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Germany's Constitutional Court on "family friendly" contributions to statutory health insurance schemes

Matthias Wismar

Concerns and issues

According to the German Constitutional Court in Karlsruhe, contributions for statutory long-term care insurance have to be 'family friendly'. This decision (1 BvR 2014/95)* was made on 3 April 2001 and is based on a large number of pending cases. Three major issues or questions were at stake:

- Is the current statutory long-term care insurance in line with the basic law (the German constitution)? In other words, did the government have the constitutional competence when, in 1995, it introduced the long-term care insurance as another mandatory statutory insurance scheme in addition to the statutory pension, health, unemployment, and accident insurance schemes?
- Are contributions which are not family friendly in line with the basic law – is it necessary to differentiate contributions by the number of children raised in a given family?
- If a differentiation of contributions is required by the constitution, should this be applicable to private long-term care insurance?

* For a summary of the ruling, consult the Constitutional Court's website at http://www.bundesverfassungsgericht.de

Understanding the Court's decision

With regard to the constitutional status of the long-term care insurance, the court clearly endorsed the government's right to establish another pillar of the German welfare state. This has ended a debate of more than 20 years which preceded the introduction of the long-term care insurance. In making its decision, the court followed the argument that those who raise children should have a deduction from their long-term care insurance contributions. The case was initially brought to the court by a father of ten, and then forcefully supported by various family associations. It was seen as unjustifiable that those who raise future contributors to the insurance schemes carry both the financial burden of raising children and paying contributions, while those who stay childless have better career chances.

The court did not give any hint with regard to the extent of the contribution differentials. The reason for this is that the Constitutional Court's competence only allows it to scrutinise whether a given law is in line with the constitution. It may order the government to have the problem addressed by a certain date, but its mandate does not allow it provide a solution.

As pertains to family friendly contributions to the private long-term care insurance, one

aspect of the court's decision was that employees who exceed the assessable income ceiling are to be free to insure themselves on the private market. The court argued that the statutory long-term care insurance is based on pay-as-you-go financing, while the private long-term care insurance is based on funding methods such as the life insurance market which does not require solidarity between generations.

The court's decision has triggered an unprecedented discussion in Germany on the capacity of the welfare state to support families. In principle, almost everyone in Germany seems to welcome the decision. Only conservative sociologists and some 'free-marketeer' economists have expressed doubts about the ruling. The former condemn it as another move to dissolve family ties by putting a price tag on intra- and inter-family relations. And the latter believe that it heralds a rebirth of the all-embracing welfare state. But their respective influence seems to be marginal in the debate. This is surprising, since the court's ruling is less convincing than it looks at first glance.

A closer look at the context

The future of long-term care insurance is not determined by the number of children raised in Germany. It is by and large determined by three factors:

1. the total labour volume (a move to full employment may compensate a drop in population size)
2. the professional status of the workforce (public servants, self-employed and those exceeding the assessable income ceiling are either excluded from statutory social insurance schemes or may opt out)
3. future productivity gains (if productivity rises strongly, we may have to work less in order to have a decent living)

Moreover, it is questionable as to whether the decision is important in monetary terms. It is most likely that it will mean only a minor reduction, especially since the long-term care insurance is a minor contribution.

Additionally, the court has asked the government to scrutinise all other statutory social insurance schemes in respect of the assumed unfairness – especially the pension scheme and the statutory health insurance. This has caused irritation, because under the latter children are insured for free. Moreover they are exempt from all user charges. The contribution rate for an individual is the same as that of a family, so long as only one of the partners is working. A father of ten may insure the whole family at the same contribution an individual would have to pay.

The pension scheme is completely different because the 'principle of equivalence' is the most basic rule. This simply means that the higher your contribution, the higher your pension. A differentiation in contribution would lead to the abolition of the equivalence principle. Moreover, each year the government subsidises the pension scheme by some DEM 23 billion to raise pensions for women who have not paid contributions during the times they have stayed at home to raise their children. In taking a closer look at German social legislation, the court's ruling appears even more puzzling. The Social Code Book I (SGB I), which contains most legislation of the statutory social insurance schemes, clearly sets out in §1 that the purpose of the Social Code Book, amongst others, is to secure and support the family.

