ESPN Thematic Report on Challenges in Long-term Care

Spain

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Summary

At the end of 2006, Spain introduced regulations for a long-term care (LTC) system that recognised the right to social protection for dependent people. The system guarantees universal coverage, on the basis of cooperation between the central administration and the Autonomous Communities and is integrated into the network of regional and municipal social services. While service oriented, it also provides cash benefits to informal caregivers and for personal support. In practice, it is a mixed system that combines the coverage of public benefits with informal care in households; it is heavily dependent on women, who account for more than 62.4% of the caregiving population.

The dependent elderly population over 65 years of age accounts for 72.2% of all beneficiaries of the system, and those over 80 years old for 54.5%. Women are the main beneficiary group, both in relation to the total population (53.4%) and (particularly) in relation to the population aged 65 and over (73.8%).

In the future, it will be necessary to strengthen formal care structures, as informal carers will not be able to meet the growing needs of LTC in the medium or long term, due to population ageing, the growth of the dependent elderly population and changes in the size and structure of the traditionally caregiving population.

Implementation of the LTC system in Spain was virtually frozen between 2012 and 2015 on account of fiscal consolidation policies. These have led to downward adjustments in public expenditure, which have negatively affected the extent of coverage, the protective intensity and the quality of benefits, especially in relation to community services and cash benefits. However, beyond the impact of the financial crisis, the System for Autonomy and Care for Dependency (SAAD) must be assessed comprehensively 10 years after its creation. Over its 10 years of existence, the SAAD's performance as a social policy has demonstrated positive aspects, such us the creation of a system of universal coverage for situations of dependency, support for informal caregivers, and an expansion in community services (as opposed to residential services). Among the challenges, it is worth highlighting the persistence of waiting lists for access to benefits even for people whose right to social protection has already been recognised; the deficient quality of certain employment positions within social services; the excessive differences in coverage among the Autonomous Communities; the decreasing financial commitment of the central administration; and the shortfalls in the development of institutional coordination between social and health services in the field of dependency.

A series of recommendations emerges from this assessment, aimed at improving the LTC system in terms of both its coverage and the quality of care. They include the following: recovering the lost investment efforts in LTC, especially on the part of the central administration; sharply reducing the waiting lists and expanding the supply of cost-effective home-based and community-based services that are in demand; improving the quality of employment, the training of informal or non-professional carers, and the compatibility between caregiving and employment for carers; and making progress in the coordination between the central administration and the Autonomous Communities, and between the latter and the municipalities, since the current performance disparities between Autonomous Communities are excessive and generate inequalities in the coverage and intensity of social protection. It is also necessary to develop indicators that better measure SAAD coverage by calculating it in relation not only to the total population, but also to the population that potentially needs it. There is also a need for official sources of information to collect more disaggregated data on employment and on LTC expenditure in relation to employment and expenditure on social services in general. Finally, it is necessary to standardise the criteria for allocating expenditure on the services and benefits associated with the SAAD among the different administrations, by developing analytical accounting that allows for greater detail on LTC expenditure and for a similar budgetary treatment of co-payments among regions.

1 Description of the main features of the long-term care system

1.1 General characteristics of policies

The current Spanish long-term care (LTC) system emerged in 2007, after the approval in 2006 of Act 39/2006 (Law on the Promotion of personal autonomy and care for dependent persons – LAPAD).[1] Prior to 2007, LTC in Spain was basically provided through informal carers (mostly women), whose costs were basically assumed by dependent people themselves and their families. LTC was very limited and subject to strict medical and official controls. Formal care was integrated into the social security system and social services system. It is currently integrated into the Regional Social Services System (*Sistema Autonómico de Servicios Sociales*).

The approval of Act 39/2006 resulted from wide consensus among stakeholders. The Act established the so-called System for Autonomy and Care for Dependency (SAAD). This system defines a universal right for all those who, regardless of age, can demonstrate stable residence in the country for at least 5 years and one of the degrees of dependency established in the Act (Moderate or Degree I, Severe or Degree II and High Dependence or Degree III).

