



Summer 2002  
Volume 4, Number 2

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If you would like more information about the Observatory please contact:  
European Observatory on Health Care Systems,  
WHO Regional Office for Europe, 8 Scherfigsvej,  
DK-2100 Copenhagen Ø  
Denmark.

Tel: +45 39 17 14 30  
Fax: +45 39 17 18 70  
E-mail: [observatory@who.dk](mailto:observatory@who.dk)  
[www.observatory.dk](http://www.observatory.dk)

## The Danish health care system: A commentary

Signild Vallgård

The Danish health care system suffers from a poor reputation, both internationally and nationally. According to WHO's 2000 ranking of health system attainment and performance, Denmark has the worst health care system in the EU and ranks 34th in the world out of 191 countries studied.<sup>1</sup> Health care quality was a major issue in the Danish general election in November 2001 and readers of the popular press at that time could have been forgiven for thinking that the health care system was on the verge of collapse.<sup>2</sup>

Does the Danish health care system deserve such a poor reputation? I argue here that it does not. The system is characterised by a high degree of equity in terms of access to general practitioners and hospital care and, when questioned in national surveys, the Danish people show a high level of satisfaction with the health care system. So why are attitudes towards the system so negative?

### Life expectancy and the health care system

The main reason for Denmark's low score in WHO's ranking is the latter's emphasis on health status as measured in terms of (disability-adjusted) life expectancy. Between 1970 and 1996 life expectancy did not increase as much in Denmark as it did in other western European countries. While life expectancy for men rose by 5.8 years in the UK, 4.4 years in Norway and 4.3 years in Sweden, it only rose by 2 years for Danish men.<sup>3</sup> Female life expectancy followed a similar pattern. While lifestyle factors such as smoking, diet and

alcohol consumption are responsible for some of Denmark's slow progress in increasing longevity during this period, they do not explain all of it. Since 1995, however, average life expectancy has increased significantly – by 1.7 years for men – and at a higher pace than in other western European countries. The reasons for this increase are not well established, but a decline in coronary heart disease (perhaps due to reductions in smoking) may have contributed to it.

In compiling its ranking, WHO attributed a weight of 50% to the level and distribution of life expectancy in a country, 25% to the level and distribution of the health care system's responsiveness to users and 25% to the distribution of financial contributions to the cost of health care. This weighting system has been criticised for making the assumption that life expectancy is closely related to the 'performance' of a country's health care system.<sup>4</sup> In Denmark's case there is no correlation between increases in resources for health care over the last 70 years and changes in mortality or life expectancy. Male life expectancy actually stagnated during the 1950s, while the health care system as a whole – and the hospital sector in particular – began to grow substantially.

It is generally accepted that mortality is a poor measure of a health care system's performance, largely because so much mortality can be explained by factors beyond the scope of the system. Many health care activities aim to improve quality of life rather than prolonging it – for example, treatment for fractures, cataract surgery and care for dying patients.

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The Government of Spain, The European Investment Bank, The Open Society Institute, The World Bank,  
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The effect of these activities is more difficult to measure, but that does not make them less important. If the quality of the Danish health care system were measured and compared to the quality of other western European systems using measures other than mortality, its ranking would be certain to improve.

### Waiting times and public expectations

Casual observers of the health care debate in Denmark – particularly in the run up to last year's general election – might get the impression that the quality of health care has declined in recent years. This is not, in general, the case. In the last two decades health care activity has increased, the number of patients treated and the number of employees in the health care sector have risen and many new procedures have been introduced, all of which contribute to improved standards of care and better outcomes.

Waiting times for treatment are regarded as a new phenomenon and a major problem, but they are not new. What is new is the attention given to them by the media and politicians. Because waiting lists are easy to measure and many of those waiting are able to articulate their discontent in the media, they have provided a focal point for politicians on all sides. To what extent are waiting times a major problem? Although some reduction in waiting times would, of course, be an improvement, waiting times in Denmark are not longer than in other Nordic countries and are considerably shorter than in countries such as the UK. In 2000, 76% of inpatients were treated immediately, 11% within a month and 6% within three months; 7% waited for more than three months.<sup>5</sup> Between 1991 and 2001 the overall proportion of inpatients waiting for more than three months was 7–8%.<sup>6</sup>

