HiT summary

Andorra

Introduction[1]

Government and recent political history

The Principality of Andorra (*Principat d'Andorra*) is an independent, democratic, constitutional microstate. Andorra is one of the oldest countries in Europe: the first appearance of the name is found in a grant dating from 843 AD. Since the end of the 8th century social, political and economic changes have led to the progressive modernization of Andorra's administrative institutions. The constitution, promulgated in 1993, undertook to separate the legislative, judicial and executive bodies of government and established the country as a parliamentary co-principality.

Population

Andorra is located in the heart of the eastern Pyrenees, on the Mediterranean side between France and Spain. It covers an area of 468 km^2 and the average altitude is 1996 metres. With a total population of 67 159 in 2002, it is divided into seven parishes each marking a territorial, political and administrative division of the country. Catalan is the only official language, although Castilian, French and, to a lesser degree, Portuguese are also spoken.

[1] The small size of the country and presence of foreign workers complicate the interpretation of statistics in some cases.

Average life expectancy

According to the *WHO World Health Report 2003* average life expectancy was 80.3 years in 2002 (males 76.8, females 83.7 years). This is one of the highest in the world. The Andorran Ministry of Health and Welfare estimates that average life expectancy is even higher. The birth rate (11.5 births/1000 population) remained higher than the death rate (3.2/1000 population). The overall fertility rate was 1.36 live births per woman.

Leading causes of death

In 1999, tumours, cardiovascular and respiratory diseases were the most common causes of mortality, respectively representing 30.3%, 25.3% and 8% of the total deaths. External factors were the primary cause of death for males aged 15 to 44 and for females aged 15 to 34. Car accidents due to alcohol consumption decreased from 79 in 1995 to 68 in 1997 and the total number of deaths caused by traffic accidents decreased from 10 to 3.

European Observatory
on Health Systems and Policies
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen
Denmark
Telephone: +45 39 17 17 17
Fax: +45 39 17 18 70
E-mail: observatory@who.dk
www.observatory.dk

Recent history of the health care system

The Andorran health care system is based on a social insurance model. Citizens' health care rights are recognized by the constitution. Health care services are provided and financed by both private and public sectors. The origins of the current Andorran health care system officially date from 24 September 1918 when an agreement was signed to establish health boards in each parish (*les juntes parroquials de sanitat*) in response to the devastating consequences of the transnational influenza epidemic. In 1935, in accordance with the Health Act (*Reglament de Sanitat*) a National Committee intended to work with the parish health boards was organized. In 1960, the Department of Public Health and Hygiene (*Direcció de Sanitat i Higiene*) and the Council of Public Health and Hygiene (*Consell de Sanitat i Higiene*) were established. Both bodies functioned until April 1989 when the General Health Law (*Llei General de Sanitat*) was enacted, leading to the creation of a Ministry of Health (currently Ministry of Health and Welfare) in 1993.

Health expenditure and GDP

Andorran data indicate that total health care expenditure was 96.0 million in 2001. This amount is equivalent to 5.9% of GDP, relatively low compared to other European countries. WHO data show higher rates (latest available: 7.9% in 2000), but nevertheless expenditure as a percentage of GDP remains relatively low.

Overview

Organizational structure of the health care system

The General Health Law (*Llei General de Sanitat*) enacted on 20 March 1989 defined the current functions of the different agents in the Andorran health care system. The central state institutions that govern health care are the General Council, Ministry of Health and Welfare, CASS (*la Caixa Andorrana de Seguretat Social* -the Andorran Office of the Social Security) and SAAS (*Servei Andorrà d'Atenciò Sanitaria* - Andorran National Health Service).

About 92% of the population is covered by the CASS, created in 1966. In principle all residents who are unable to pay are entitled to health care services at the government's expense. Before the establishment of the CASS, primary care doctors were contracted by the parishes to deliver basic services during set hours each day.

Planning, regulation and management

The Ministry of Health and Welfare is in charge of health care planning at the national level. After the enactment of the 1989 General Health Law, the first National Health Plan was approved for a period of two years. It aimed to promote health care in different sectors – environment, lifestyles, immunization, car and work accidents, health care awareness, maternal and child health and primary care – but did not specify what means could be used to achieve these goals.

Decentralization of the health care system

In spite of Andorra's small size, historically it has had a rather decentralized health care system. This is partly in response to the relative isolation of the parishes given their mountainous setting. During recent decades, however, the country has been moving towards a more centralized system as a result of improved communications and the perceived need to develop a more comprehensive and coordinated approach to health care. From the 1980s, and especially since the creation of the Ministry of Health in 1993, regulations have been systematized and more services have been placed under the administrative responsibility of the SAAS.

