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Participation of disabled people: A 'paradigm shift' in the German rehabilitation system?

Markus Wörz and Matthias Wismar

In June 2001 the German Parliament passed the *Rehabilitation and Participation of Disabled People Act*. The purpose of this law is to overhaul the rehabilitation system by directing all efforts towards disabled people's better participation in society and working life. The law is based on international concepts of disability and constitutes Book IX of the Social Code (SGB IX) which, so far, had been missing from the Social Code Book (SGB). This development contributes to a continuous effort over the last 25 years to complete the SGB which provides the legal basis of social security and social services in Germany. Whilst it marks the end of a difficult reform process that has lasted more than eight years, the final reform was passed unanimously by parliament. It is no wonder, then, that commentators have labelled the reform a 'paradigm shift'. Yet, while the German rehabilitation system has not received much attention for a long time, a 'paradigm shift' is long overdue given several distinct problems with the system:

- Concepts of rehabilitation and disability are not standardised and are codified differently for the seven responsible financing institutions (See Table 1 overleaf).
- Moreover, there are different traditions in providing rehabilitative services due to historical reasons and the public-private-mix among providers. In 1998, 60% of the 1 395 inpatient facilities and 70% of all beds in the rehabilitative sector were in private ownership. The rest was distributed among various public and non-for-profit providers.
- The governance structure is complicated since ownership of inpatient facilities and contractual relationships vary widely due to the fact that the purchaser-provider split does not apply to the rehabilitative sector. The statutory pension insurance scheme which is organised for salaried employees by the Federal Insurance Institute for Salaried Employees (*Bundesversicherungsanstalt für Angestellte*) and for manual workers by 22 Regional Pension Insurance Funds (*Landesversicherungsanstalten*) own a large number of rehabilitative inpatient facilities. Some sickness funds own a handful of inpatient facilities too. The trade associations, which organise the statutory accident insurance, do not own rehabilitative inpatient facilities as such, but many of the hospitals owned by them incorporate fully fledged and modern rehabilitative units. It has been argued that the financing institutions try to protect their own facilities against competition and reform.
- The service is difficult to administer due to its complexity.
- The competencies for the provision of the three major forms of rehabilitative services overlap a great deal (Table 1 overleaf).

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The World Health Organization Regional Office for Europe, The Government of Greece, The Government of Norway, The Government of Spain, The European Investment Bank, The Open Society Institute, The World Bank, The London School of Economics and Political Science, and The London School of Hygiene and Tropical Medicine.

– Currently, no coherent data is available for all the institutions involved (Table 1).
– Patients find it difficult to find the appropriate, responsible provider due to the fragmentation and complexity of the system. In turn, this repeatedly has delayed handling of applications for rehabilitation.
– There is a clear bias towards inpatient rehabilitative services. While on scientific grounds out-patient services are highly relevant, they play a negligible role today due to historical reasons.[1] At the end of the 19th century the German statutory pension insurance funds began to build up hospitals specialised in the treatment of tuberculosis and as late as 1956 roughly half of these hospitals were dedicated to the treatment of this disease. As the prevalence of tuberculosis declined these hospitals were not abolished but rededicated into specialised rehabilitation hospitals.[2]
– There is a severe under-supply of rehabilitative services for the German population as identified recently by the Advisory Council for the Concerted Action in Health Care (*Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen*).[1]
– Prevention in rehabilitation does not play the role scientific evidence ;suggests.[1]

As a reform the *Rehabilitation and Participation of Disabled People Act* not only addresses some of the above-mentioned deficiencies with rehabilitative services, conceptually it explicitly follows the World Health Organization's (WHO) endorsement of the International Classification of Functioning, Disability, and Health (ICF) which stresses participation by disabled people. Among the major reform measures are:

– The introduction of patient information regarding access to rehabilitation. The responsible financing institutions will implement joint service facilities at the municipal and district level. Their task is to inform and support disabled people and people who are threatened with a disability with regard to their eligibility to receive rehabilitative services, how to find the relevant provider, how to apply for services and also to provide information following any rehabilitation treatment. In addition, these joint service facilities will guarantee that the applicant receives an overview of the whole spectrum of benefits and services available from providers.
– Faster access to rehabilitation. Administrative processes will be expedited by setting time limits within which rehabilitation providers must handle applications.
– Strengthening ambulatory rehabilitation. Ambulatory rehabilitative services will focus on employed mothers and disabled people in part-time employment for whom ambulatory rehabilitation is particularly suitable.
– The primacy of prevention is entrenched in the law by obliging rehabilitation providers to contribute to the prevention of disability and chronic illnesses.

In addition to these measures, which will affect how rehabilitation is organised, the law contains no cuts to existing benefits but provides some new ones:

– Extended choice for patients. Applicants will be allowed to make requests concerning the supply of rehabilitative services. Providers are obliged to justify their decisions if these are not responsive to applicants' requests. In addition, rehabilitation patients will be allowed to have their own 'personal budget' with which they will be able to 'buy' their own services.
– Disabled people obtain the right to receive working assistance from the rehabilitative services provider if this helps them to gain employment.
– Deaf people will obtain the right to use sign language when interacting with public authorities.
– The reform law explicitly allows for the provision of rehabilitative services abroad on behalf of the responsible German institution.

The current reform also has to be assessed within a wider context. In order to promote the participation of disabled people in society and working life the parliament has introduced, amended or drafted several laws. First, in 1994, prohibiting discrimination against disabled people was entrenched within the German constitution – the *Basic Law*. Second, the *Law to Combat Unemployment of Disabled People*, which

Table 1

Financing institutions responsible for rehabilitation in Germany and their expenditure for different rehabilitation services in the year 1999 (in million Euros)

	Medical rehabilitation	Vocational rehabilitation[a]	Social rehabilitation[b]
Statutory pension insurance	2 746	777	N/A [c]
Statutory health insurance	2 633	N/A	N/A
Statutory unemployment insurance	N/A	2 301	N/A
Statutory accident insurance	2 270	251	— [d]
War victims relief	208	—	—
Social assistance	435	—	1 319
Youth assistance	—	—	—

Source: Federal Working Group for Rehabilitation.[3]

a New category: participation in working life
b New category: participation in the community
c No rehabilitation services are provided
d Rehabilitation services are provided but data are not available

was passed in 2000, explicitly sets the goal of creating 50 000 additional jobs for disabled people within the next two or three years. Third, another law, which will provide more participation rights for disabled people in society, is currently going through parliament and is expected to be passed this year. Undoubtedly, the new Social Code Book IX is a bold step forward and an ambitious piece of legislation that is part and parcel of a wider reorientation of policies towards disabled people. It is based on sound scientific concepts and has the potential to properly modernise the system.

The question that remains is: will the actual implementation of rehabilitation services in Germany follow the spirit of the law? It is most likely that patients will benefit most in terms of swift and adequate access and that the joint service facilities which are currently under way are likely to succeed. The key problems are likely to be in the areas of under-supply and preventive services within rehabilitation. A more adequate supply does not depend on legislative prose but on raising the budget which was introduced for rehabilitation in 1997. The same is true for ambulatory rehabilitation. It is unclear who would be responsible for financing these services and it is unlikely that existing financing institutions which own their own inpatient facilities would be eager to abolish or reform some of them in order to provide outpatient rehabilitation. With regard to prevention in rehabilitation, the same financial and organisational (if not political) questions remain unresolved. If the 'paradigm shift' turns out to be a conceptual shift without a shift in budgets, institutions and politics, the impact on the provision of services will remain limited.

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Armenia: Progress amid setback

Ellie Tragakes

Armenia declared its independence from the former USSR in September 1991. Extreme crisis faced by the country upon independence initially prevented a structured approach to change, and efforts focused on maintaining basic supplies, many of which were unobtainable.