As a consequence of the economic crisis, the LTC system was modified in 2011, 2012 and 2014 with the aim of reducing expenditure on the SAAD. Currently, the debate focuses on improvement to and sustainability of the system approved in 2007. A Commission for the Analysis of the Situation of Dependency has started work on the revision of LAPAD, in order to improve the sustainability and current financing mechanisms of LTC.

1.2 Principles of governance and system organisation

The central government regulates the basic conditions that guarantee the equal exercise of the right across the nation, and is also responsible for the Information System of the System for Autonomy and Care for Dependency (SISAAD). By means of the Inter-territorial Council of the System for Autonomy and Care for Dependency (CISAAD), the central government and the regions agree on a framework for intergovernmental cooperation, the intensity of services, the terms and amounts of economic benefits, the criteria for co-payments by beneficiaries, and the scale for the recognition of dependency. The regions represent the operational structure of the system, as they have responsibility for managing the register of providers, for inspecting and evaluating the dependency degrees according to the official evaluation scale, and for recognising the right to benefits (Rodríguez Cabrero and Marbán Gallego, 2013). Local authorities take part in CISAAD and can also complement the basket of benefits within their constituencies, mainly by financing community services. In practice, though, they play a subordinate role in the system.

1.3 Type of financing

The system is essentially financed by taxes and co-payments by beneficiaries, according to their income and assets, and the type of service received. It is financed jointly by central government and the regions. There are various levels of public funding: a) the *minimum level,* which is the same throughout the country and which is financed by central government; b) the supplementary *agreed level,* co-financed by the central government and the regions; and c) the *additional level,* voluntarily financed by the regions from their own budgets. Each regional government may establish a wider set of benefits for its residents.

[1] LAPAD, http://goo.gl/amWVXq

1.4 Type of benefits: description, evaluation of needs and eligibility criteria

The SAAD includes different services and cash benefits.

The main LTC services are the following: technical assistance, home care, day/night centres and residential care. There is no free choice of professional providers. Technical assistance includes home tele-assistance (advice via the internet, alert system, monitoring system, etc.), which is offered to persons with a moderate degree of dependency who live at home. The home care service can be considered a support service for the carer of persons with a high degree of dependency. It includes help with personal care. The day centres have a double objective: 'improving and maintaining the highest possible level of personal autonomy and *supporting the families or carers*' (Article 24 of LAPAD). Night centres provide a respite service and are much less widespread than day centres; they are considered primarily as a support service for carers. Residential care may be permanent if it becomes the dependant's habitual residence (only valid for Degree II or III dependants), or temporary (involving short stays for convalescence, holidays and illness, or to provide some rest for non-professional carers). Institutional LTC service providers include regional and municipal centres, as well as private sector institutions (Rodríguez Cabrero et al., 2016). The providers forming part of the SAAD network must be accredited by the Autonomous Regions. The CISAAD[2] sets the state-wide criteria with respect to staff qualifications, minimum careworker-to-recipient ratios and material resources, equipment and documentation.