People tend to forget that ten or twenty years ago they were not able to access much of the treatment available today. What is more, many of those waiting are not prevented from working while they wait, and a significant proportion prefer to wait rather than be treated sooner in a hospital that is further away than their

local hospital. Nevertheless, the newly elected centre-right coalition government promised to cut waiting times during the election campaign and now considers it a key task to deliver on this promise. It has issued a new waiting time guarantee of two months, with effect from July 2002, for most types of non-acute treatment (excluding infertility treatment, sterilisation etc). Patients unable to receive treatment within two months in the public sector will have the right to seek treatment at private facilities or abroad. In 2002 an extra DKK 1.5 billion (equal to about 2.3% of public expenditure on health care in 1999) will be awarded to those counties that experience an increase in their activity levels (relative to the previous year). The increase includes private sector activity financed by the counties.<sup>7</sup> The government's plans have been criticised for not providing more funding for acute areas in internal medicine and psychiatry, although DKK 25 million has been allocated to child and youth psychiatry.

### Conclusions

From a comparative and an historical perspective, the Danish health care system functions well. Its strengths include the central role of the general practitioner as gatekeeper and provider of continuous care, relative equity in access to health care and care for elderly people. The latter is an area which is often criticised, but is actually superior to the care provided in other western European countries, with higher levels of funding and better facilities. Patient satisfaction with the health care system can be attributed to substantial regard for general practitioners, easy access to health care and the fact that most health care is provided free at the point of use.

As with any system, however, there is room for general improvement. There are also specific areas in which other countries have made more progress than Denmark. One weakness of the Danish health care system is cancer treatment, which seems to be less effective than in some comparable countries. For example, case fatality rates for lung and breast cancer are 10% higher in Denmark than in Sweden.<sup>8</sup> And the current shortage of

nurses and doctors is an urgent problem, although not one that can be fixed simply by an injection of extra cash.

It has not been my intention, in this commentary, to ignore the problems that are present in the Danish health care system, but to call for a degree of proportion in criticisms of the system. While health care in Denmark suffers from some weaknesses, there are strengths too, and the extent of the weaknesses is not so great as to justify Denmark's poor international and national reputation.

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Signild Vallgård is Associate Professor, Institute of Public Health, University of Copenhagen.

# NICE and its implications for health inequalities

Adam Oliver

In all countries, the funds to provide public sector services are limited. This is unfortunate because it means that the needs, much less the demands, for these services will never be completely satisfied. No service is more subject to this dilemma than health care, where technological advances, rising public expectations and an ageing population are likely to place an ever-increasing strain upon the gap between demand and feasible supply.

It has been implied that a major factor for the discrepancy between health care demand and supply is profiteering by the pharmaceutical industry.<sup>1</sup> If these profits were cut, so the argument goes, we would be able to supply enough health care to meet demand (or at least need), and therefore any debate on rationing health care is in fact a non-debate. In the context of the UK, whilst recognising that the Government certainly ought to be acting to ensure greater corporate responsibility, pharmaceuticals still consume a rather small percentage of the total NHS budget. There are daily pressures on *all* NHS human and financial resources, and to assume that an across the board cut in pharmaceutical prices will eradicate excess demand for health care resources is erroneous. Rationing is not a choice: it is inevitable. It is therefore just a question of *how* we ration health care.

Rationing can be *ad hoc* or structured. A structured approach is synonymous with an effort to ensure that scarce resources are used in the most socially advantageous ways, an example of which is to issue guidance informed by health economic evaluation. The practical use of economic evaluation is perhaps best exemplified by the UK's National Institute for Clinical Excellence (NICE),<sup>2</sup> which issues guid-

ance on which health care interventions ought to be provided within the National Health Service (NHS) in England and Wales. Though NICE does offer an encouraging model for the explicit rationing of health care interventions, the manner in which it issues its guidance, and the information on which it relies to inform its guidance, may create worrying implications for health-related inequalities. Some of these potential problems are briefly detailed below.

## Postcode prescribing

As suggested by its name, NICE was established ostensibly to promote clinical excellence. More accurately, in that the foundations of its guidance are based on evidence of the clinical and cost-effectiveness of health care interventions, NICE was established as an attempt to generate more health with available health care resources. However, NICE was also established in the hope that it would eventually eradicate what was being perceived as an important failure of the NHS: postcode prescribing.