Concerted reforms in the health sector began in the mid-1990s, and were based on the premise that health care can no longer be provided free and upon demand to the entire population. Severely constrained budgetary resources forced the introduction of a predominantly private out-of-pocket payment system of health care financing.

In March 1996, a law *On Medical Aid and Medical Services for the Population* was adopted by the National Assembly, which in effect abolished the previous system of financing by legalising alternative financing mechanisms including out-of-pocket payments. A government decree in 1997 introduced out-of-pocket payments for the bulk of health care services provided to all non-targeted and non-vulnerable groups of the population.

As state-funded health care services were cut back, coverage was limited to certain priority areas and priority (vulnerable) groups. Thus, the majority of the adult population, no longer covered under ordinary circumstances, must pay in full for all medical care. The government attempts to ensure that a basic package of services is provided free of charge to socially vulnerable groups. However, even these groups must sometimes pay out-of-pocket as state funds are insufficient to cover the basic package. These developments have severely undermined the principle of equity, and there are serious concerns about the impacts on health status.

Funding sources

In 1999 the state health budget amounted to 1.7% of GDP and accounted for approximately 25% of total health care expenditure. An additional 15% of health care expenditures was contributed by humanitarian aid, and the remaining 60% by private out-of-pocket payments. Therefore, total health care expenditure can be roughly estimated to have amounted to 6.8% of GDP in 1999. External sources of funding include a considerable amount of international humanitarian assistance, as well as a World Bank project for the improvement of financial management and development of primary health care.

Although 6.8% is not a particularly low percentage of GDP to be spending on health care, the problem concerns the very large portion (60%) consisting of out-of-pocket payments. According to WHO's health for all statistics, this is by far the highest share of private, out-of-pocket payments in total health care expenditure in the entire European Region. Clearly, significant portions of the population do not receive needed medical care and pharmaceuticals because they cannot afford them.

There is no effective insurance system currently in operation. The State Health Agency was established in 1998 as an initial step in the direction of developing a full-scale social insurance system. It receives the state allocations for health from the Ministry of Finance and distributes these to health care facilities with which it contracts. There are plans to introduce a system of compulsory medical insurance, together with supplementary voluntary insurance. A draft law was prepared in 2001 and is currently being reviewed by the government. It is hoped that the introduction of compulsory medical insurance will contribute to increasing the funds available to health care while also creating conditions that will promote efficiency gains.

Efficiency, capacity and equity

There are a number of areas in which efficiency gains can be made. For example, bed numbers are in excess of estimated levels of need. Acute hospital beds in Armenia are above the average for the European Union, although below the average for the Newly Independent States (NIS). Acute hospital beds show a clear downward trend: from 8.3 per 1 000 population in 1990 they dropped to 5.5 in 1999, representing a 34% decline. There is still more room for bed reductions.

Occupancy rates fell to the very low level of 33.4% in 1999, compared to about 65% in 1990 and 70–80% in the 1980s. This is a remarkable drop in view of the decline by about one third in bed numbers over the same period. A portion of the apparent excess bed capacity is due to poor access as health care became unaffordable for a significant portion of the population. This is substantiated by the sharp drop in admissions, which fell from nearly 14 per 100 population in 1990 to under 6 in 1999.

Whereas the Ministry of Health estimates that Armenia is massively overprovided with doctors, it is actually very close to the NIS and EU averages. The number of nurses, on the other hand, is below these averages. The number of physicians per 1 000 population increased by over 20% in the 1980s but by 1999 had dropped to nearly the 1980 level, and stood at about 3.3 doctors per 1 000. The Ministry of Health is cutting back on the number of places in the single state medical school but there are also reductions in the number of places at nursing colleges, though the cuts are less extreme. In addition, the Ministry has introduced post graduate residencies for physicians wishing to pursue medical specialties and is developing new training for general practitioners/family doctors.