There are cash benefits for informal care at home and for personal assistance, as well as a cash benefit linked to the purchase of services. These cash benefits and their amounts are granted according to the person's degree of dependency and economic resources. In 2018, the cash benefits range from EUR 153 (Degree I dependants) to EUR 387.64 (Degree III dependants) per month for informal care at home; and from EUR 300 to EUR 715 per month for personal assistance or for the purchase of services. Beneficiaries do not have discretionary use of cash benefits. In the case of cash benefits for informal care at home, the care must be provided by family members[3]; only in exceptional circumstances it can be provided by others in the home setting. Households can choose informal carers freely, so long as they meet the requirements. This benefit is granted if the beneficiary has been cared for by non-professional carers in the year prior to the application, and only if there is no suitable formal care available. The amount received may be lower, because (depending on the beneficiary's income) there may be co-payments that have to be deducted from the amount of the benefit. Informal carers can subscribe to voluntary insurance in the social security system with reduced contributions (until 2012, contributions were paid for by social security). The allowance must be used to compensate the informal carers for their work and the costs of care in the household setting. In practice, these amounts cover only a very small part of the costs of care. However, the public administrations do not usually check whether the money received by the beneficiaries goes on these expenses. The cash benefit for personal assistance is geared towards hiring a personal assistant for a number of hours, to improve the dependent person's personal autonomy and access to work/education, as well as to provide help with daily activities, regardless of the degree of dependency (until 2012, this was only allowed for Degree III dependent people). The beneficiary may hire an accredited company or a worker registered with social security as self-employed. The cash benefit linked to the purchase of services[4] enables the care recipient to contract services from private licensed providers if the public sector is not able to provide these. There is free choice of professional providers. Services may be home assistance services, day centres, night centres or residences, depending on what is established in the

[2] Resolution of 2 December 2008, http://goo.gl/Q1QfxU partially amended on 7/10/2015.

[3] Spouse and family members up to the third degree of consanguinity, living in the same home as the dependent person before requesting the benefit.

[4] More details at: http://goo.gl/UWF3YQ

Individualised Care Plan (*Plan Individualizado de Atención* – PIA) according to the degree of dependency. The amount received can only be used to contract services.

The beneficiaries of cash benefits for personal assistance and cash benefits linked to the purchase of services are usually asked to account for how the sums they receive are spent.

There are some incompatibilities between cash benefits and services. The cumulation of cash benefits with benefits in kind is not possible, except for services to prevent situations of dependency, to promote personal autonomy and for tele-assistance.

Eligibility is determined through an assessment of the degree of dependency, evaluated on the basis of the Scale of Dependency by a qualified professional, who carries out interviews and direct observation of the person in his/her everyday environment. The degrees of dependency are determined according to the frequency and intensity of the assistance required (Moderate/Degree I: intermittent support at least once a day; Severe/Degree II: extensive support two or three times per day; High Dependence/Degree III: indispensable and continuous support several times a day). Once an individual has been assessed as being in need of care, an Individualised Care Plan is prepared by the social services, including a list of appropriate services or cash benefits according to the degree of dependency.

On average, each beneficiary receives 1.23 different benefits. The availability of LTC services varies across the different regions: in Madrid, Castile-La Mancha, The Rioja and Andalusia, service benefits represent over 70% of all benefits; whereas in the Balearic Islands, Valencia, Extremadura and Navarra they represent only around 30%.

The cash benefit for informal care at home is the most common of all benefits: according to SAAD data, in December 2017[5] 385,476 beneficiaries received it (32.7% of all dependent persons receiving benefits, compared to 54% in January 2014); 9.4% of beneficiaries received a cash benefit linked to the purchase of services; and 0.56% a cash benefit for personal assistance. In-kind benefits represented over 57% of all benefits: in December 2017, 13.3% of beneficiaries were receiving residential care; 16.5% received assistance in their homes; 15.8% were included in a programme of home tele-assistance; 7.7% received services in day/night centres; and 3.9% received prevention benefits.

People aged 65 and over constitute the majority of beneficiaries of the LTC system. Thus, on 31 December 2017, 72.2% of the entire beneficiary population were over 65 years of age and 54.5% were over 80. By gender, women over 65 account for 53% of all beneficiaries of the system and 73.8% of all beneficiaries aged 65 and over.