Postcode prescribing is the phenomenon where a person's access to a particular NHS intervention is often dependent upon their area of residence. It arose because the different geographically-defined health authorities were free to decide which services to commission. For example, in some parts of the country women had access to *in-vitro* fertilisation therapy, whilst other women lived within the remit of health authorities that refused to reimburse this service. Differential access based on area of residence was deemed by the Government as unfair, and NICE, by providing guidance on which health care interventions ought to be provided

across the whole of England and Wales, would, it was hoped, help to address this perceived problem.

However, though there are several types of economic evaluation, NICE has chosen to recommend the use of 'incremental cost-outcome analysis', which may actually serve to introduce a new form of postcode prescribing. The incremental cost-outcome ratio for a study intervention is calculated by dividing the *difference* in costs between the study intervention and a comparator intervention, by the *difference* in outcomes generated by the two interventions. Through this calculation we derive the cost per unit increase in health outcome offered by the study intervention. If the cost per unit of outcome gained falls within some accepted threshold of cost-effectiveness (for example, £30 000 per life year gained), conventional practice has been to recommend the intervention for inclusion within the NHS.

Unfortunately, many health care interventions that are deemed to be cost-effective are also cost-increasing.<sup>3</sup> This essentially means that the local purchasers of health care may well have to scale back existing and/or planned health care services in order to introduce those that NICE decides ought to be provided.<sup>4</sup> Unfortunately, the purchasers of health care receive no guidance as to which services they ought to scale back on, which may well mean that:

- (i) different purchasers will scale back on different things, which will amount to the introduction of postcode prescribing by an alternative route, and
- (ii) some purchasers will cut services that are even more cost-effective than the new ones that NICE recommends.

Inadvertently, the NICE guidance as it stands could therefore sustain postcode prescribing and may actually exacerbate at least some conceptions of inefficiency. On top of this, the current guidance may also cause widening inequalities in the distribution of health outcomes.



## Some are more equal than others...?

The standard forms of clinical and cost-effectiveness analyses that underlie the NICE recommendations are essentially neo-utilitarian tools. They are concerned only with the total increase in health gain generated by a health care intervention, and not with how that health gain is distributed. If certain groups of individuals benefit relatively more from a particular intervention than others, it is quite possible that guidance (if acted upon) based upon the results of clinical and cost-effectiveness analyses (as currently practised) will serve to widen existing inequalities in health. For example, smoking cessation policies in the UK over the last 30 years have proved to be effective over the whole female population, but those relatively higher up the social scale have tended to benefit relatively *more* than those further down the social scale.<sup>5</sup> That smoking negatively influences health status is well established; thus, we could conclude that smoking cessation policies have (probably) served to widen inequalities in female health across social classes.

The lack of a distributional dimension in standard forms of clinical and cost-effectiveness analyses is *perhaps* a problem if the prevailing societal distributions of health across groups defined by, for example, social class, income, gender, race, geography or lifestyle, are considered unfair.<sup>5</sup> If (1) a generally accepted ethical framework could be put forward which explains why certain health inequalities are unfair, and if (2) health care is deemed to be an appropriate conduit through which to redistribute health outcomes, then (3) it may be desirable to attempt to modify the health maximisation approach that is currently implicit within most clinical and cost-effectiveness analyses to account for distributional concerns. Far more research and debate needs to be undertaken in relation to (1) and (2), but even if both of these requirements were met, there will be considerable (though not necessarily insurmountable) difficulties in addressing point (3).<sup>6</sup>

## Conclusion

The Government ought to be congratulated in establishing NICE, as it is one of the few institutions in the world with a responsibility for explicitly promoting the most socially advantageous use of scarce health care resources. The institute is still very young, and thus inevitably there are fundamental problems inherent in the process by which NICE introduces its recommendations into the NHS and in the forms of evidence that it relies on in informing its guidance. A few of these problems have been briefly discussed here. With sufficiently open minds in the relevant research and policy communities, these problems will eventually be successfully resolved.