The planned introduction of compulsory medical insurance with supplementary voluntary insurance, together with decentralisation of Ministry of Health functions and increased provider autonomy may accelerate the process of improving efficiencies, while also helping to mobilise funds for the health sector. The autonomous, self-financing status of publicly owned hospitals is expected to lead to the closure of many provider units and therefore to the rationalisation of services. The Ministry of Health is gradually reorienting its activities to focus more on monitoring, regulating and licensing health service activity. The establishment of the State Health Agency represents a separation of financing from provider responsibilities. Changes are taking place in the methods of paying health professionals at all levels of care (from fixed salary to salary calculated as a percentage of out-of-pocket payments brought in plus a percentage of case payments) as well as in hospital payment methods (to volume-based case payments). Moreover, as part of their increasing financial and managerial autonomy, hospitals are permitted to retain any savings. As a result, doctors and nurses now have incentives not only to treat more patients but also to pursue patient satisfaction, and hospital management has an interest in cost-effectiveness and prescribing levels. Emphasis is being placed on the development of primary health care. In the long term expanded roles for primary care, health promotion and preventive measures should lead to improvements in health status.

Challenges ahead

Although successive governments have generally supported reforms in the health sector, in practice the reform process has encountered some resistance, particularly from professional groups who expect to be negatively affected by change. Whilst frequent changes in government and in health ministers do not ensure sustainability of reform directions, the overall reform process is being pushed forward by the Ministry of Health. The most challenging problem that must be faced involves the drastic decrease in access to health care services and the decline in the population's and health professionals' confidence in the health care system and its ability to provide even the most essential services.

The prospects for health status and the health system are now inextricably linked with the future course of the Armenian economy. As the economy stabilises and embarks upon a longer term period of sustained growth, increasing incomes will generate additional funding for health care services. In this context, the government must make every effort to re-channel resources currently in the underground economy so as to increase public funds flowing to the health sector. More public funds may make it possible to address, once again, the issue of equity in financing and access, so as to correct some of the inequities that characterise the system today.

The Health Care System in Transition profile on Armenia is written by Samvel G Hovhannisyan, Ellie Tragakes, Suszy Lessof, Hrair Aslanian and Ararat Mkrtchyan, and edited by Ellie Tragakes. Copies can be downloaded from the Observatory website: www.observatory.dk

Health care in Slovenia

Elke Jakubowski

As part of the Austro-Hungarian Empire, Slovenia maintained a social insurance system that followed the Bismarkian model. In 1945, Slovenia became part of the Socialist Federal Republic of Yugoslavia and in the socialist era, health care facilities became state owned, financed through the Yugoslav republic's central budget. Health insurance was separated from social insurance in 1955 and from 1974 to 1992, insurance funds were managed by so-called 'self-management committees'. Slovenia declared independence in 1991 and one year later the government introduced some structural reforms in health care. The key provisions of the legislation included the introduction of a compulsory health insurance system (with the possibility of top-up supplementary voluntary insurance), and the establishment of private practice in primary health care delivery.

However, the financial sustainability of the system, with regard to revenue raising may be jeopardised to some extent through a progressive aging of the population – with a critical decline in the population of working age. There are also problems related to the collection of contributions and rising expenditure in certain health care sectors, most notably in pharmaceuticals (see below).

Centralised management

Management of the health care system remains relatively centralised. Most of the system's administrative and regulatory functions take place at the state level with the lower governmental levels mostly having implementation duties. Yet, there have been attempts to delegate responsibility for planning primary care facilities and associated capital investments to local government ('self-governing communities'). Their role is to collect revenue at the local level in order to allow capital investment in primary care facilities. However, the local governments are said to make limited use of the autonomy they have. This is related partly to the very small population coverage which in some instances hardly reaches 500 inhabitants. Consequently, the level of funds prospectively generated locally cannot be quantified because the self-governing communities differ in the extent to which they use their autonomy to collect taxes and invest the funds in health care. Currently, the role and degree of autonomy of local governments in planning primary care services is being reviewed.

Compulsory insurance

Compulsory health insurance also is centrally managed and contributes around 85% of health care system funding. Virtually every person with permanent residence in Slovenia (about 2 million) is covered under a single insurance fund either as a mandatory member or as a dependant.