1.5 Balance between institutional and home care services

In Spain, home care services predominate over institutional services. According to the SAAD, 32.3% of beneficiaries received home care services (tele-assistance, home care), compared to 13.3% of beneficiaries receiving residential care (21% if day/night centres are included) in December 2017. With regard to the population aged 65 and over, the percentage of the population receiving institutional services was 1.9%, while 7.1% received home care services (OECD Health Statistics, 2017).[6]

1.6 Balance between and levels of informal and formal care

The care model in Spain is above all family based, female dominated, informal and time intensive. Concerning formal care, since 2015 all professional carers have been required to hold an intermediate professional training qualification or a certificate of

[5] SAAD website: https://goo.gl/tMqgqp

[6] OECD Statistical Online database on long-term care resources and utilisation: https://goo.gl/WVJ8iD

professionalism. Some studies have pointed out that a large proportion of formal caring jobs tend to be temporary and that there are few mechanisms for staff promotion (Aragón eta al., 2008), as we will explain in Section 2.

As for the training of non-professional carers, the CISAAD sets common accreditation criteria. According to the OECD (Colombo et al., 2011), Spain has one of the highest percentages of informal carers (15.3% of the population) and is among the highest-ranked countries in the OECD (more than 20 hours per week) in terms of the number of hours dedicated by family carers. More recent estimates point out that 15.7% of dependants over 65 years of age receive mixed care (formal and informal), with the rest receiving only informal care (Minguela and Camacho, 2015). According to Bouget et al. (2016),[7] in 2010, 62.4% of those who regularly take care of relatives/friends aged 15 or over and in need of care were women (60.2% in the EU-28). More than half (51%) had a low level of education, and 47% were over the age of 50. Other sources emphasise that there are three times more informal female carers than male, a figure that rises to 4.5 times for those under 65 years of age. Those between the ages of 30 and 65 assume over 80% of the burden of care (Durán, 2015).

In any case, it will be necessary to strengthen formal care structures in the future, as informal carers will not be able to meet the growing need for LTC in the medium and long term, especially given the following considerations:

- Projections on the need for LTC care in Spain indicate an increase in the dependent population from the current 1.4 million to 2.2 million in 2030 (Abellán et al., 2017). According to the Ageing Report 2015 (European Commission, 2015) the share of dependants in Spain will increase from 5.3% of the total population in 2013 to 6.5% in 2030 and 8.6% in 2060 (an increase of 64%).
- The proportion of potential dependants in relation to potential caregivers[8] has tended to decrease: it is estimated that the number of people aged 80 and over will increase from 22% people aged 45-64 to 25% in 2020 – and to 63% by the middle of the century, triple the current proportion (Abellán et al., 2017).
- The number of dependants over 65 living alone or as a couple has been increasing, while the relative weight of multigenerational households has been decreasing (CIS, 2014). Likewise, it is estimated that the number of women reaching 65 years of age without having children will have doubled by 2040 (Abellán et al., 2017).

[7] See Statistical Annex in Bouget et al. (2016). Data based on LFS ad hoc module, 2010.

[8] These indicators reflect the possible relationship between people aged 80 and over, where the proportion of dependants is very high, and potential caregivers aged 45-64 years, the age cohort which clusters the majority of caregivers.

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

2.1 Assessment of the challenges in LTC

2.1.1 Access and adequacy challenge

The Spanish LTC system is characterised by a combination of formal and informal care. This is because of the medium-low development of the provision of public and private services and because of the weight of family tradition, which continues to prioritise care at home under the direct or indirect control of the family. In the latter case, it is important to highlight the importance of the formal or informal recruitment of migrant workers by households with dependent persons, especially as substitutes for working women.

The expansion of the social services' LTC offering since 2007 has progressively shifted towards home care and community-based care (day and night centres and home tele-assistance). However, the public and private supply of these services remains inadequate to meet potential demand. Residential care does not appeal to dependent persons or their families: in fact, in the first decade of this century there was an oversupply of residential places – places that were not occupied either due to their cost or because of preference.