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*Adam Oliver is Research Officer at LSE Health and Social Care, London School of Economics and Political Science.*

# Health reforms in Georgia

Laura MacLehose

Georgia, which gained its independence from the former Soviet Union in 1991, has a long medical tradition which can be traced back to the fourth century.<sup>1</sup> From 1921 up until the health system reforms initiated in the 1990s, Georgia was part of the large scale Soviet health system (the Semashko model). Independence followed by civil war brought major political, economic and social change. One outcome of these changes was a combination of severe financial shortages faced by the health care system, increased health needs due to population migration (due to civil unrest) and a desire to move from the Soviet model to a new national structure. In 1993 planning for the first set of a series of radical health reforms was initiated and implementation of change began in 1995. Under these reforms, one

key element has been the move from a tax financed centralised health care system to a social insurance funded system. The challenge for the reforms overall is to bring tangible health benefits to the whole population.

## Health reform

Since 1993, the government has designed and subsequently implemented a broad and bold set of reforms. These include: structural reforms to separate financing, purchasing and provision functions; introducing health insurance (in the form of a payroll tax) to supplement tax financed budget transfers; redefining the content of services provided in the public system with a 'Basic Benefits Package' of primary and secondary care services; and strengthened regulation of the phar-

maceutical supply. In addition, efforts to rationalise the very large inherited hospital sector have been undertaken. The strengthening of primary care has been a key goal of the reforms and training and certification activities are ongoing. Decentralisation is an important theme of the reforms. Key decentralisation activities undertaken to date include the establishment of the 12 regional health administrations for the local management of health services and the privatisation of health care facilities (pharmacies and most health care facilities), resulting in the creation of autonomous primary and secondary care providers.

### Finance and expenditure

Georgia spends one of the lowest levels on health as part of GDP, and also in real terms per person per year in Europe. Expenditure as part of GDP has fallen sharply from just over 4% in 1991 to just 0.59% in 1999.<sup>2</sup> In real terms, total health expenditure (including health insurance system expenditure and direct payment by patients) was around US\$104 per person per year in 1999. Around 87% of all expenditure on health is out of pocket payments made directly by patients, either formally through user fees or informally through 'under-the-table' payments.<sup>3</sup>

The new form of financing healthcare through an insurance system was introduced in 1995. The State Medical Insurance Company (SMIC) runs the insurance programme in which employees and employers must contribute 1% and 3%, respectively, of employee salaries for health care entitlements. The state must make payments to SMIC for the unemployed and vulnerable groups (such as the elderly). Participation is compulsory and entitles people to the 'Basic Benefits Package' (BBP), which was defined after extensive negotiations but debates continue as to what it should include. Commencement of the new insurance system coincided with the introduction of user fees for health services that are not covered under the BBP. Services that are covered are free or require a form of co-payment. However, although the BBP lists entitlements for

SMIC participants, due to the low level of financing provided to the health system, there have been difficulties in meeting these obligations. Private health insurance provision is allowed. However, this market is relatively undeveloped and few people have taken out policies.

Informal charges for health care make up a large part of the health system's complementary sources of finance. It was hoped that by formalising payments for certain health services that the high level of informal payments taking place in the first years of independence would be reduced. However, it appears that informal payments continue to be requested of many patients. In 2000 it was estimated that formal and informal payments were deterring as much as 30% of the population from seeking health care services. A 1999 World Bank report identified the illness of a family member as one of the main causes of impoverishment in Georgia.<sup>4</sup>

### Delivery

Strengthening primary care provision is a major goal of the Georgian health reforms. It is hoped that by 2003 there will be national and regional centres in place for family medicine, full financing mechanisms in place by 2005 and the completion of a national network of primary care centres with trained primary care teams by 2008. The challenges are, however, considerable. Georgia, like other former Soviet republics, has a large secondary and tertiary care sector, which was traditionally given greater emphasis and funding than the primary care level. A range of measures have been undertaken to strengthen primary care since independence, including: privatisation of primary care facilities, new forms of contracting with facilities to provide the BBP, the development of an Essential Drugs List, the introduction of family medicine training for health staff, the setting up of a Society of General Practitioners and Family Medicine in

1995, and the recognition of family medicine as a speciality in 1998. Licensing and revalidation has been introduced for Family Medicine as well as other specialities. In addition, the government has introduced reforms to rationalise the secondary and tertiary sectors to release funds to primary care and improve specialist care.