The court's intervention would be more understandable if we had clear evidence on the distributional quality of the welfare state. Twenty years ago, a parliamentary commission did endeavour to enquire into the distributional characteristics of the welfare state and the tax system.[1] The outcome was very clear-cut: there was a very strong redistribution from the middle income strata to the low income strata. Both the tax system and the welfare-state have changed since then, but are probably less significant than the changes seen in the labour market. Unemployment has risen dramatically and is still very high despite some decreases in the last two years, while over the last 20 years wage increases were very slow. So although the distributional quality of both the welfare state and the tax system is probably still very high, today there are more dependants and, of course, less to distribute.

Final remarks

What may seem to be the revival of the egalitarian welfare state is instead some kind of consumer empowerment. Some commentators have argued that a reduction in contribution will not ease pressure from parents, nor would it make a significant contribution to the household income. A family friendly welfare state would provide free nurseries and kindergartens and guarantee all-day schooling to allow both parents to re-enter the labour market.

But why then is there such nation-wide support for a ruling which is neither entirely convincing, nor based on scientific evidence? First of all, due to an extremely low reproduction rate the population size will drop drastically in the coming decades. By population, Germany is the twelfth largest county in the world. The coming decline has raised serious concerns over the potential economic effects ranging from labour to the housing markets. To encourage parenthood thus seems to be economically sound. Second, we have entered a pre-election period, with a general election set to take place in autumn 2002. Playing the family card will therefore make a big impression on the electorate – even more so if it involves a cash benefit – no matter whether it makes sense.

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Slovakia: progress and problems after seven years of compulsory health insurance

Reinhard Busse

History

By the end of the 19th century, the Austro-Hungarian monarchy had passed the first acts on social insurance covering accident and sickness insurance for certain groups of the population. After the creation of the Czechoslovak Republic in 1918, the Bismarck type of health care system, based on social insurance, was further developed. After 1948, radical changes occurred in the health system. The national insurance unified all types of insurance i.e. sickness, disability, and pension. All health care facilities were nationalised, becoming state-owned. After 1966, the socialist type of health system was further developed and the insurance system was replaced by general taxation. The radical political, social and economic changes after November 1989 brought about radical reforms in the health sector as well.

The previous method of financing was replaced by a compulsory health insurance system. The structure and organisation of health care was changed. The primary health care providers and pharmacists became private, and many specialists working in outpatient care also turned to private practice. As well, almost all spa facilities have become private. The state monopoly on health care provision was thus markedly reduced. However, most hospitals remain under state ownership with centralised management. The process of decentralisation has not been fully accomplished regarding the state administration in health care and the municipalities.

This article is based on the Observatory's Health Care in Transition Report (HiT) on Slovakia, published in 2000, and available via the Observatory's website (http://www.observatory.dk).

Changes: 1994–2001

The Slovak health insurance system began to function in 1994 based on the legislation adopted. Today, seven years later, it has experienced a severe financial crisis. The available resources in the system do not cover the volume provided by health care providers. The debts of the health insurance companies to the health care providers reached SKK 5 billion in 1998, which is about 12.3% of the total resources available to them. One of the main reasons has been insufficient allocations of the contributions paid by the state to the health insurance system.

By the end of 1998, an overall economic downturn in the economy led to insufficient payments by the employers to the health insurance system. This was worsened by the fact that many private companies were closed without paying their debts. In addition, it has become clear that a comprehensive system with services free of charge at the point of delivery was no longer sustainable within the existing resources. An open-ended system of reimbursement led to increased population demand for services of high quality. Although numerous limitations were imposed on health care providers, the situation is only improving slowly. A lack of appropriate control and regulatory mechanisms has led to a rapid increase in drug costs, an expansion of hospitals as concerns their equipment, and a shift towards more expensive and more specialised services.

During the health care reforms, appropriate reimbursement systems have not yet been found to motivate health personnel to provide better quality, more efficient and cost-effective services. In fact, the salaries and incomes of health care providers have dropped significantly. The principle that the health care provider who provides better care and has more patients receives more money is not true at the current time. In addition, the restrictions imposed recently on primary health care providers have turned their role into a more passive one. Patients often bypass the primary health care doctors despite their gate-keeping functions. The passive attitude of the population has changed only slightly and has not resulted in a wise and appropriate demand for health care services.

Thus, the goals to strengthen primary care and to shift in-patient care to outpatient care have not been fully achieved. In addition, cooperation between primary care and other areas is not ideal. This, despite the fact that the agencies for nursing home care have recently been recognised as a cost-effective substitution for hospital care and their number has increased rapidly.

