examination appears to result in appropriate referrals to other services when required.

The work of ANAEM is complemented by that undertaken within accommodation centres for asylum applicants that are run by CADA under ANAEM supervision. Here again, epidemiological investigations are undertaken. Monitoring procedures, like those used for type II diabetes, allow immigrants to assume personal responsibility for their own health when medical conditions are at a less advanced stage. Results can still be improved and constitute good practice examples for other vulnerable populations.

Obligations and benefits
Since 2005 each accommodation service of ANAEM (23 in France) has also proposed a ‘contract of accommodation and integration’ (CAI) to migrants coming for family or long-term work reasons, or who are refugees. An evaluation of their needs in terms of social services, knowledge of French, and adhesion to France’s republican values is provided at the same time as the medical evaluation. Then they are given the CAI. It places an obligation on them towards the French state, while ensuring access to health and social services, French language lessons, and information about the civic basis of the republic.

ANAEM’s public health activity has undergone a true ‘silent revolution’ during the last six years. It has become instrumental in relaying, emphasising and implementing public health policies. It has engendered a culture of partnership extending beyond the ANAEM medical departments to administrative and social departments. It has successfully promoted the primary objectives of ANAEM in relation to the integration of migrants in France.

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Health inequalities in the decentralised Spanish health care system

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Summary: Despite the optimistic health outcomes that the Spanish population enjoy, there are still disparities in health between different socioeconomic groups in the different Autonomous Communities. Given the process of decentralisation in the Spanish health care system and the lack of a national programme to reduce inequalities in health, initiatives at regional level are particularly relevant. However, not all regions include this target in their health plans, with the exception of the Basque Country. The balance between diversity at regional level and social cohesion remains a challenge in the Spanish health care system.

Keywords: Socioeconomic Inequalities, Health status, Health Plans, Spain, Decentralisation

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As the European Union continues to expand, disparities in the health of the European population, both within and between countries, are increasingly a cause for concern. Several studies quantifying health inequalities at the European level have shown that they are related to socioeconomic factors such as education, income and job status. Spain is no exception. The Spanish health care system is decentralised, with health being the responsibility of the seventeen Autonomous Communities (ACs) that make up the country. However, devolution has not been
homogenous as health care responsibilities were transferred at different rates to all the ACs. This has negatively affected the principal objective to guarantee the system’s equity and quality.

**Organisation and performance of the Spanish health care system**

The Spanish health care system is publicly funded and has a regional organisational structure resulting from a process of devolution. Population coverage under the Spanish National Health System (NHS) is almost universal (99.5%), including low-income populations, immigrant adults and children, hence providing a benefits package to all inhabitants independently of their ability to pay. It is a health system financed mainly by general taxation, which is intended to favour financial sustainability.

The central government is responsible for strengthening coordination and cooperation in the health sector, guaranteeing the quality of all services and equity in access to health care throughout the national territory. In particular, the Spanish Ministry of Health assumes responsibility for general coordination and basic health legislation, foreign health, international relations, undergraduate and postgraduate education, together with research and high-level inspection.

At the regional level, the seventeen ACs have the power to establish their own health plans and to organise their own health services. These competencies were transferred over the past twenty years, although this process did not take place simultaneously. While several regions obtained responsibility for health many years ago (Catalonia in 1981, Andalucía in 1984, Basque Country and Valencia in 1988, Galicia and Navarra in 1991 and the Canaries in 1994), the devolution of health care responsibilities nationwide was only completed in 2002.

To promote the cohesion of the NHS, the Inter-territorial Council of the NHS was created in 1987, consisting of health representatives from central and regional governments. It is defined as an institution facilitating the permanent coordination, cooperation, communication and exchange of information on health care services across the ACs and with the state administration, thus helping to guarantee the rights of citizens across all of Spain.

In terms of the performance of the Spanish health care system, the international ranking varies according to the source considered. The World Health Report 2000, which focused on health systems performance, ranked the Spanish health care system sixth in the world. However, this result has been challenged. Recently, a report by Health Consumer Powerhouse, a private consultancy collecting consumer information on health care at EU level, ranked the Spanish health care system fourteenth among twenty-nine countries studied. Although Spain was three places up compared to its 2006 ranking, waiting lists and the lack of information for patients were still considered weak points in this report.

This classification has already been criticised by the Spanish government which has argued that the focus on consumer information does not permit a fair evaluation of the universality of the Spanish system. Furthermore, the ranking is not in line with others such as the European Union Barometer, where Spain occupies seventh place. Nonetheless, despite the different rankings reported, there is a common consensus that waiting lists and waiting times, despite the efforts to tackle them made to date, remain important policy issues in Spain.

**Spanish health outcomes in the European context**

As with other high income countries, Spain has experienced a significant improvement in health during the last twenty years. According to recent statistics provided by the Instituto Nacional de Estadística (INE – Spanish National Institute of Statistics), life expectancy at birth increased between 1995 to 2005 by more than two years and now is 80.23 years. Furthermore, mortality data in Spain reflect a decrease both in mortality rates and in the probability of death within each age group.

According to Eurostat, life expectancy at birth in Spain ranks ninth in Europe. Spanish female life expectancy is second only to that in France. However, life expectancy for men from Sweden, Ireland, Holland, Italy and the United Kingdom is higher than that observed in Spain. These generally optimistic figures on life expectancy at birth and mortality rates in Spain are linked to the increase in the number of older people; these now account for approximately 15% of the population. Furthermore, it is projected that by 2010 40% of the Spanish population will be more sixty years of age.