Slovenia has two main groups of those insured. The first group comprises white- and blue-collar workers whose contributions depend on income and include non-earning spouses and children. The contribution rates are shared between employers and employees and are subject to parliamentary approval.

Since the beginning of 1996, insurance contributions for employers and employees account for a total of 13.25% of gross salaries (6.36% by employers and 6.36% by employees, plus an additional 0.53% by employers to cover occupational injuries and diseases).

The second group comprises people who contribute a fixed proportion of their income – mainly the self-employed, craft workers and farmers. There has been criticism that this group does not pay a high enough proportion of their income. There are also reports of cases bypassing the compulsory insurance system (believed to result in a loss of up to 4% of total revenue per year to the public compulsory insurance system).

In addition, Slovenia has maintained a policy of keeping wage increases well below the level of GDP growth. As real contributions depend on the level of salaries, the consequence has been a diminishing share of GDP generated through compulsory health insurance contributions. Combined with a critical decline of the working-age population, Slovenia faces problems with respect to the generation of income in the publicly financed system. These problems are reflected in the deficit of the National Health Insurance Institute, which amounted to several billion tolars in 2001.

Private spending on the rise

In recent years, Slovenia has spent between 7.7% (in 1993) to 7.6% (in 1999) of GDP on health care in total. Public health expenditure has been about 7% of GDP (7.1% in 1993, 6.6% in 1999), with the balance of total expenditure mainly comprising voluntary health insurance and user charges.

From year to year private resources within the system have increased. The largest source of private financing is voluntary insurance. As a percentage of total health funding, this rose from 1.5% in 1991 to 8% in 1994 and 11.6% in 1998, with the majority of all insured people purchasing voluntary health insurance. Voluntary insurance is mainly purchased to cover out-of- pocket payments which were formally introduced with the post-independence health reform legislation. Moreover, a primary concern is expenditure levels on pharmaceuticals. Pharmaceutical consumption is considered (by policy makers) to be relatively high in Slovenia and it is on the increase, mainly because of price increases for domestic and imported pharmaceuticals.

Delivery

Since 1992, both public and private providers have delivered primary care. About two thirds of private providers –

either individual practitioners or group practices – are contracted and financed by one of the ten regional branches of the compulsory insurance fund. The introduction of private practice in primary care has encountered some difficulties partly because of an inadequate regulation of the relationship between publicly owned primary care facilities and private practitioners. For example, initially it was unclear to what extent publicly owned premises could be utilised by (potential) private practitioners. As a result, many, often profitable, providers left publicly-owned premises to develop their own, and therefore some public premises became underutilised and the costs of maintaining them rose sharply.

Access to secondary and tertiary care services is through referral by the personal physician (GP). However, cooperation between primary and secondary care leaves much to be desired. Primary care services and hospitals mainly cooperate on referrals and exchanging test results. The number of acute hospital beds in Slovenia has decreased from 5.0 per 1 000 to 4.6 in 1998, mainly due to a shift of resources from inpatient to outpatient care. This level is low relative to both EU and eastern European averages. Slovenia reports waiting lists on hospital diagnostic and surgical procedures; while these have been reduced in outpatient clinics, they have increased in cardiac, ophthalmologic, orthopaedic, gastroenterology and urology. Some policy makers in Slovenia have expressed an interest in changing the hospital payment system to a system similar to that of diagnosis related groups; currently, hospital services are paid on the basis of a prospectively fixed budget combining bed-days and special fees for high cost services. Some of the interest in introducing case related payments may be linked to the objective of tackling waiting lists by further decreasing average lengths of stay in acute care. However, there are policy makers counter-arguing that the case related payment systems may not alter the situation of waiting lists which result from a number of factors, including the level of skilled health professionals, technical equipment and hospital beds.