Another reason for the problems of the health insurance system was the initial instability of the pluralistic system of health insurance funds whose number peaked in 1996 at 12. At that time, the previously rather loose legal requirements for running a health insurance fund were strengthened. As a result, only five health insurance funds operate today. The coverage of the largest decreased from about 96.5% of the population in 1995 to almost 50% in 1997, though has increased again to around 70% today.

The transformation process in Slovakia is thus not yet complete. While the previous version of the HiT on Slovakia (published in 1995) concluded that the country had achieved a relatively painless transition from socialist, central planning to a pluralistic, health insurance based health system, today the health sector finds itself facing severe financial and

organisational difficulties.

The future

In 1998, the new government in its health policy document, "Transformation Steps in Health Care Provision for 1999–2002", concludes that the health care sector is in severe crisis. A new set of comprehensive health care reforms need to be prepared and implemented. The 2000 HiT mentions the following issues to be addressed: defining the appropriate role of the Ministry of Health *vis-à-vis* the health insurance companies and the health care providers; finding better ways to balance positive and negative incentives in financing, resource allocation and provider reimbursement; and institutionalising health technology assessment for pharmaceuticals as well as for health services. However, the implementation and evaluation of such reforms is a matter for the future – and the next edition of the HiT on Slovakia.

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The HiT on Slovakia was written by Svatopluk Hlavacka (Ministry of Health) and Dagmar Skackova (former WHO Liaison Office in Slovakia). The Observatory is grateful to Eduard Kovàc (General Health Insurance Company) and to Armin Fidler (World Bank) for reviewing the report.

Clinical governance reviews in the United Kingdom

Seán Boyle

The United Kingdom Commission for Health Improvement (CHI) was set up in November 1999 and has been operational since April 2000 (see *Euro Observer* Vol. 2 No. 4). As part of its statutory functions, the CHI is tasked to undertake reviews of clinical governance in all National Health Service (NHS) organisations. Four pilot reviews were completed at acute trusts in the latter part of 2000 – Chesterfield and North Derbyshire Royal Hospital NHS Trust, Southampton University Hospitals NHS Trust, City Hospitals Sunderland NHS Trust and North West Wales NHS Trust. The final reports were published in December 2000 and January 2001, and are available on CHI's website (http://www.chi.gov.uk).

This article outlines briefly the early development of the review process, between April and October 2000, during the pilot stage for acute trusts. The detailed approach will continue to change as the Commission learns from its work with the NHS. The CHI is particularly keen to share its experience, and welcomes input as a way of learning and improving its own clinical governance review process.

The Review Process

The review process, from initiation to production of the CHI report ready for publication, spanned 24 weeks. There were three key stages:

Weeks 1–15:	Preparation before the visit
Week 16:	The week of the review visit
Weeks 17–24:	Writing the report

Once the report was completed there was an action planning period involving the acute trust, the regional office or National Assembly for Wales and the CHI.

Preparation

The review was initiated by a letter from the Commission to the trust announcing that it had been chosen for review and explaining the process. The CHI had appointed its own internal review manager who would organise the review. The trust appointed an overall coordinator for the period of the review and a start-up meeting was arranged. At this point the CHI also requested a body of information and data from the trust. It is this that formed the basis of the analytic part of the process which led to the production of a pre-visit briefing for the CHI review team.

The Commission also developed a number of other tools designed to enhance understanding of the organisation before the review visit. These were:

- Trust self-assessment
- Stakeholder meetings
- Patient diaries
- Surveys of clinical teams

These were designed to elicit the views of patients, clinicians and local stakeholders. In this context stakeholders means all interested parties from the general public to voluntary organisations, district audit and local primary care groups and trusts (in the case of Wales, local health groups) and health authorities.

Pre-visit brief

The CHI analytic team produced a synthesis and analysis of the information and data collected from each trust. The purpose of this document, in combination with the other analyses discussed below, was to:

- select the clinical teams that would be the focus of the review visit
- focus on particular issues at the review visit
- familiarise the review team with the trust's structure and organisation

Self-assessment

The Commission sent each trust a questionnaire designed to allow the trust to present a picture of its overall clinical

governance arrangements.

Stakeholder meetings

There were two days of semi-structured individual and group interviews in the vicinity of each trust, for all local people including staff and representatives of local organisations and pressure groups. These meetings were advertised in local newspapers and on local radio. Local people were advised that they could also contact review managers by post, phone, fax or email.