Health care financing and expenditure

Main system of finance and coverage

There are three health care financing agents: the government, the parishes and the CASS, although private financing also plays a role. In 2001, public expenditure was 71.0% of Total Health Expenditure (THE). Social health insurance (CASS) amounted to 86.1% of total public expenditure, while the remaining 13.9% consisted of government tax-expenditure. Private expenditure (almost exclusively out-of-pocket payments) was 29.0% of THE.

Complementary sources of finance

Additional sources of health care finance derive mainly from private expenditure, mostly through public co-payment mechanisms by CASS members and direct private payments by non-CASS members. About 25% of people insured through CASS also have private health insurance.

Health care benefits and rationing

The CASS covers expenses for general and specialist care (diagnostic, treatment and rehabilitation), medicines, odontostomatology, optical care, orthopaedic care and prostheses) for its members both inside and outside Andorra. The central government pays out of taxes for mental health care, basic primary nursing care, health prevention and health promotion. In practice people without social or voluntary health insurance have to pay directly for services, with the exception of emergency hospital care. It is estimated that 8% of the population was without cover in 2002, but it is not known what percentage is poor and unable to afford private care.

Health care expenditure

During the 1990s health expenditure as a percentage of GDP increased steadily, but remains low when compared with other European countries. In 1998 there was a temporary increase caused by the government acquisition of the Andorran Hospital Centre (CHA).

Health care delivery system

The Andorran health care delivery system includes a state-owned hospital (the CHA) with 189 beds, a private geriatric centre with 50 beds, 10 health care centres, 54 pharmacies and 203 physicians. Independent

office-based physicians, both inside and outside Andorra, provide most ambulatory care including primary care and outpatient secondary care.

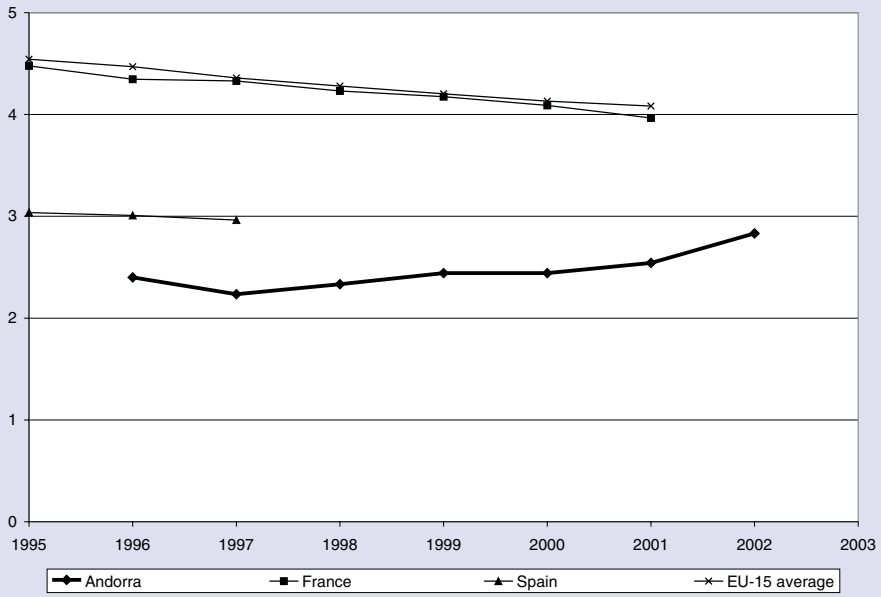
Primary health care (PHC)

In addition to the independent private, office-based general physicians (GPs) there are ten publicly funded and managed health centres (HCs). Located in the seven parishes, these are part of the movement towards strengthening primary and community care. Each HC provides the following services: first aid, preventive care, prenatal and child care, home care and family planning and counselling. The professional nursing staff in HCs provides primary care services which complement the services provided by private GPs. The nursing staff also manages a home care service. In 2002/2003 a few of the HCs employed GPs.

Secondary and tertiary care

Secondary outpatient care mainly is provided by private physicians in their own offices. Hospital care in Andorra is provided by one hospital (*Nostra Senyora de Meritxell*) managed by the SAAS. Besides the public hospital, there is a small private geriatric centre (*Centre Geriàtric Sant Vicenç d'Enclar*). The Andorran health system also relies on hospitals outside the country for complicated or uncommon surgical procedures. Compared with other European countries, Andorra has very low hospital capacity and admission rates. Consistent with that, and in contrast with the prevailing European trend, the number of hospital beds did not show a clear downward trend during the late 1990s (Fig. 1).

Fig. 1. Hospital beds in acute hospitals per 1000 population, Andorra, selected countries and EU-15 average, 1995–2002



Source: WHO Regional Office for Europe health for all database, June 2004.