A further problem facing hospitals is physicians' and nurses' dissatisfaction with working conditions in the public sector. This has led to collective agreements between the insurer, the National Health Insurance Institute, and hospitals to increase the salaries of health professionals. In addition, analyses of demographic data on physicians and the general population indicates that there may be potential shortages of physicians in certain regions. The number of physicians per population has remained nearly unchanged over the last 10 years with a marginal increase from 1.9 per 1 000 in 1990 to 2.1 in 1999, and is lower than in most CEE and EU countries. There are already substantial problems in ensuring sufficient health care coverage in certain areas and it may be necessary to consider recruiting some health care workers from outside Slovenia. Whilst there has been a recent decision to increase admissions to faculties of medicine by 15%, the situation with nurses is somewhat different; their numbers show relatively constant growth.

Summing Up

In theory, the Slovenian health care system provides nearly universal and comprehensive health care benefits for all Slovenian citizens regardless of income. However, the system may promote further inequalities in access to health care services as affluent people are able to obtain faster access to more and higher-quality services by paying out-of-pocket or to secure better coverage through voluntary insurance while the less well off may not be sufficiently protected. In addition, there are waiting lists for some surgical procedures, a problem that may become more pronounced with potential shortages of physicians in certain regions. With respect to health care costs, rising pharmaceuticals expenditure is a problem area.

The Health Care System in Transition profile on Slovenia is still under preparation. The draft has been written by Tit Albreht, Marjan Cesen, Elke Jakubowski, Boris Kramberger, Mladen Markota, Vesna-Kerstin Petric, Marjan Prmik, Martin Toth, and edited by Elke Jakubowski. Gratitude is extended to the Minister of Health for his technical and analytical support in finalising the profile.

Observatory Summer School 2002

'Making Health Policy in a Changing World'

The 6th annual Observatory Summer School will take place in August 2002. The school has four objectives:

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- To explore what level of policy cooperation is needed to address different issues
- To consider examples of international policy making and examine their effectiveness
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Series Editors: Josep Figueras, Martin McKee, Elias Mossialos & Richard B Saltman

FUNDING HEALTH CARE: OPTIONS FOR EUROPE

Elias Mossialos, Anna Dixon, Josep Figueras and Joe Kutzin (eds)

The question of how to generate sufficient revenue to pay for health care has become a serious concern for nearly all European policy-makers. This book examines the advantages and disadvantages of funding arrangements currently in use across Europe. Adopting a cross-national, cross-disciplinary perspective, it assesses the relative merits of the main methods of raising funds including taxation; social, voluntary and supplemental forms of insurance; and self-pay including co-payments. Chapters written by leading health policy analysts review recent evidence and experience in both eastern and western Europe. The volume is introduced by a summary chapter that integrates conceptual issues in funding with an overview of the main advantages and disadvantages of each method of funding drawn from the expert chapters.

ISBN 0 335 20924 6 Paperback: £22.50 Hardback £65

HEALTH CARE IN CENTRAL ASIA

Martin McKee, Judith Healy and Jane Falkingham (eds)

Central Asia remains one of the least known parts of the former Soviet Union. The five central Asian republics gained unexpected independence in 1991 and have faced enormous challenges over the last decade reforming their health care systems, including adverse macro-economic conditions and political instability. To varying extents, each country is diverging from hierarchical and unsustainable Soviet model health care systems. Common strategies have involved devolving the ownership of health services, seeking sources of revenue additional to shrinking state taxes, 'down-sizing' their excessive hospital systems, introducing general practitioners into primary care services, and enhancing the training of health professionals. This book draws on a decade of experience of what has worked and what has not. It is an invaluable source for those working in the region and for others interested in the experiences of countries in political and economic transition.

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HOSPITALS IN A CHANGING EUROPE

Martin McKee and Judith Healy (eds)

- What roles do hospitals play in the health care system and how are these roles changing?
- If hospitals are to optimise health gains and respond to public expectations, how should they be configured, managed, and sustained?
- What lessons emerge from experiences of changing hospital systems across Europe?