Variability in life expectancy can be found at AC level, with the highest figures found in Navarra (81.51 years), Madrid (81.39), Castilla-León (81.28) and La Rioja (81.18), while the autonomous city of Ceuta (78.62), Andalucía (78.83) and the Canaries (79.16) have the lowest rates. There are also variations in how individuals perceive their health. Citizens from northern ACs, including La Rioja, Aragón, Navarra and Cantabria, are the most satisfied with their health, while those from the south of Spain, including the Canaries and Extremadura report the worst levels of perceived health.

**Socioeconomic inequalities in health within Spain**

Regional and gender-based health inequalities persist in Spain, as in most other European countries. By age group, inequalities in health increase with age until age 45–54; after 64 years of age they tend to decrease. Furthermore, studies have shown that those inequalities in health are related to socioeconomic factors. The prevalence of chronic illness and disability is greater among those at the bottom of the income distribution. Inequalities in self-assessed health (SAH) status between social classes have been reported, as well as education-related inequalities in SAH and chronic diseases.

These inequalities also apply to other health outcomes such as obesity and smoking. The socioeconomic inequalities in the prevalence of obesity are largely explained by education and demographic characteristics. Education and income characteristics have been found to be strong predictors of smoking. These socioeconomic differences in smoking behaviour in turn influence inequality in lung cancer and total mortality.

According to the 2003 National Health Survey, most Spanish ACs have significant differences in self-assessed health status by social class. In the Canaries and Galicia, 40% of men and 50% of women from the working class have the highest levels of bad health, while in contrast Aragón and La Rioja have very small differences according to social class. Moreover, there is evidence to suggest that those ACs with the highest levels of income-related health inequality are also likely to display low levels in average health status. Using data from the Spanish National Health Survey for 2001, García and López observed that the Basque Country, Navarra and La Rioja had the highest levels of average health.
status and present the lowest degree of income-related health inequality. At the other extreme, Murcia’s population reports one of the lowest levels of average health status and suffers the greatest degree of income-related health inequality, reinforced by the effects of education. Compared to the Basque Country, other ACs presenting high income-related health inequality include Madrid, the Balearic Islands and Catalonia.

Policies to reduce inequalities in health
The number of countries and international organisations acknowledging the need to reduce inequalities in health is increasing. Most of these countries follow the equity principles and values of the World Health Organization and as such are explicitly concerned with the socioeconomic dimension of health inequalities. However, there is considerable diversity in the public policy goals and targets that aim to address health inequalities across different European countries.

In Spain, there is relatively little evidence of national policies to tackle socioeconomic inequalities in health, but there are a few examples of important regional or local initiatives. The different Spanish ACs specify their health policies in regional health plans, including principles and values, objectives, strategies and interventions to achieve certain goals over a specific time period. Borrell and colleagues undertook a systematic review of the health plans of the different ACs in Spain, excluding Madrid, Asturias and Cantabria. They found that the regional health plans tend to include a description of health areas by socioeconomic status (SES) rather than including specific policies to reduce inequalities in health by SES.

Exceptions include the health plans from the Basque Country and Extremadura, where descriptions of health by socioeconomic characteristics were made and the reduction of inequalities by SES were included in their key plan objectives. However, it was only in the Basque Country that specific policies linked to SES could be found. In particular, the Basque Country health plan adopted specific quantitative targets such as reducing social class differences in mortality from diseases of the circulatory system by 25% from 39% in 2002 to 30% by 2010. Elsewhere, while Galicia and the Canaries do not include a description of health status by SES, they do include some targets in respect of reducing inequalities in health by SES in their health plans.

In terms of regional inequalities, the central government is focused on improving equity in access to the health care system. The current Minister of Health recently expressed an interest in guaranteeing geographical equity in access to the health care system, meaning an equivalent level of benefits for all citizens provided independently of the place they live. For this purpose, one of the objectives of the current Minister of Health is to strengthen the role of the Inter-territorial Council of the NHS in order to enhance territorial cohesion.

Some initiatives developed by the central government target particular health care services or segments of the Spanish population with the intention of improving health. For example, as access to dental care varies throughout Spain, one central government objective has been to address this issue head on and assure equity in access to dentists for all children. Recently, it announced that it will become mandatory for all Spanish children between seven and eight years of age to have access to dentists free of charge from 2008. These treatments will be financed equally by the Ministry of Health in Madrid and the ACs. Access will then be expanded over the ensuing five years, with the goal of coverage for all children between seven and fifteen years of age by 2012.

Final comments
Although there has been an increase in the understanding of socioeconomic inequalities in health within Spain in recent decades, this has not impacted sufficiently on the policy agenda. At regional level, little attention is paid to inequalities in health by socioeconomic status in AC health plans. Few ACs take them into account, but even then not all areas are covered. The importance given in the literature to the effect of socioeconomic factors on individual health appears to be in contradiction to the lack of reference to this issue in health plans elaborated at regional level. There is also a lack of a national strategy to tackle health inequalities related to socioeconomic factors such as education, job status or level of income.

Thus there appears to be more to do in reducing regional inequalities in health and improving coordination mechanisms between the central and regional levels, so as to link evidence to policymaking. These equity challenges for the NHS should be addressed within the context of the broader goal of achieving a balance between diversity and social cohesion within the country.

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