### Conclusions

Although reforms have been introduced to strengthen the provision of basic care for all, the benefits have not yet been widely felt by the Georgian population. Access to care continues to be limited by the widespread payments demanded by many health providers. The health insurance system faces difficulties due to the sometimes inadequate financing it receives through the central government and is unable to provide all parts of the basic package to those who both need it and are entitled to it. However, a reformist Ministry of Health, Labour and Social Affairs is pushing through further financing, organisational and programmatic reforms to address these challenges. As the economy improves, it is hoped that the new reforms will bring benefits and a basic level of care to all.

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*The Health Care in Transition (HiT) profile on Georgia was written by Rifat Atun, Amiran Gamkrelidze, George Gotsdaze and Laura MacLehose; and edited by Laura MacLehose and Martin McKee. The HiT is available online from the Observatory's website: [www.observatory.dk](http://www.observatory.dk)*

# Radical devolution in Finnish health care

Ana Rico and Wendy Wisbaum

The Finnish health care system provides comprehensive coverage to all residents. Its principal features are tax-based funding, public provision of most services and municipal governance. Finland is an exceptional case, however, in that its health care system is characterised by the radical devolution of health care powers to 500 relatively small municipalities. This unique institutional feature, which has a long historical tradition, was developed gradually, and experienced considerable impetus during the 1970s and 1990s. Moreover, during the 1990s Finland faced a dramatic economic downturn which put the welfare state under considerable financial pressure. According to recent estimates<sup>1</sup> cost containment policies resulted in an approximate decrease of 20% in health care expenditure throughout the 1990s.

The 5 million members of the Finnish population are younger than the EU average, although the population is ageing at a very fast rate. Despite the lowest infant mortality in western Europe, male life expectancy is below the EU average. Circulatory diseases comprise half of all deaths whilst suicides are a significant cause of death in men under 35.

In 1999, approximately 43% of total health care costs were financed by proportional municipal taxes, 18% by central transfers, 15% by National Health Insurance (NHI), and circa 24% through private sources (that is, user charges and private sector provision). There is no explicitly stated basic package of benefits, which in practice, vary significantly by municipality. Another feature of the devolved Finnish is that there are no exemptions from user charges for low-income groups. In addition, the NHI system subsidises pharmaceuticals and services delivered by private providers. Pharmaceutical costs

increased annually by 10% during the period 1990-1998 (mainly due to new expensive drugs), and the use of generics is small.

Since 1984, primary care has been provided in health centres which provide curative and preventive services to their assigned populations. Most health care professionals are salaried public employees. In 1999, there were approximately 3.1 physicians per 1000 population in Finland, which was slightly below the EU average while the number of nurses, 31.7 per 1000 population, was the highest in western Europe. Primary and secondary care are not always well coordinated due to ineffectual gatekeeping mechanisms (for example, wealthier Finns can pay to go directly to specialists, rather than be referred by GPs, who then refer them directly to hospital treatment). Hospital beds decreased by a third (by 50% in short-term acute care) during the 1990s, and length of stay fell by about 40%. However, following the economic downturn, estimated expenditure in home care and nursing homes also dropped by 40% and 30%, respectively, making this a priority area. Another important priority is care for the elderly and disabled who have suffered the most from the economic crisis.

As mentioned above, two major institutional reforms took place in Finland during the first half of the 1990s. The first was devolution in 1993 in which further regulatory and financial powers over health care were transferred to the country's municipalities. A sharp decrease in the central share of financing (from 35% to 18%) followed. Simultaneously, municipalities faced a squeeze in local tax bases. Municipalities now plan and organise health care and are politically accountable to their citizens. When the bulk of

health care regulation was devolved to municipalities in 1993, the National Board of Health was abolished and most of its personnel was transferred to STAKES, a Research & Development Agency. This represents a significant innovation in health care governance, and entailed a shift in the role of central government from hands-on regulation and control to external steering through information provision.

Municipalities receive prospective block grants from the central government, calculated under a weighted capitation system according to population, age structure and morbidity. Hospitals receive revenue from municipalities according to the services used by inhabitants. Although hospital reimbursement systems vary, hospitals are increasingly using diagnostic related groups as the basis for billing municipalities. There is an equalisation mechanism within hospital districts, which spreads the risk of high cost patients among municipalities.

