribing every participant in DMPs higher standardised expenditure for risk adjustment)[2] there will be an incentive for funds to offer their insured DMPs or to attract new members into DMPs.

However, the development of DMPs is a difficult process. First, a Coordinating Committee, established in September 2001 as a result of the SHI Reform Act, (2000), which is made up of representatives from the sickness funds, physicians and the hospitals association,[3] has the task of proposing chronic illnesses suitable for DMPs. In January 2002, the Coordinating Committee proposed the following four illnesses: diabetes (Type I and II), coronary heart diseases, asthma and breast cancer. It is then the task of the Coordinating Committee to develop evidence-based guidelines as the basis for DMPs, with the statutory sickness funds and health care providers being responsible for developing actual DMPs based on these guidelines. Finally, the Federal Insurance Office must accredit the DMPs. So far, the legal application procedure for a DMP has only been fulfilled for diabetes II and breast cancer, with the first charter for a DMP being signed on 14th of October 2002 for breast cancer. According to the government's plans, DMPs should continue to be developed for other chronic illnesses and they are also seen as a means of promoting integrated care and overcoming the strict separation between in-patient and outpatient sectors. For example, hospitals currently are not allowed to provide ambulatory services and consequently diagnoses are often performed twice, once by the outpatient physician and again in the hospital with DMPs; now hospitals will also be allowed to provide ambulatory services.

Moreover, it is envisaged that integrated care will become standard practice for people with chronic illnesses and that there will be improved coordination between GPs, specialists, hospitals, rehabilitation facilities and other health care providers. In particular, GPs will be given an enhanced gatekeeping role by actively advising patients on which services, specialists and facilities they should utilise. Currently, patients can access specialist services without a GP's referral and indeed, the free choice of physician is so popular amongst citizens that the government will not remove this choice altogether.

The government also announced the establishment of a new 'German Centre for Quality in Medicine' whose tasks will include developing guidelines on the treatment of chronic diseases, making decisions for the statutory benefit package and undertaking cost-benefit analysis on pharmaceuticals. This announcement is remarkable insofar as the task of developing evidence-based guidelines has been delegated to the recently established Coordinating Committee (see above) and decisions on the statutory benefits package is currently the responsibility of the Federal Committee of Physicians and Sickness Funds (FCPSF). Notably, both the Coordinating Committee and the FCPSF have been criticised on the grounds that despite their decisions affecting circa 90% of the population, they are neither transparent nor democratic, and that they impede competition under EU law by operating as trusts. Therefore, this may indicate that the government is considering an overhaul in institutional design.

As a further reform measure, prevention is to become an autonomous pillar alongside acute care, rehabilitation and long-term care, with the government intending to pass a specific law on disease prevention. The government also announced the introduction of mammography-screening for women between 50 and 70 years old and the establishment of interdisciplinary breast cancer centres. The detailed announcement on the introduction of mammography-screening is something of a windfall gain to the government as a decision to adopt this measure was already made by the federal associations of the SHI in September 2002.

Strengthening the rights of patients is also a key aspect of the government's coalition agreement. This will be implemented through the introduction of a Patient's Charter and introducing a patients' representative at the federal level akin to the current government representative for disabled people. Indeed, a Patient's Charter has existed in Germany since 1999, having been developed by the conference of the health ministers of the German Länder. However, the existing

Patient's Charter was further developed and expanded by a working group containing representatives from all health care sector stakeholders, and was presented to the federal ministers for justice and health on 16th of October 2002. The revised charter focuses on patients' information rights. Furthering patients' rights, the government also announced its intention to pass a law on genetic testing which will be based on the principles of voluntary testing, non-discrimination against people who have tested for a predisposition to certain illnesses, data confidentiality and mandatory patient consent prior to any transfer of genetic information and restricting genetic information to medical practitioners; that is, bodies such as insurance agencies will not be allowed access to the results of genetic tests undertaken by patients.

According to the Minister of Health and Social Security, the government's reform programme will be developed until Spring 2003. On 12th November 2002, Ms Schmidt also announced the establishment of an Experts Commission whose remit will be the development of reform proposals for the sustainable financing of the SHI system, pensions and long term care insurance, and for securing justice between generations. The latter is a core concept promoted by the Green Party and aims to ensure that one generation does not burden the following with unsustainable (public) debts. As far as SHI is concerned, the Commission will also develop proposals on how emphasising the importance of prevention can contribute to avoiding illnesses as well as financially stabilising social security. The Commission's final report is expected in Autumn 2003 and the government will then consider further reform in the area of social security based on its recommendations.

Without doubt the German health policy agenda is a very full one for the next legislative period and it will be interesting to see how much success the government will have in accomplishing all of its reform programme. In particular, it will be a difficult task to transform the sophisticated plans of the coalition agreement into policy within the space of only a few months. Furthermore, the implementation of any wider structural reforms based on recommendations from the newly established Experts Commission would need to avoid skirting too close to the next general election in Autumn 2006. Thus, the next legislative cycle will be a crucial time for German health policy.

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Will hospital management reform in Portugal work?

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Traditionally, Portuguese public hospitals perform poorly in terms of efficiency, accountability and cost containment. During the 1980s and 1990s, Portuguese policy makers failed to define policies to improve the achievement of these objectives but in 2002, new pressures for change emerged as severe economic problems beset Portugal and the public debt greatly surpassed the 3% ceiling allowed by the EU Stability Pact. The State is currently under pressure to cut public spending and to implement structural reforms,[1] thus urging the new centre-right coalition government to carry out reforms in the hospital sector. Despite protests from key stakeholders, a new hospital management law was passed through parliament in September 2002.

The new law follows similar trends in other countries (such as the UK) by moving NHS hospital management structures away from a single-category of public status (see below), with significant implications for the future of hospital settings in Portugal. This article analyses the potential impact of this reform, which paradoxically has been hailed both as a path-breaking measure and as a law that was hastily pushed through without adequately ensuring the necessary background conditions for the delivery of its policy objectives.

Current problems

The Portuguese health care system is based on a National Health Service (NHS). Hospital supply is dominated by public provision and most hospitals belong to the NHS. Despite attempts to decentralise with internal market reforms in 1997, hospitals remained under central control and the hospital sector continues to dominate the health system. Hospitals operate with high allocative and technical inefficiencies, with low levels of accountability, which, in turn, contributes to cost containment problems.[2] Some reasons for this are:

– Doctors have little incentive to be productive in public hospitals: they have dual employment status in the public and private sectors; the payment system based on salaries does not reward productivity and doctors maximise income by doing overtime in NHS hospitals and working in the private sector.