HEALTH CARE AND FISCAL DECENTRALISATION IN SPAIN

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I. Introduction: Universal access and regional devolution

The consolidation of a universal system in Spain since 1986 coupled with a process of regional devolution ended in 2002, which have characterised the institutional reforms of the National Health System (NHS) in Spain. Spain is a widely heterogeneous country in many grounds due to economic as well as cultural and political factors. With the new democratic regime (1978), a devolved model of welfare governance had set up. Health and Education are in the core of Spanish fiscal decentralisation. However, the devolution process of health care to the regions, which ended in 2002, has brought some controversies about its effects on social cohesion and health care performance. Some suggest that devolution might lead to a more uneven geography of welfare. The Spanish National Health Service (NHS) has been one of the most dynamic European health care systems. In the early forties the health system was based on means test and covered around one fifth of the population, expanded to almost a half in 1960. During the 1960s and 1970s, significant investment, financed by the social security regime, was made in developing a brand new network of public hospitals and outpatient clinics, trying to show the social protection concerns of the dictator. Coverage was roughly 80% by the mid 1970s and, as it was commented earlier, it was with democracy, in the 1978 Constitution, when citizens' rights to health care were recognised. Health care was a central responsibility, basically financed by social security funds and partly financed by general taxes in order to offset the social security financial crisis.

With the approval of the General Health Care Act in 1986 under the second socialist government, the right to health care was defined in the lines of a *universal* and decentralised NHS. Although asset ownership of facilities nowadays still depends on Social Security, central and regional governments have put into force extended coverage and fostered the implementation of primary care reforms on decentralised basis. Finally, in 1999 the gradual transition in sources of tax financing towards a full general tax revenues financing regime was ended by the conservative party, and in 2002 the decentralisation process of health care to all the Spanish regions was concluded (previously only just the historical regions managed health care). All this has been achieved in less than three decades. Despite some problems are still there, which mainly concern on geographical equity and on the financial sustainability of the system, no doubts exist on the fact that the building of the Spanish NHS is basically a success story.

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Table 1 Comparative per capita health care expenditure among OECD countries in $ PPP 2000

	TOTAL	PUBLIC	PRIVATE
Austria	2162	1507	655
Belgium	2269	1616	652
Canada	2535	1826	709
Czech Republic	1031	942	89
Denmark	2420	1986	434
Finland	1664	1249	415
France	2349	1785	564
Greece	1399	777	622
Hungary	841	637	205
Ireland	1953	1480	473
Italy	2032	1497	535
Netherlands	2246	1517	729
New Zealand	1623	1266	357
Portugal	1441	1025	414
Slovak Republic	690	618	72
Spain	1556	1088	468
United Kingdom	1763	1429	335
United States	4631	2051	2580

Source: OCDE Data File 2003

II. The Spanish Health System: Main features

Universal access to health care to all citizens was formally included in the Spanish 1978 Constitution, articulated in 1986 by The General Health Bill, financially implemented (by fully substituting general taxed for payroll taxes) through a process ended in 1999 and regionally decentralised step by step since 1981 up to the present (2002).

Indeed, the Spanish National Health system is the result of a system consolidation process started in 1978 leading to the nearly universal coverage to all citizens. After the approval of the 1986 General Health Act, the health system became progressively universalised followed by the decentralisation of responsibilities to the Autonomous Communities (AC). In 2002 the decentralisation became completed and today all regions, with population ranging from 8 million inhabitants up to less than half have full health care responsibilities. In addition, a so called- Cohesion and Quality Law was passed by in 2003 stating the need of improving quality of care and stating the goal of geographical equality of health protection.

The NHS in Spain is financed today by funds raised through general taxation with user co-payments having a markedly restricted role (just for drugs, 8% of this expense). The population has the right of free access to services (even illegal immigrants are entitled to) and benefits are quite comprehensive, although minimal for long-term care and dental services, with some regional diversity in these concepts. Health care expenditure accounts for 7.5 per cent of GDP, and approximately three quarters (5.5) correspond to public expenditure and a quarter (2.1) to private expenditure (see Table 1 and 2).

Individuals supplement the NHS coverage by purchasing private health insurance (PHI), commonly providing not the publicly excluded care mentioned above, but some forms of primary care and hospital amenities. Insurers commonly offer a fixed providers' list, working in both public and private sectors under a flexible regime, more than on a pure reimbursement scheme.