Hospitals of the future will confront difficult challenges: new patterns of disease, rapidly evolving medical technologies, ageing populations, and continuing budget constraints. This book explores the competing pressures facing policy-makers as they struggle to respond to these complex challenges. It argues that hospitals, as part of a larger health system, should focus on enhancing health outcomes while also responding to public expectations. Reviewing evidence from eastern as well as western Europe, the study combines academic research with real-world policy experience.

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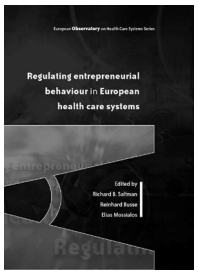

REGULATING ENTREPRENEURIAL BEHAVIOUR IN EUROPEAN HEALTH CARE SYSTEMS

Richard B Saltman, Reinhard Busse and Elias Mossialos (eds)

- What have been the major trends in entrepreneurial behaviour and regulation in European health care?
- To what degree do approaches to regulation and entrepreneurialism differ amongst subsectors and countries across Europe?
- What does the evidence show about successes and failures, and which successful options are open to policy-makers?

A wide range of entrepreneurial initiatives have been introduced within European health care systems during the last decade. While these initiatives promised more efficient management they also triggered concerns about reduced equity and quality in service provision. This book synthesises evidence from across Europe, combining academic research with practical experience, and bringing together perspectives from different disciplines from medicine to management science, public health to law, to inform health policy formulation on this increasingly important issue.

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New Observatory Study:
Social Health Insurance Countries

Wendy Wisbaum and Reinhard Busse

A workshop to discuss the Observatory's comparative study on Social Health Insurance (SHI) countries was held on October 5–6 in Storkow, near Berlin, Germany. This workshop convened 27 experts on SHI from all over Europe – chapter authors, policy experts and Observatory staff – for a 1-day provocative, brain-storming exercise that was claimed to be unprecedented for SHI countries by many participants.

This study is using the seven SHI countries in western Europe – Austria, Belgium, France, Germany, Luxembourg, the Netherlands and Switzerland – as well as Israel to review the core structural and organisational dimensions of SHI and assess current reforms and innovations. Actual funding, allocation and delivery arrangements in place in western Europe SHI countries, have undergone considerable change during the past decade and additional reforms continue to be under serious consideration for the near future.

The study will explore the nature of the pressures these health systems need to confront in order to be more efficient, more effective, and more responsive, and will review their success in addressing these pressures to date. It will also examine the implications of these responses on the defining characteristics of SHI. Finally, the study will draw out a set of policy lessons about past experience and likely future developments in SHI systems in a manner that is hoped to be useful to policy-makers in Europe and elsewhere.

The study will have two parts: an overview, written by the editors Richard Saltman and Reinhard Busse, which will synthesise and assess SHI characteristics and systems, and a set of analytical chapters (usually written by three authors from different countries and with differing experience) will cover: Governance and (self-) regulation; The changing role of the individual and of choice; Contracting and paying providers; Shifting criteria for benefit decisions; Solidarity versus competition; The role of private health insurance; Beyond acute care I: prevention and public health in SHI systems; and Beyond acute care II: long-term care in SHI systems. The study will be published in 2003 as part of the Observatory Series with Open University Press.

At the workshop, chapter authors made presentations of their draft chapters. These were followed by comments and reactions by invited external policy experts, and then open discussion by participants. The ensuing debates were energetic and lively and, while the workshop clarified many unclear areas, it certainly raised many further questions. The study editors are sure that bringing together a vast array of participants from one side of Europe to another, and from institutions ranging from sickness funds to regulating agencies to academic institutions, has reaped many benefits, not only as a collaborative process but also in terms of the final quality of the study.

An evaluation conducted after the workshop pointed to its overall success and also provided useful lessons for future studies. Among the most mentioned strengths of the exercise was the opportunity it provided to bring together knowledgeable people from many SHI countries for what was considered by many to be the first time.

The Observatory is grateful to the AOK and BKK federal sickness fund associations for co-sponsoring this workshop.

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