Occupancy rates and length of stay placed Andorra slightly below the western European average.

Social and community care

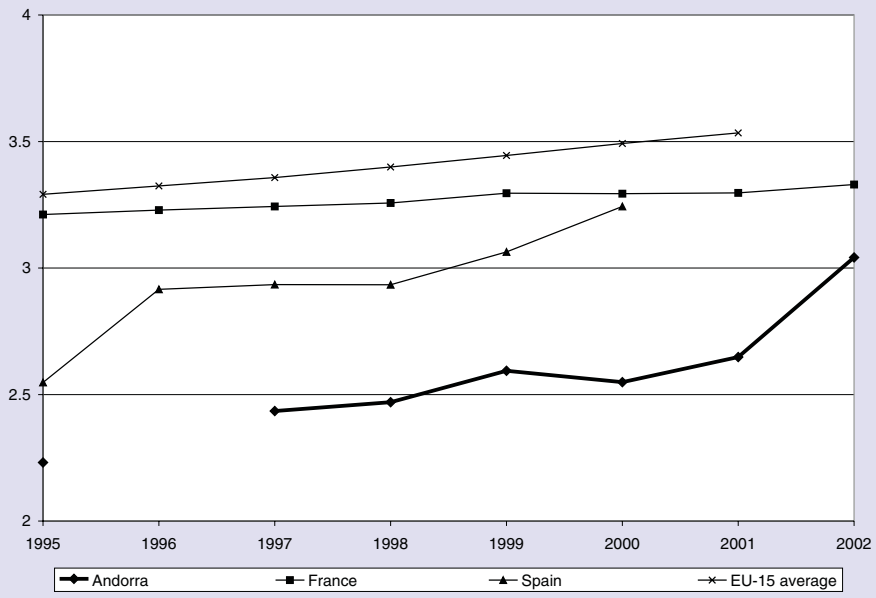
There is little institutionalized social and community care in Andorra. Existing community care is provided by the HCs. There are also two nursing homes for elderly people (one public, one private), each with 50 beds. In 1996, a public psychiatric care centre (*Serveis de Salut Mental*) opened.

Human resources and training

Traditionally, there have been no medical educational programmes available in Andorra, therefore doctors and other health professionals are trained outside the country, normally in France or Spain. Since 1988 Andorra has had its own university-level nursing school that awards internationally recognized degrees. In 1997, as part of the *Universitat d'Andorra*, a virtual study centre was created that currently offers a degree programme in educational psychology, among other things. Furthermore, as part of the quality improvement programme in 1999, training professionals were appointed to give courses in accordance with the European Foundation for Quality Management Model to health workers (nurses, nurse assistants, administrative staff, physicians and social workers).

It is difficult to determine the number of physicians that provide care to Andorran residents. Physicians from abroad work for irregular periods in Andorra and many citizens are treated in France and Spain. WHO

Fig. 2. Physicians per 1000 population, Andorra, selected countries and EU-15 average, 1995–2002



Source: WHO Regional Office for Europe health for all database, June 2004.

data indicate that there were 3.0 physicians and 3.2 nurses per 1000 inhabitants in 2002. The number of physicians per capita seems to have increased during the late 1990s, as elsewhere in the EU15 (Fig. 2).

Pharmaceuticals and health care technology assessment

The Pharmacy and Health Products and Establishments Unit at the Ministry of Health and Welfare develops and implements regulations to ensure the quality, safety and efficacy of imported drugs and to promote the rational use of drugs. It licenses pharmacies, importing agents, distributors and manufacturers; conducts inspections; issues safety alerts; and disseminates drug information bulletins. Drug consumption in 2001 was equivalent to €104 per capita, after having increased steadily during the previous decade.

Financial resource allocation

The budgets of the SAAS and CASS are subject to approval by central government and the parliament. In addition to patient contributions, payments made by private insurance companies and the parishes also finance health care provision.

Payment of hospital

In 1997 ownership of the CHA was passed to the Ministry of Health and Welfare; in 1999 the SAAS was allocated responsibility for a period of ten years. The SAAS is reimbursed by the CASS for the services performed by its employees according to officially established fees. As part of the physicians are salaried employees, this hospital payment system brings some financial risk with it for the hospital.

Payment of health care professionals

Salaried physicians and auxiliary staff members who work in the hospital are paid by SAAS. Private physicians under contract with the CASS are paid on a fee-for-service basis. The conditions of their work contracts are determined by national labour regulations and internal SAAS labour regulations.

Health care reforms

Three waves of health care reform can be identified over the last two decades.