Table 2. Health Expenditure in Spain 1995–2001

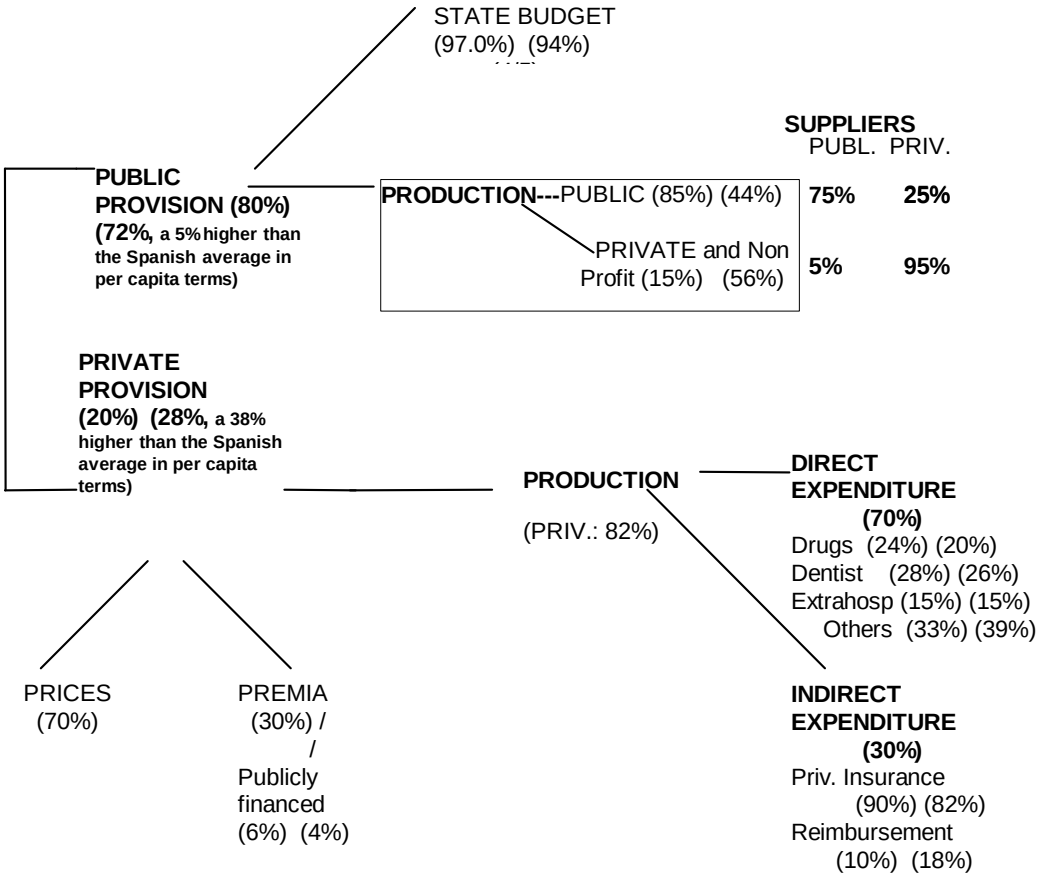
	1995	1996	1997	1998	1999	2000	2001
Public Expenditure							
Million €	24,125	25,686	26,877	28,616	30,681	32,671	35,131
% Total	72.3	72.4	72.5	72.3	72.2	71.7	71.5
% GDP	5.5	5.5	5.4	5.4	5.4	5.4	5.4
Private Expenditure							
Million €	9,262	9,774	10,176	10,978	11,831	12,866	13,987
% Total	27.7	27.6	27.5	27.7	27.8	28.3	28.5
% GDP	2.1	2.1	2.1	2.1	2.1	2.1	2.1
Total Expenditure							
Million €	33,387	35,460	37,053	39,594	42,512	45,537	49,118
% Total	100	100	100	100	100	100	100
% GDP	7.6	7.6	7.5	7.5	7.5	7.5	7.5

Source: Ministerio de Sanidad y Consumo, 2003.

Health care delivery is mainly undertaken through a network of publicly owned, staffed and operated inpatient and outpatient centres, with significant geographical differences in the way services are contracted out to the private sector (Catalonia, Madrid and Navarre as the most). Primary care is managed at the Health Areas' level with 50-100 thousand inhabitants. The distribution of health expenditure is 40% primary care, 57% inpatient care and 3% other. Freedom of choice of primary physicians and some basic ambulatory specialists is allowed, but no much exercised.

(Figure 1, here)

Figure 1.



Key words: Finance refers to the revenue sources; provison to the service responsabilities; production, regards to who produces the service; and supply, to the inputs ownership. Prices can be identified with direct expenditure and premia with indirect expenditure. Source: own elaboration, from different sources. In the second bracket, similar figure for the region of Catalonia, with the most different idyosincratic model oh health care.

The hospital average length of stay is 9 days and the bed occupancy rate is 80%. The number of beds per 1000 inhabitants is 3.9 and inpatients admissions 11.4. The average time per GP consultation is 6.6 minutes. Interestingly, the ageing process places its effects as the most frequent age cohort; whereas in 1982 discharges of people among 75 were 6.6% in 1998 they were 17.59%.

In parallel terms, Spain set up a process of asymmetric devolution to the regions, started in 1981, to three types of autonomous communities (ACs): a) ten new-branch type of regions (approximately half of the population) running education and some general services, but with no health care responsibilities and very low-powered regional financing (mostly state transfers) up 2002; b) five regions (Catalonia and Galicia plus some other aiming for a higher self-governance status as Valencia and Andalusia) having in addition to these services, health care responsibilities under limited fiscal self-responsibility (being politically more than fiscally accountable); c)and finally, a third group of two ACs (Navarre and the Basque Country) both fiscally and politically accountable, in running almost all public service provision in their boundaries, collecting taxes and transferring resources to the central state for the common services still in hands of the central government.