The second package of reforms addressed the pro-welfare spending consensus that was entrenched in the 1928 Parliamentary Act. This Act was amended in 1992 to facilitate the approval of cost containment policies. Although there is no available data on the impact of these reforms, their effect is likely to have facilitated the marked decrease in health care expenditure accomplished during the decade. It is noteworthy that the early 1990s also saw a significant drop in popular support for welfare state expenditure. However, in 1995, there was reversal in policy when, for the first time, a newly elected government included within the Constitutional Act guaranteed social rights for all residents.<sup>2</sup>

Further reforms launched during the late 1990s and early 2000s included: several measures targeted at expanding benefits; dental care cover was to be gradually expanded to previously excluded groups, reaching full population coverage between 2000-2; and since the late 1990s, there has been an improvement in outpatient mental care services through central subsidies and quality guidelines. In the field of financing, a centrally-



regulated ceiling for annual out-of-pocket expenditure was introduced in 2000, and a package of measures aimed at curbing pharmaceutical expenditure was launched in 1997. Furthermore, at the municipal level, several organisational pilots are currently underway: some are designed along the lines of the purchaser-provider model, several municipalities are experimenting with virtual and real integrated primary-secondary providers, and some are contracting-out primary care to external providers.

The main problems which remain within the Finnish health care system include the large variations in care and per capita expenditure among municipalities, insufficient levels of community services, and physician shortages. Concerns have also been noted regarding the growing inequity in financing, mainly derived from higher out-of-pocket payments and the increased use of publicly subsidised private care by the better off. The latter, in turn, constitutes an obstacle for further integration across the primary-secondary interface (as patients who use private care do not need a referral from a GP); and also affects territorial imbalances, as private providers are concentrated in urban areas. In spite of this, the role of the private sector, as well as of the NHI in subsidising it, remains an area that has not been addressed by reform measures.

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*This article is based on the Health Care in Transition (HiT) profile on Finland, written by Jutta Järvelin and edited by Ana Rico and Teresa Cetani. The HiT profile is available online from the Observatory's website: [www.observatory.dk](http://www.observatory.dk)*

## Spotlight on 'Living HiTs' Spain - two decades of reform

Ana Rico and Sandra León

The *Health Care in Transition Profile* (HiT) on Spain, published in 2000, provides an extensive review of Spanish health care developments during the democratic period which began in 1978. A devolved National Health System (NHS) was instituted during these years but its most striking feature was that only 7 out of 10 regions held self-government rights in health care. From 2001, further devolution was pushed forward through major institutional reform and these more recent changes are now covered in the *Living HiT* on Spain, which was published online on the Observatory's website in April 2002. Such updates are termed *Living HiTs* as their aim is to provide an ongoing review of recent reforms. As the coverage of countries is expanded, *Living HiTs* will become regular online updates of another Observatory product, the HiT Profile Summary, which provide a succinct synopsis of a country's health care system.

The Spanish health care system, with its ongoing reform processes, is particularly suited for monitoring through the *Living HiT* format. During the 1980s and 1990s, the Spanish health care system underwent major change, achieving a significant expansion of coverage and the rationalisation of both financing and management structures. The two outstanding reforms of the period were the transition from a Social Health Insurance (SHI) system to a tax financed NHS, and the process of devolution to the regions. While there are still important problems to be addressed in these two areas, citizen satisfaction has consistently increased during the 1990s.<sup>1</sup>

The Spanish Constitution (1978) only ambiguously established the universal right to health protection in that the public health care system does not actually cover 100% of the population, since cov-

erage is still linked to employment and not to citizenship or residence. The 1986 General Health Act ratified the formal transition to a NHS model and entailed 3 critical policy moves: 1) a shift in the financing of the system, which after a transition period of almost 10 years, is now 100% financed out of general taxation; 2) an expansion of the public primary care sector; and 3) a process of organisational integration of the overlapping health networks inherited from the past.

The development of a new, publicly owned and staffed primary health care (PHC) network undoubtedly represents a major institutional change. This was made possible mainly due to a new generation of PHC professionals who opted for the post-graduate programme in family and community medicine created in 1980. The low political priority given to PHC throughout the democratic period probably helps to explain the long implementation process of PHC reforms (which is still on-going) as well as their mixed results. In spite of the impressive institutional and professional development within PHC, which is reflected in rapidly rising citizen satisfaction figures, the Spanish NHS is still centred around hospitals.