Patient diaries

A sample of patients discharged over the previous two months were asked to complete a diary of experiences. The sample was drawn by the trust. The trust also obtained consent and sent out the diaries, but these diaries were returned to the CHI. The Commission approached two multi-centre research ethics committees as well as local ethics committees for ethical approvals.

Clinical team questionnaires

The CHI sent confidential surveys to the clinical teams that were interviewed during the site visit. These focussed on communication within the team, induction, workload, appraisal, personal development, clinical audit, incident reporting, complaints, consent-giving, security of medical records, equipment failures/lack, and access to clinical information.

Review team briefing

The CHI review team met before the review week to assimilate the range of material outlined above.

Remark

The preparation period before the formal visit of the trust by the CHI review team was crucial to the success of the whole process. It was these activities that gave the review team a robust view of the nature of the trust before the visit took place. Not only could the team gain some initial understanding of the trust itself, its clinical governance arrangements and how effective these appeared to be, but also during this period a decision was made on what particular elements of the trust to concentrate on during the review visit.

The visit

The principal tools developed for use during the review visit were:

- corporate interview schedule
- combined clinical team interview schedule
- observation tool
- environmental checklist
- checklist for locum doctors and agency/bank staff

The interview schedules

The 'corporate interview' schedule was used when interviewing board members and managers of cross-cutting areas like clinical audit, complaints, information technology or research. Meanwhile the 'combined clinical team interview' schedule was employed when interviewing medical, nursing and other clinical staff, at all levels.

Both interview schedules covered a number of 'standard' items designed to elicit information about the key processes in clinical governance, i.e. the taking of consent, its timing, and whether those taking consent were competent to carry out the procedures for which they were obtaining consent, cardiopulmonary resuscitation (CPR) training, and implementation of do-not-resuscitate (DNR) policies. These were supplemented with issues and themes that the review team identified as important for each trust on the basis of work prior to the visit.

The observation tool and checklists

The observation tool covered how clinical staff interacted with patients, what it is like to be a patient (in terms of environment), and hazards in the environment while the environmental checklist covered the general environment such as user-friendliness, safety and cleanliness. In particular it covered services and facilities for disabled people. The checklist for locum doctors and agency or bank staff included issues such as induction, and how references, qualifications and criminal records are checked.

Meetings with officials from the responsible regional office or the National Assembly for Wales, and representatives of local health authorities, community health councils and primary care groups and trusts (or local health groups in the case of Wales) also took place during the review visit itself. Finally, during the visit, the CHI analytic team provided extra analysis relating to issues arising during the review. The information and data collected earlier proved invaluable for this purpose.

Writing the report

Apart from the writing of the final report, two other significant events followed on from the review week. The review team came together fairly quickly to discuss the review itself and potential findings which would be fed back to the acute trust. There was then a feedback session with each trust where key findings were presented and discussed.

The final version of the report on clinical governance itself was written and agreed over a fairly short timescale. This involved the synthesis of a considerable volume of material. There was also the opportunity for further analysis using the data and information gathered earlier. Reports were subjected to strict quality assurance by the Commission before being distributed to the trust for comment and clarification.

At this point the reports on clinical governance in these four pilot trusts were complete. However, there remained the action planning (objective-setting) sessions before the reports could be put into the public domain. The CHI now intends to disengage the publication of the action plan from that of its own report. This will allow earlier publication of the CHI report.

The future

The review process has now started in over 40 NHS organisations, and the Commission expects to publish its next round of reports on clinical governance reviews in late spring of 2001. The CHI is reviewing the key features of the assessment framework for acute reviews, and has also been developing methods for reviews of health authorities (with a focus on general practice) and reviews of

mental health services. Four health authorities and three acute mental health services are among the reviews that will report in the spring. These will be available on CHI's web-site (http://www.chi.gov.uk).

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Czech Republic: A history of change

Alena Petrakova & Reinhard Busse

As an independent country, the Czech Republic was formally established on 1 January 1993. It is located in the middle of Europe covering an area of 78 867 km^2 with 10.28 million inhabitants (1999). The Czech Republic has been a member of the Organisation for Economic Cooperation and Development (OECD) since December 1995 and a member of the North Atlantic Treaty Organisation (NATO) since February 1999. Currently, its main priority is to gain membership in the European Union (EU).