Devolution has gone hand by hand with democracy for the historic regions such as the Basque Regions, Catalonia and Galicia. In addition, decentralising decision-making has

been sees as a procedure to improve efficiency in both production and distribution of health services. As it has been emphasized in the literature, regional health systems can adapt better to specific health care demands and regional preferences. However, the split of responsibilities may cause concerns, given the lack of information and coordination of the central government among regions. We will describe in this paper the present fiscal arrangements related to health care regional finance.

III.- The regional decentralisation process

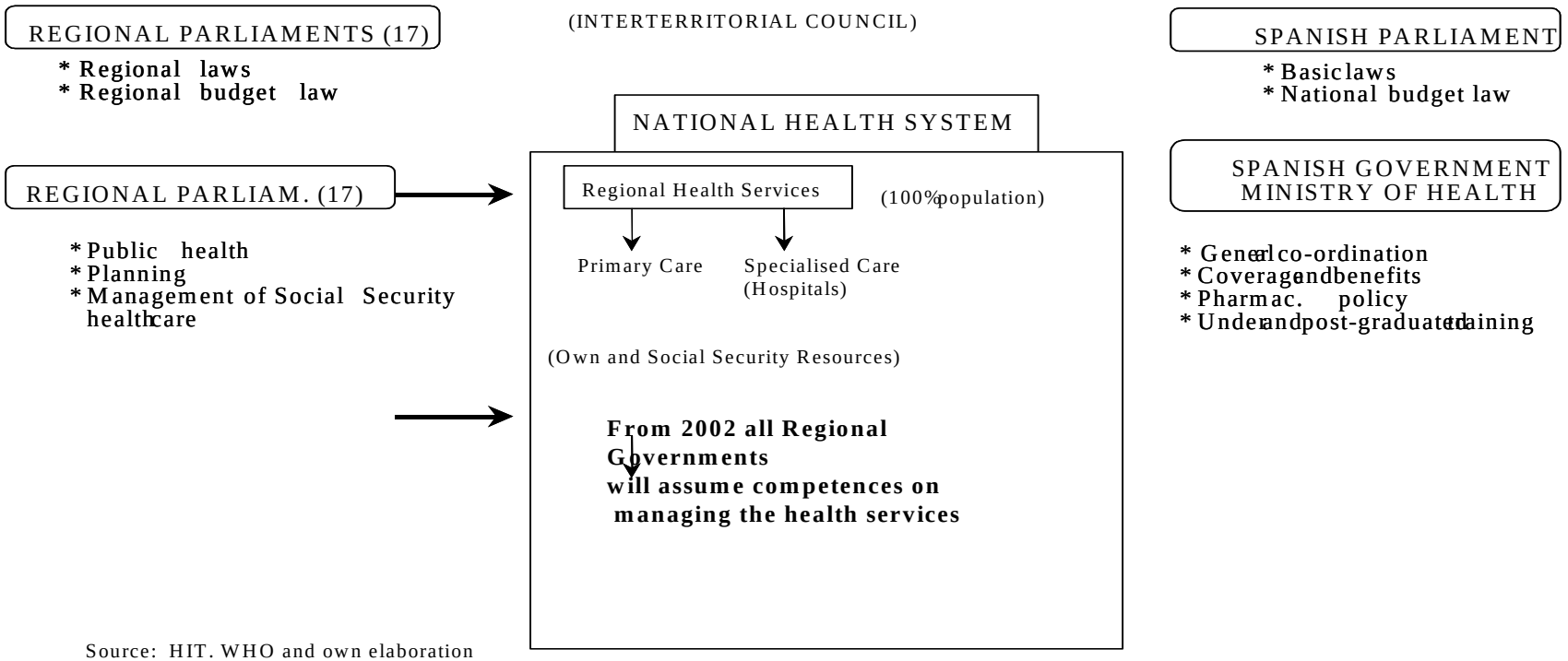
The Spanish NHS follows the model of a quasi-federalist state, where health care accounts for about 40 per cent of regional expenditure. The transfer of health responsibilities to Catalonia completed in 1981, followed by Andalusia and The Basque Country (1984), Valencia (1988), Galicia and Navarre (1991) and the Canary Islands (1994). Throughout the time, health care financing remained an exclusive central power, with the exception of two regions (the Basque country and Navarre), which have enjoyed almost full fiscal autonomy in accordance with their historical statutes. As previously commented, since 2002, all ACs have been empowered with health care.

Regional parliaments, initially in the seven regions listed above, and latter in all of them, have enjoyed large legislative capacity. Basic legislation is in principle issued by the central state. For certain common decisions, it draws on the input of the Inter-territorial Council of the NHS -an advisory committee involving representatives from central and regional governments-, where coordination must legally take place (see figure 2). Central governance of the public health care system is formally undertaken by the Ministry of Health (MoH), although in some critical domains the Ministry of Social Security (still the owner of the health equipments) and the Ministry of Finance exercise important powers. As a result, the MoH can be classified as comparatively weak, bearing in mind the shared responsibilities with other ministries at the central level, and the strength of regional ministries after the devolution process.