Cost control and new forms of management constituted the two main areas of reform during the 1990s. This was exemplified by the introduction of legislation to gradually separate provider and purchaser functions. This has been put into practice mainly through the establishment of contracts that are based on targeted activity and financed through global budgets. Public satisfaction regarding waiting times and the administrative procedures required to access specialised care remain low, suggesting that the main problems in this area still require further attention.<sup>2</sup>



A distinctive feature of the Spanish system is asymmetric federalism. Between 1981 and 1994, the SHI network was integrated within the NHS and the resulting health care system was transferred to 7 regions, which were given fully devolved powers. In the meantime, the other 10 regions in Spain remained centrally managed. Most regions (15 out of 17) have very limited fiscal autonomy, as most taxes are centrally raised. During the 1990s, the management of some 30% of income taxes was transferred to the Spanish regions. In July 2001, the regional resource allocation system was reformed. The major element of this process was the transfer to the regions of 40% of all VAT revenue plus a proportion of other special taxes (the proportion varies from 40% to 100% depending on the region).

These reforms, still seen by some as falling short of desirable levels of fiscal autonomy, do however represent a major step towards fiscal federalism, particularly in the sense that health care ceases to be a specific, earmarked programme funded separately to the general block grants transferred to the regions each year, and becomes subject to the decisions of regional political representatives. In January 2002, after two years of negotiations, the transfer of full health care powers to the ten still centrally managed regions was completed.

At the start of the 2000s, the most important challenge for the Spanish health care system is to consolidate the impressive efforts at institutional building that have been accomplished during 20 years of democratic governance. On one front, consolidating the NHS model requires that the issue of social and community care be addressed. This area remains one of the most important problems, together with dental care, in terms of what is currently

excluded from the public benefits package. Only mental health care has been incorporated into the NHS and been subject to major reform measures. In addition, there is a pressing need to improve efficiency through transferring responsibilities to local budget holders. An issue which remains unexplored is the potential transfer to PHC professionals of new powers to coordinate other care levels.

On another front, there is still a long way to go to achieving the consolidation of the new territorial structure of the NHS. There are two pressing issues. First, the weakness of information gathering across regions; existing data are of limited use due to the lack of homogeneous coding or a common data bank that pools information. Second, there is an urgent need to design a new regulatory and institutional framework at the central government level in order to adequately steer health care governance in a deeply devolved state. Oversized central political institutions need to be downsized, and their role transformed. Moreover, given that in Spain the Senate only very imperfectly represents regional interests, new forms of cooperative decision-making would need to be designed as part of this process, as would new financial equalisation mechanisms. Therefore, the current draft bill on Health Care Coordination, which is still in the making, represents a critical legislative stage in the process of consolidating the devolved Spanish NHS.

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*This article is based on the Health Care in Transition (HiT) profile on Spain, written by A Rico and R Sabes and edited by A Rico and T Cetani, and on the Living HiT on Spain. Both are available from the Observatory's website: [www.observatory.dk](http://www.observatory.dk)*

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Telephone: +45 39 17 14 30, Fax: +45 39 17 18 70  
E-mail: [observatory@who.dk](mailto:observatory@who.dk) Website: [www.observatory.dk](http://www.observatory.dk)

#### Editor

Anna Maresso

#### Editorial Team

Josep Figueras  
Elke Jakubowski  
Martin McKee  
Elias Mossialos  
Richard Saltman

#### To join the mailing list, please contact

Anna Maresso

Observatory – London Hub

Tel: +44 20 7955 6288

Fax: +44 20 7955 6803

Email: [a.maresso@lse.ac.uk](mailto:a.maresso@lse.ac.uk)

*Euro Observer* is published quarterly by the European Observatory on Health Care Systems, with major funding provided by a grant from Merck & Co., Inc., Whitehouse Station, New Jersey, USA.

The views expressed in *Euro Observer* are those of the authors alone and not necessarily those of the European Observatory on Health Care Systems or its participating organisations.

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#### Design and production by

Westminster European  
[westminster.european@btinternet.com](mailto:westminster.european@btinternet.com)

ISSN: 1020-7481