Health care reform

In 1990 and 1991 a dramatic liberalisation of the health care system took place. In December 1990 the Czech government approved the proposal for the establishment of a new health care system. The principle of free choice of health care provider was introduced, and the huge regional and district health authorities were dismantled. In 1991 several new laws were approved, most notably the General Health Insurance Law (Act No. 550/91 Coll.) and the Law on the General Health Insurance Fund (Act No. 551/91 Coll.). Since then, the health care system has moved towards a compulsory social insurance model, with a number of insurers financing health care providers on the basis of contracts. This does not appear to have caused any adverse effects with regard to the health status of the population. Indeed, indicators are for the most part showing positive trends. For instance, in the period 1990 to 1999, life expectancy increased from 67.6 to 71.4 and 75.4 to 78.1 years for men and women respectively. In the period 1990 to 2000, infant mortality decreased from 10.8 to 4.2 per 1 000 live births. The successful implementation of curative technologies has caused both a declining trend in mortality rates and a growing demand for higher investment in health.

Between 1993 and 1996, decentralisation was the priority, with a particular focus on ambulatory services. There are currently more than 20 000 (mainly private) health care providers in the Czech Republic. The network of health care providers is comprised of: general practitioners for adults; general practitioners for children and youth; primary health care gynaecologists; primary health care dentists and stomatologists; ambulatory specialists; hospitals (only approximately 9% of beds are in private hospitals); other bed-care facilities; emergency and first-aid services; home-care services; and pharmacies and hygienic (public health) stations.

There are now nine health insurance funds in the country. In recent years some 18 health insurance funds have disappeared from the market. Some went bankrupt while others were abolished by the government for not meeting legal requirements. Nevertheless, consumer choice has been well served – at least in part – by the reforms. Patients may choose their doctor and, as many physicians are in private practice, there are incentives for doctors to satisfy their patients.

The Future

In summary, the Czech health care system has evolved rapidly over the past few years. To date, its achievements have outweighed its mistakes. As a result the health care system is facing not only a new set of challenges, but also long-term problems which have to be solved creatively and dynamically, without any prejudices and with an emphasis on consensus building in health policy. The most important issue for the coming period is to solve problems systematically, contrary to the former prevailing philosophy of a single problem oriented approach. Over the last decade the situation was complicated by a lack of communication between health policy makers, health care providers, health insurance fund representatives, representatives from various professional associations, patient associations and the public. The next steps of the reform should thus focus on a number of priority problems: the need to create both national and regional health policies, including a division of responsibilities; the development of necessary legislation; harmonisation with European Union policies and measures; and the search for and use of more appropriate financial solutions for the health care system.

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The HiT for the Czech Republic was prepared by Alena Petrakova, Reinhard Busse and Roman Prymula (Medical Military Academy of J.E. Purkyne) on the basis of a first draft written by Peter Struk (Ministry of Health, Czech Republic) and Tom Marshall (WHO).

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Denmark: concerned and yet content with itself

Nils Rosdahl

Health and health services are high on the political agenda in many countries. Denmark is no exception. The fact that increases in life expectancy in Denmark have been falling behind all other western European countries became obvious ten years ago. However, it took some years to convince both the public and politicians that this was due to increased mortality among middle-aged Danes, and not simply about the loss of a number of months at the extreme end of life. The recognition of this fact was a real 'eye-opener' *vis-à-vis* health in Denmark.

Government committees have since analysed the available data and have, in general, advocated the view that the Danish lifestyle, i.e. too many smokers, too much fat intake, too little exercise and too high alcohol consumption, is the main cause. Scattered voices have, however, pointed to underlying social conditions as being responsible, at least in part, for the high mortality rates. The 80/20 divide between the 'haves' and the 'have-nots' has been an important health status issue to only a limited extent, although equity in health was one of the two key targets in the Government's Health Promotion Programme of May 1999.[1]

The authorities responsible for health services, primarily the counties, have downgraded the significance of health service influence on mortality rates and hence life expectancy. The Ministry of Health (MoH) which only has coordinating and supervisory, but no operational, responsibilities for health services, apparently holds the same view.

Since 1980, hospital services in Denmark have been subject to very tight budgetary control, allowing only limited increases in real terms. Public expenditure on primary health care and pharmaceuticals has been more difficult to control due to the 'clinical freedom' of GPs. Mechanisms of varying sophistication have been introduced to control the rising public cost of pharmaceuticals, but generally the trend has been towards increasing patients' 'out-of-pocket' payments. However, there has been no apparent decline in consumption as the number of Daily Defined Dosages has risen steadily at approximately 4% per annum since the mid-1990s.