(figure 2 here)

Figure 2

Organizational chart of health care system



Source: HIT. WHO and own elaboration

III.1- The resource allocation process

Funds are centrally collected -with the exception of Navarre and the Basque Country, and for some minor taxes also the remaining regions (see figure 3). In the past (up 2002) the system has operated under a single central transfer. Once the Spanish Parliament determined the amount of health care expenditure in the National General Budget, expenditure was allocated to regions by means of a block grant according to a mostly unadjusted capitation formula. Although fiscal autonomy was increased in 1992 by transferring a 15 per cent of the personal income tax revenues collected in the regions (a percentage raised to 30 per cent in 1997), and by allowing to the AC a +/- 20% surcharge on the personal income tax, the vicious cycle of overspending -prevalent as normal practice both before and after devolution process- remained. The reasons for this practise included the lack of incentives to cut expenditure and the scarcely transparent fiscal agreement between the AC and the central state. In 1994, the government unsuccessfully try to commit expenditure growth rates to GDP increases and impose tighter conditions on the access to extraordinary financial resources, by defining full regional responsibility for any overspending. This later provision was, however, not very credible within the context of limited regional fiscal autonomy and regional political pressures for larger social spending. In 1997, the principle of quasi-capitation was again broken through the establishment of a supplement to compensate those regions which decreasing population. In addition, calculations for supplementary contributions for teaching and research and for cross-boundary flows were improved. By 2002, a deeper structural reform was implemented, ending with the split of regional health care finance from the rest of the regional transfers, by inserting health care funding in the general regional resource allocation system.

Under this new scenario, central responsibilities on health policy coordination are trying to be developed ex novo by the Spanish Department of Health, following the 2003 Health Quality and Cohesion Act. At any rate and purpose, Health care is the foremost policy responsibility of the AC, ranging from less than three hundred thousand millions up to over seven millions inhabitants. The central state forces however some symmetry amongst different AC, that makes for some regions (different historically, culturally and in self-governance aims) a ‘low quality’ decentralisation (‘coffee-for-all’ or ‘at the same speed’ all type of policies). Jointly with education, these social expenditure items account for 60 to 70% of total public funds in hands of AC.

Table 3 offers some basic indicators on health care outcomes.

Table 3 Health indicators by Autonomous Communities

	LE male	LE female	Mortality 2000	Infant M 2000	Neonatal M2000	Postnatal M 2000	Perinatal M2000	Premature M 1998	Premature M 1998
	years	years	rate per 1000	rate per 1000	rate per 1000	rate per 1000	rate per 1000	health care rate per 10000	health policy rate per 10000
Andalusía	73.5	80.7	8.3	5.8	3.5	2.3	6.9	18,32	11,04
Aragón	75.6	82.3	10.8	3.7	2.5	1.1	4.8	19,39	6,07
Asturias	73.1	81.3	11.8	4.6	2.8	1.7	7.3	20,90	8,45
Balears	73.2	81.1	9.3	4.6	2.5	2	8.2	22,49	8,03
Canaries	73.8	81.3	7.1	5	2.9	2.1	7	22,98	10,42
Cantabria	74.4	82.2	10.1	3.1	0.8	2.3	1.8	19,70	6,31

Castilla-LM	76.1	81.7	9.7	5.2	3.1	2.2	6	15,08	6,03
Castilla-León	76.3	83.2	10.4	3.6	2.6	1	4.4	22,34	5,93
Catalonia	74.7	82.3	9.1	3.8	2.4	1.4	5.2	14,50	6,44
Valencia	74.1	81	9.1	4.5	3.2	1.3	5.4	18,28	8,06
Extremadura	74.6	81.5	9.7	4.3	2.6	1.7	5.8	24,01	7,15
Galicia	73.9	81.8	10.6	5.2	3.1	2	5.3	17,21	6,88
Madrid	75.1	83	7.4	4.2	2.3	1.9	4.3	15,05	4,17
Murcia	74.5	80.9	8.2	5.9	3.4	2.4	6.9	25,50	7,30
Navarre	75.7	83	9.2	5.5	3	2.4	6.9	20,09	6,55
Basque C.	74	82.2	8.8	6.1	4.1	2	6.5	19,76	6,47
La Rioja	72.2	82	9.6	5.9	3.6	2.3	7.3	19,18	5,96
Total	74.4	81.6	9.4	4.9	3	1.9	5.9	-	-
INSALUD	74.5	81.9	9.7	4.5	2.6	1.9	5.7	-	-
CVTotal	0.015	0.009	0.129	0.186	0.239	0.238	0.260	-	-

Source: MSC 2002, INE and own calculation following De Manuel et al (2001) Methodology

III.2 -Decentralisation and efficiency

Health system changes for efficiency improvements in the Spanish National Health Service (NHS) in the last two decades deserve some attention. Built on contributively bismarckian grounds, the Spanish NHS is today a universal public system under an important decentralisation process with several agents trying to guarantee its financial sustainability. This part analyses the link between reforms and the overall system performance in order to achieve the goal of offering good quality health at a reasonable cost.