- 1986–1990: first period of reforms concentrated on setting up a general regulatory framework and increasing government influence on health care policy.
- 1990–1995: second period of reforms concentrated on increasing further the government's influence on both health care policy and specific health issues.
- 1995–2000: third period of reforms addressed problems such as the lack of quality control, weak community care and public health care, and barriers to the integration of services.

Successfully implemented reforms included the setting-up of state institutions, establishment of an emergency service, improvement of public health policy coordination and the expansion of public coverage of community care services. Some critical reform goals remain outstanding in

spite of their high political priority during the last decades. Firstly, there is insufficient quality control of health care providers. Secondly, a lack of coordination among public and private providers and across levels of care. Thirdly, limited access to the public health system. Public coverage in Andorra is more restricted than in several other western European countries as it is linked to formal employment, i.e. payroll contributions to the CASS.

Conclusions

At the beginning of the 21st century, Andorran health care can be characterized as a comprehensive social health insurance system that compares well with other western European health care systems. Governance has been limited as, until relatively recently, private physicians had a lot of autonomy at the expense of state regulation.

Historically, and consistent with the topography of the country, most government functions were decentralized to the tiny, mountainous parishes that compose the Andorran state. Independent doctors provided most health care and also ran informal private insurance schemes for their patients. Accordingly, central government's role in health care was virtually non-existent. The creation of an independent social health insurance fund during the late 1960s did not change matters much, and there was no state regulation of the sector until the late 1980s. During the last two decades of the 20th century Andorra experienced a thorough transformation of its political system, with its first constitution being approved in 1993. In health care, the central state authorities have adopted an increasingly proactive role since 1986.

The primary challenge was to build government institutions and introduce comprehensive state regulation of the health care sector almost from scratch. Contrary to other European countries, which reformed their health care system during the last decades of the 20th century, the creation of regulation and institutions was thus only minimally influenced by already existing structures. As a result, Andorra is an interesting case study for policy-makers in other countries. Furthermore, the small scale of the Andorran health care system provides useful study material for policy-makers interested in issues related to decentralisation.

When introducing health care reforms, central government dealt with a high degree of opposition, mainly from Andorran private physicians who were backed by the courts. The main controversial issues revolved around the role of state authorities vis-à-vis physicians in controlling (publicly funded) private health care services, as well as government reform initiatives intended to expand the public provision of health services. Despite the problems encountered, many of these reform initiatives have been implemented successfully.

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Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2002 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Andorra	2.8	10.1	6.7[c]	77.4[c]
France	4.0[a]	20.4[c]	5.5[c]	75.5[d]
Spain	3.0[e]	11.5[d]	7.5[d]	76.1[d]
EU-15 average	4.1[a]	18.1[c]	7.1[c]	77.9[d]

Source: WHO Regional Office for Europe health for all database, January 2004.
Notes: [a] 2001, [b] 2000, [c] 1999, [d] 1998, [e] 1997.

The Health Care Systems in Transition profile (HiT) on Andorra was written by Hans F.W. Dubois (European Observatory on Health Systems and Policies), Ferrán Martínez (Universidad Complutense de Madrid/Harvard University), Teresa Cetani (European Observatory on Health Systems and Policies) and Ana Rico (European Observatory on Health Systems and Policies). The research director of this HiT was Richard B. Saltman.

The European Observatory on Health Systems and Policies is grateful to Margarita Coll (Ministry of Health and Welfare), Josep Goicoechea (Minister of Health and Welfare, 1996–2001), Guillem López Casasnovas (Universitat Pompeu Fabra), Vicenç Martinez Vecina (President of the Andorran College of Doctors, 1999–2001), Eduard Portella (General Director of the Andorran National Health Service (SAAS), 1986–1989) and Josep Vilanova Trias (President of the Andorran College of Doctors, 1990–1992) for reviewing this report.

The editors are also thankful to Margarita Coll, José María Francino (Ministry of Finance), Josep Goicoechea, Josep Gómez Jiménez (Andorran Hospital Centre), Rosa Maria Mandicó (Ministry of Health and Welfare), Vicenç Martinez Vecina, Angelina Mas (Board of Directors, Andorran Office of the Social Security (CASS)), Eduard Portella, Josep Romagosa (SAAS), Josep Vilanova Trias and Felix Zapatero (CASS) for providing them, through interviews and documentary support, with all the information necessary to write this report. Documentary support from the Ministry of Finance's statistical office (Servei d'Estudis), the Embassy of Andorra to Spain, the Supreme Council of Justice, the Andorra University School of Nursing and the Official Gazette of the Principality of Andorra, as well as editorial support from Misha Hoekstra (European Observatory on Health Systems and Policies), is also gratefully acknowledged.

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

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