According to MoH statistics on health expenditure (which now include social sector expenditure on nursing homes and home nursing care for pensioners) Denmark is now spending the EU average percentage of GDP on health services. The Organisation for Economic Cooperation and Development statistics has for the last few years used the MoH's figures.

Hospital services have in general been able to adapt to the tight economic climate. The number of beds has been reduced by 30% over 20 years. The number of patients treated has gone up, mainly by extending services via one-day surgery and out-patient facilities. There have been understandable complaints and frustration among nursing and medical staff about working conditions. And there now seems to be an increasing tendency amongst hospital consultants to opt for early retirement. However, only the sacking of a chief physician and professor following his complaints over restricted resources created headlines.

For a number of years, the Danish medical profession and health services at large have been subjected to claims that curative health services have little impact on the state of health of the population. The profession might have objected, but in general its members have not done so publicly. The one eloquent exception has, over the last few years, repeatedly claimed that the stagnation in Danish life expectancy is due to three main factors: lack of funds for health services; the deterioration of medical post-graduate training; and the squeezing-out of the medical leadership by the professional, non-medical administrators. This medical professor has retained his post – possibly the 'system' finds it useful to allow one critical voice, especially as this voice has over time come to be considered repetitive and exaggerated.

In fairness, it should be allowed that there was increased funding of hospital services during at least part of the 1990s. The government has sanctioned increases in county budgets and has also provided additional state funds for the improvement of some services, such as those for heart disease and cancer. This was due in part to comparisons with activities (and outcomes) in other countries, in particular, Norway and Sweden.

No serious discussion has yet emerged on how to evaluate the effects of health services on mortality. Last year I wrote a commentary in the *Journal of the Danish Medical Association* on the recent rise in Danish life expectancy.[2] Between 1995 and 1998 it rose by 1.1 years for men and 0.8 years for women. For both genders these increases were greater than in the previous decade. I suggested that part of the effect could be due to health service activities. The observed decrease in heart disease mortality since 1995 could be owed to a range of activities improving hypertension control, coronary surgery and prophylactic aspirin therapy. The decline in AIDS mortality is, without doubt, due to antiviral treatment, and the observed fall in suicide mortality might partly be the result of improved diagnosis and treatment of depressions. This decline in mortality did not cause any major debate. We are now awaiting regional figures for life expectancy which are due out later this year.

Denmark is facing a general election by March 2002 at the latest. Health (and especially health care systems) are likely to become key issues in the election

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campaigns which are already slowly starting. Interestingly, there are no great differences of opinion on the structure of health services. The Norwegian decision to abolish the county-operated hospital services in favour of a state-organised service does not seem to have any parallel in Denmark at present. However, there are recent examples of decisions taken by parliament and the government which directly involved matters which have traditionally been the province of hospital owners. There is almost total political consensus on further increasing functional coordination between the services run by the 15 regional hospital owners, the counties and the Copenhagen Hospital Corporation.

The right wing opposition parties have been cautious in advocating the privatisation of health services. They consider – rightly, in my opinion – that most Danes want to retain hospitals in the public sector, despite criticisms voiced over issues such as waiting times. These parties have put forward the idea of "money following the patient", allowing the patient to purchase services outside the ordinary hospital setting. They also regard favourably the increasing number of Danes taking out private health insurance policies, contrary to the opinion of the Social Democratic Minister of Health. However, the number of beds in private hospitals/clinics is still less than 200, compared with the 25 000 in public hospitals.

The Social Democratic-led minority government is anxious to position itself as the defender of the welfare state. This includes the almost exclusively tax-financed health services. The post of Minister of Health has become central to the government's efforts to convince the population that health and health services are of prime significance. The tenure of Danish health ministers has, however, been rather short; with three ministers in 2000. The present minister, appointed in December 2000, is very actively engaged promoting government policy in the media.

An important issue in the debate on health services has been the rights of patients. Various proposals have been discussed, but so far the consequences, including financial ones, have been blocked for final acceptance. Currently, there is a tendency to create entitlements for patients in specified areas. The latest government proposal being the establishment of a system whereby patients with most types of cancers are offered treatment abroad if it is not available in Denmark within eight weeks.

Thus, despite the tendency to minimise the role of health services in health status, there has recently been quite a number of political initiatives for health service improvements.

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