Spain ranks in a middle point in cost-containment compared to other NHS, and in terms of overall performance is fifth in the WHO table. Good value for money seems then to be achieved at the aggregate level. Decentralisation of health care to regions has aimed to bring efficiency improvements at the micro level by breaking a more central monolithic bureaucratic pattern and spilling financial pressures over more politically and fiscally accountable regions.

Health care reforms tend to focus on cost-containment analysis, but hardly ever there is an explicit assessment on what the health system buys and which is its worth. This is outstandingly important when health care management is devolved to several jurisdictions, accounting for regional heterogeneity, since a more diversified view of the system is exhibited. For all these aspects, Spain is an excellent case-study.

Indeed, health care is generally perceived as a right and recently in 2001 has been defined as an “essential public service” jointly with education. However, it is difficult to find the precise content of the health care Spaniards are entitled with and the explicit definition of NHS goals, both for the state and regions. Practice variations and differences in quality are present at personal and geographical levels, and some of them are better documented than others, and after full decentralisation, these disparities are monitored on a strong political basis. As stated in the 1986 General Health Care Act, the NHS is expected to work towards both health promotion and illness prevention, by providing health care to all residents in Spain, and achieving equality of access, as well

as to help to overcome social and geographical differences. Efficiency is blurredly defined and just very recently has become a primary goal (enhanced by the concept of financial sustainability). Therefore, the assessment about the extent to which policies adequate to its specific goals is an unavoidably normative and it is not always informative.

In the structural organisational arena, reforms in health care provision in Spain have lead commonly to the development of regional agencies for health care purchasing with a semiautonomous status (commonly public corporations) brought away from the Health Departments. Provision has been structured with primary care centres, with salaried full time physicians (instead of former capitated part-time doctors), and with a set up of contracting-out hospital care policies. All these measures have been particularly implemented in Catalonia (6 millions inhabitants and one of the more innovative AC), where there is a clearer split between public provision and public and private (non profit) production of health care, and more than half of the hospital activity is publicly financing non Social Security owned beds (see Figure 1 for the main differences between Spanish and Catalan Health Systems).

In financing providers, the public financer during the nineties had progressively included variable performance incentives (the so called 'contratos programas' as financial agreements on activity), with less than fully satisfactory results due to the lack of effective financial commitments for overruns. In addition, a supplementary health insurance for one sixth of the population, which is mostly developed in richer urban areas, provides an instrument for 'waiting lists avoidance' in elective care, as well as hospital amenities, and quick access to 'soft' private health care.

III.3- Some other organisational aspects

Primary care in Spain has progressively moved towards a better integrated public system, geographically organised in 'health zones' and managed at the health area level. Ambulatory care is organised in Health Care Centres, where most of GPs and specific specialists work full time with a basic salary payment and a civil servant status position (so there are weak incentives to limit spending). Although capitation formulas are progressively re-introduced in financing primary care (as it is the case in Catalonia and Valencia for some geographical areas), their effects are substantially limited by the fact that doctors are *salaried* (few with exceptions with physicians cooperatives and limited responsibility corporations, at the experimentation level these days in Catalonia) and the fact that finance does not account for the level of specialist referrals, nor the cost of drugs prescriptions. A gate keeping system was formally set up in 1986, so patients are asked to pursue GP referral to visit the specialists, unless they make use of the emergency care (the fastest growing item of expenditure, together with drugs, in the Spanish Health system). This process can be avoided by consuming health care privately. Accessibility and number of patients treated in primary care shows to performing better than the European Union average due to a larger follow up consultations. Spain has a surplus of health professionals, which doubles the UK ratio. This helps to depressed physicians' relative wages and allows the compatibility of public-private practice. About 70% of active physicians are employed in the NHS. Organisational reforms in primary care teams have been important in Catalonia. Some of the new organisations are self governed by their professionals and financed on capitation grounds. This has caused trade unions complaints on retributions and

working conditions of these professionals. Evidence on the effects on performance is controversial but overall results seem to be better and not worse than for the rest.

The hospital network is made up of approximately 800 hospitals largely dispersed among AC. With the exception of Catalonia, where just 36% of total beds are provided by public hospitals, the system is predominantly integrated (approximately 68% being publicly owned) although contracting out implies about a 15% of public expenditure. (see figure 3). The majority of the staff are salaried employees and hospital payment has moved from retrospective to quite-prospective payment systems. Spain displays one of the lowest EU ratios of hospital beds/1000 inhabitants. Trends exhibit a reduction in acute beds and a small rise of long term care centres. Reforms in organisation have been important in Spanish public hospitals. From 1997 on, some few public hospitals are self-governed, and since 1999 some other public hospitals have become independent agencies. These changes have also caused trade unions complaints on wages and working conditions, although there is no evidence on its effects on hospital performance yet.

Figure 3 Frameworks for decentralised Health Care.

FRAME 1

Planning/Insurance	**Purchasing**	**Production**
Health Department	Health Care Service	Managerial Units

FRAME 2

Planning	**Insurance**	**Purchasing**	**Production**
Health Department	Health Care Service	Regions, Areas	Managerial Units

FRAME 3

Planning	**Insurance**	**Purchasing/ Production**
Health Department	Health Care Service	Regions, Areas, Networks of Managerial Units

FRAME 4

Planning/Insurance	**Insurance Management /Purchasing**	**Production**
Health Department / Health Care Service	Networks of Providers / Non public Insurers	Health Care Managerial Units

During the eighties, health care management relied on introducing a contract system at hospital and service level based on activity. Catalonia and the Basque country were first to establish a sort of independent public agency to coordinate the public coverage function, while decentralising the purchasing at health care areas. In Catalonia, there was implemented a purchaser provider split and almost 2/3 of hospitals were private (non-profit). As a result, purchasing services from private sector hospitals were comprehensively integrated, with few exceptions. A weighted health care unit (UBA) was designed by the Catalan system to measure hospital activity and reimburse hospitals, which was finally adapted by the Spanish Ministry of Health. During the mid nineties, Andalusia and the Basque Country introduced a semi-prospective payment system based on DRG´s case-mix adjustment and in Catalonia, in1998, a system that

combines payment of hospital structure and activity DRG-measured was introduced in order to finance hospitals. In the past, INSALUD implemented a contractual system using indicators of the development activity, and contracts were linked to regional health plans to improve efficiency. However, there is some evidence about the lack of restrain of actual budgets and the so-called ratchet effect (Gonzalez López and Barber, 1996).

The NHS funds 87% of total pharmaceutical expenditure, which once added to the patient co-payment, amounts for the 92% of total pharmaceutical expenditure. There is a small density of pharmacies compared to other countries as UK, France or Germany. Pharmacies are paid under margin basis and regulation of drugs prices is based on a relatively recent reference pricing system, even though the so far unavoidable small market share of generics drugs (due to the late implementation of patents in Spain) does not allow for raising too many expectations for significant reductions of drug expenditure.

Long term care is characterised by a very low level of public home care (4% of total offer) and very low involvement of the public sector financing elderly residential care (only 40% is publicly financed) and just 6.9% was public financed (Casado and Lopez, 2001). Currently, Spain faces significant problems on how to integrate health and social care, where social care is in addition a responsibility of social security and of local authorities, although regulation is regionally determined.

Dental care is mainly provided by the private sector with the exception of some procedures (e.g., extractions). However, some regions have started to include coverage for dental care for children under a certain age (12) in their regional health care packages.

-III.4- The flow of funds

At the time of the approval of the Health Care Act in 1986, public health expenditure was mainly funded by social insurance contributions (74.27%); general taxation was 23.77%, and other sources around 2%. In 1995 the balance between general taxation and social insurance contributions was reversed (77.28% and 20.43%), and in 1999 general revenues accounted 97.6% and other sources (mainly co-payments for medicines, prothesis and other services) 2.4%. Today the NHS provides with hardly any exceptions 'universal health care' coverage funded by general taxation. As a result of the decentralisation process, the NHS health care package has slightly expanded, with some minor regional differences, in principle as a response to political preferences.

From a demand's side, the Spanish NHS still offers care free-of-charge at the access point, with infrequent and low co-payments (a 7% of total expenses on drugs) Non-transparent waiting lists counterbalance tight (particularly in the last decade) NHS budgets, playing the role of actual 'implicit prices'.

Private health care plays a complementary function to the NHS, when it does not provide coverage for certain services (e.g., dental care), and it fulfils the demand for quality of care (hospital hotel facilities and waiting list avoidance in primary care). Moreover, private provision is substituting NHS coverage, financed by public provision, for some civil servants at no additional cost (see figure 2). The share of the population

with these schemes shows a steady rise pattern from 1987 (12%) to 1992 (14.5%) leading to 15.5% in 1997, and loosing a relative share at present (not in monetary terms due to the constant increase in premia).

Up to 1999, a 15% tax relief in the personal income out of total private expenditure on health care was directly promoting private expenses, including the purchasing of private health insurance, although excluding luxury treatments (e.g., plastic surgery when this was not included in public benefits, or spa treatments). As a result, fiscal expenditure increased over time, both on total amount and as a percentage of total deductions: in 1990 amounted 3% of total fiscal deductions and doubled at the end of the period. Since 1999, tax expenditures were abolished from the personal income tax. They are considered expenses on the corporate income tax and not taxed as fringe benefits in the personal income tax. This seems to have reduced the fiscal incentives for private health expenditure

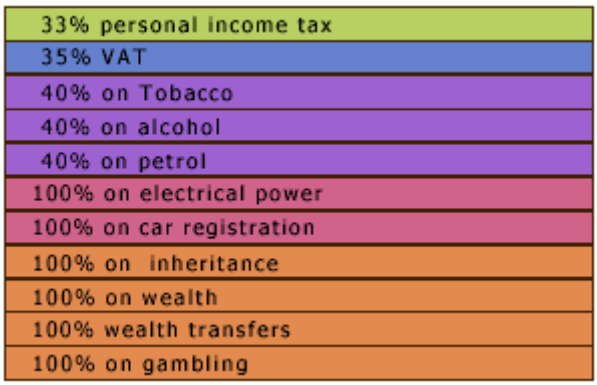
Cost containment goals lead to the definition of the basic package of benefits covered by the Spanish NHS. An example of this effort was the implementation of *negative lists* for pharmaceuticals, although in practice only minor drugs were listed. In 1995 the package of benefits was defined as distinguishing primary care, specialised care, pharmaceutical benefits and finally complementary benefits (i.e. prothesis, orthopaedic products, etc). As a result of the definition of NHS package, some benefits were implicitly excluded from coverage, such as some mental health treatments and diagnosis tests (psychoanalysis and hypnosis) and dental care (although Navarre and the Basque Country do provide some additional coverage), sex-change treatments (explicitly covered in Andalusia), regular health checks or plastic surgery. The "implicit" package does not include social nor community care, partly decentralised but under the hands of the Ministry of Labour and Social Affairs as a part of the social security regime. This has lead to the discussion about the coordination and integration of these services, and specifically on how social and long term care should be provided and financed. In addition, the Spanish Minister seems to be now willing to enlarge health care benefits (dental care, long term care, new drug therapies) too, but passing the bill, and so having the opposition of the AA.CC.

The NHS in Spain is nowadays financed by funds raised through general taxation with user co-payments having a markedly restricted role. The population has the right of free access to services and benefits are rather comprehensive, with the above commented exceptions, and some regional diversity.

IV.- The 2002 fiscal agreement to finance regional health care

As commented earlier, since the first of January of 2002, regional health care finance is included into the general financial ACs agreements. Given the importance of the health care budgets (around 40% of regional expenses), the future evolution of health care spending will seriously affect the overall regional finance. (Table 4)

Table 4: The new Tax Revenue Sharing System (01-01-2002)



Source: Own elaboration

As a result, health care transfers are not going to be determined anymore by political bargaining between central and regional Departments of Health, but between Finance Ministers at the regional internal level, and between the regional expenditure ministers within each AC. The regional parliaments will now have a more decisive ultimate word on heath policy issues.

The bottom line of health expenditure is estimated as the minimum amount to be spent. For this estimate two values should be considered: (i) the effective cost at the moment of the transfer and (ii) the share of the overall central expenditure funds according to population (weighted by 75%), age structure (by 24.5%) and the 'insularity factor' (just for the Balearic and Canary Islands, at 0.5%). If the former is above the latter, the central government is committed for three years to finance the basic figures increased by the GDP growth in nominal terms and at factor costs. However, over the basic amounts, each AC in the future will be able to spend whatever it wishes if financed by its own budgets.

Since 2002, general revenues to the regions to finance all the AC services (not just health) come out from revenues on sharing Personal Income Tax (33%), VAT (35%), Petrol, Tobacco and Alcohol Taxes (40%), and 100% of the revenues collected in the region from some other minor taxes (car registration, energy tax, inherited and donated dwellings, property transfer, gambling...). Initially, everything, including the equalisation central transfer, will be computed in order to guarantee that all the basic needs (health, estimated as described, and education - in per capita terms) are covered. Similarly for some pre-set increases over time (see Table 4)

Nevertheless, if revenue sharing capability increases, due to, for instance, an increase in percentage terms of regional consumption indicators, or a surcharge on personal income tax is applied (+/- 20%), no offsetting mechanism will apply to this additional expenditure. However, in order to preserve cohesion by avoiding 'excessive' deviation in per capita health spending amongst regions, central transfers will help those AC that show increases in public health coverage (say due to legal immigration) three points above the Spanish average. In addition, all the AC will have to finance at least some (increased) basic health care. On the other hand, no maximum is defined and then a mobile average according to the effective regional revenue raising capacity may result. The chances of devoting larger amounts to health care may come out of the open possibility to impose a petrol tax at the final retail level (as a surcharge) just to finance health care.

A Cohesion Fund to be funded by the central budget will devote resources to compensate for cross boundary flows of patients amongst regions. The central state is proposing to create a homogeneous information system and close to DRG type of billing, which needs, however, to be negotiated with the regional health authorities. Some regions seem to be prepared to co-ordinate themselves to avoid those adjustments without central intervention, as, for instance, it is the case for the extended central (Madrid and both Castillas) health region.

At any rate, some caveats exist on how the central state will compensate for new central regulations or pricing policies (new drugs to be reimbursed, centrally authorised new health technologies...) that affect regional expenses. Without compensation, regional acceptance is less likely. A defined basic entitlement package will become a necessity if patients are not to exploit differences. Diversity itself should not be a reason to concern (so legal precedent suggests) provided that the basic minimum package is covered and any additions are financed from regional sources. Handling other variations in policy, such as those applied to drugs, may not be straightforward. Although regions will not negotiate drug prices themselves, they may well influence the prescribing habits of their professionals. This will pose new challenges to the marketing departments of drug companies.

In short, since 2002 health care follows the general trend of regional financing, according first, to the evolution of revenues of a pre-established 'tax basket' (sharing on major taxes, excluded the corporation income tax), and second, to the regional priorities on public spending. All this is made under some central state safeguards (a minimum amount has to be committed by the Autonomous Communities every year for health care expenses), which are not easy to evaluate so far.

IV. 1.- Challenges and opportunities

At the beginning, the completeness and speed of the transfer came as a surprise, because past decentralisation (of seven regions accounting for 60% of the overall expenditure) was argued by some to have eroded social cohesion. This view was even supported by some trade unions in a recent publication of The Spanish Social and Economic Council. Secondly, the opposition party was divided in its views, one side representing a regional partisan view, while the other defended the idea on an alternative central Government keen not to weaken central powers. Thirdly, the speed of implementation was a surprise as some areas lacked detailed agreement at the moment, notably on finance (for instance, on costing services and redistribution parameters) and on the basic central regulation of health planning and co-ordination. The latter is not a trivial issue given that in Spain 10 AC have less than two million population.

Why then has this happened? A political interpretation is that politicians may think that health care is unmanageable in public hands (because of complaints, demands for extra resources, resistance to administrative change etc) and that decentralisation is a first step towards privatisation (jumping from the framework 4 to nowhere, as pointed in Figure 3). Additionally, by limiting central finance commitments, the central Government may protect its own purse while leaving the political costs to be faced by the regions.

There exists some caveats on this interpretation, as the Conservative Party is itself involved in managing health care in a number of regional Governments (Madrid, Galícia, Castilla –Leon and Cantabria) and there is only anecdotal evidence to support the view that the Conservatives favour privatisation of public facilities and finance. It may be the case that at present other arrangements looked extremely complex. For example, organising health care for 40% of the population, with high disparities between the INSALUD centrally managed regions (because of the impact of the generous treatment of the Madrid AC) by consortia agreements, regulated cross boundary flows and other mechanisms proved to be very complicated. Moreover, there was an expectation from partisan politicians that transferring health powers would change political powers both between Nationalist/Socialist and Conservative administrations and even within Conservative areas of influence.

A further consideration is that the extension of devolution has been a way of weakening the search for a differential power position by the more nationalistic ACs (Catalonia, Galicia, Basque country and Navarre) in favour of the so called "café para todos" (*coffee for all*). By devolving health care to all the regions, arguments to pass a new bill (may 2003) to 're-order' the whole autonomic process are made more likely. This has proved to enable a re-centralisation of powers under the general arguments of 'coordination' and the need of 'social cohesion'.

IV.2- A general assessment: The future evolution of regional health care finance

The integration of health care finance under the general financing system for all the AC for an indefinite period should end a political process that has been very contentious. The past system has promoted little consensus amongst health authorities, with merely the claim of more resources from central Government as common point. There have been endless disputes on the size of the share each region should have relative to the others and, as a result, all health problems have been presented as due to lack of resources, with little discussion of evidence based on new policies.

Under the new arrangement, complaints about central under-finance of regional health care will have to cease. This is appropriate because, despite common perception, Spain is not an unequal country in terms of health delivery and finance. This is borne out by a recent study (BBVA Foundation and the Institute of AC Studies, 2001) that evaluated the impact of regional health policies since the first health transfers for Catalonia in 1981. Indeed, the coefficient of variation in regional health care finance per capita is one of the lowest amongst health care systems for which territorial health care expenditure may be identified. By contrast, France and England are among the countries with most uneven distribution of health care resources. This probably reflects the fact that in these countries health regions are a geographical artefact with no parallel in regional Government. Therefore, these differences are not readily translated into the political arena, as happens in Spain or Italy. This means that the central Government is under little political pressure to justify the differences that exist.

Additionally, the differences observed between regions in Spain are related to relatively few programs that have little practical relevance to health status. For example, Andalusia finances from the public purse certain low therapeutic value drugs that are

exempted in most of the other regions; only a few regions will finance sex change operations or the "morning after" contraceptive pill.

These differences should cause little concern in equity terms as they reflect different political views on public preferences. They should be self-financed as there seems little basis for interregional transfers to support them. Indeed, where conducted, regional opinion polls seem to favour keeping such decisions close to the citizenry affected.

As a final point, we should also recognise that we know relatively little about health differences that derive from variations in quality of care and variations in clinical practice. It is probably not the case that there is a fundamental regional pattern in such disparities. The main equity concern probably relates to intra regional differences rather than interregional differences. Those who have spoken loudest against the dangers of interterritorial inequities have not usually made most effort to redress imbalances between local areas within the regions.

V.- Final comments: fewer taboos about geographical equity and more fiscal accountability

At the time of writing this paper, I have had the opportunity to read '*Better Health Systems for India's Poor. Findings Analysis and Options'* from the Human Development Network of The World Bank 2002. Thereafter, It is even more difficult to me to feel able to advise on what to do and not to do in the Indian context in order to improve health of the Indian population. My heart tells me in any case that economic growth is the way forward. For this, unfortunately, be prepared to see how income inequality increases and be aware in the meanwhile to check whether this leads to health improvements among those in the most poverty levels. In addition, do not be afraid of diversity: allow for differentiation and experimentation, not trying to fight inequity by uniformising health care delivery at the federal level. And finally, move society and politicians towards a cultural change in order to make possible that one day there would a minimum consensus in parliament for entitling the right to health care access to the whole Indian population.

For this purpose only the Spanish experience can be of some interest; this is, the implementation of a regional decentralisation process as the way to change the existing situation for improving health care management, going this hand-by-hand with the extension of universal coverage of health care as a democratic value.

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