Despite the limitation of the supply of social services for dependent persons, the beneficiary population amounted to 738,587 in December 2011, 5 years into the implementation of the law. The fiscal consolidation policies implemented from May 2010 and especially from April 2012 froze the extension of coverage, which reached a low point in 2014 of 736,267 beneficiaries. In 2015, the extension of coverage resumed, with 796,109 beneficiaries by the end of that year and 954,831 by 31 December 2017 (an increase of 31.1% between 2011 and 2017). The incorporation of the Degree I, level 1, dependent population on 1 July 2015 is the main factor explaining the new growth in coverage.

The freeze in the expansion of coverage during the most acute years of the financial crisis has meant that the availability of services and benefits suffered a rollback for a period of almost 5 years – that is, during the period 2011-2015. On the other hand, people have little precise knowledge of the potential supply of care services for dependency, since these are usually integrated into the general offer of services for people over 65, as evidenced by the latest Report on Older Persons in Spain (IMSERSO, 2016). The public supply received by the beneficiaries of the SAAD must be considered effective. There is no information on the non-take-up rate in this system, but some will be people with resources who do not apply for social benefits from the public system.

According to the SAAD, there were 1,264,951 people included in the SAAD as potential beneficiaries in December 2017, although only 954,831 (689,650 are 65 and over, 7.9% of the total elderly population) were receiving benefits (the remaining 310,120 – 24.5% – were on the waiting list). In December 2017, 2.05% of the population was receiving LTC benefits in Spain. This figure was 3.66% in Castile-Leon, 2.83% in the Basque Country, 2.63% in Cantabria and 2.53% in Castile-La Mancha, but only 0.92% in the Canary Islands, 1.24% in Valencia and 1.50% in the Balearic Islands.

The coverage of public LTC for people over 65 years of age can be assessed on two levels. SAAD beneficiaries aged 65-79 and 80 or over account for 2.8% and 18.7%, respectively, of the total population of those age groups. On the other hand, it is worth assessing the extent to which the coverage of the dependent older population envisaged by the system in 2007 has been achieved. Based on estimates of the dependent population (Jiménez Lara, 2014; Rodríguez Castedo and Jiménez Lara, 2010), the coverage of the dependent population over 65 by SAAD was 59.4% in 2011. Updating

the estimate of the dependent population for 2017, the coverage ratio of SAAD beneficiaries aged 65+ over the total dependent population estimated for that age group was 62.1%. Although it is a significant coverage ratio, there is still ample scope for enhancement of social protection for the population aged 65 and over in a situation of dependency. Had there not been a freeze on the expansion of the LTC system between 2012 and 2015, the coverage rate would probably have been higher.

The second problem of the Spanish LTC model is the unequal implementation and coverage of the system in the different Autonomous Communities. This problem has not been corrected over time and constitutes an obstacle to the objectives of equality and effectiveness. This inequality in coverage between regions is due, on the one hand, to the different personal social services systems (in which LTC is institutionally integrated), and on the other to the very different institutional and financial commitments of the Autonomous Communities in relation to care for dependency. In addition, there are problems of coordination between the different levels of government, central and regional, whose cooperation is key to the effective development of the SAAD (Arlotti and Aguilar Hendrickson, 2016, 2017; Martínez-Buján, 2014).

A chronic problem of the LTC system is the long wait between formal recognition of dependency and the actual exercise of the right to an economic benefit or service (known as an 'Individualised Care Plan'). In December 2017, this waiting list affected 25% of those entitled to recognised protection. This percentage varies from 37% in Catalonia and the Canary Islands to 1% in the Community of Castile and Leon. It is estimated that 27% of SAAD deregistrations between 2012 and 2017 were due to the death of people with recognised rights to care, but who did not qualify for the benefit system because they were on a waiting list (around 150,000 people during those years).

In short, SAAD is a system characterised by a territorially unbalanced availability; a coverage of the dependent population hindered by a long and chronic waiting list; and a limited affordability, given its inadequacy to address the needs of the most serious degree of dependency and the low protective intensity of the benefits, which requires them to be supplemented with family assistance or economic resources.

2.1.2 Quality challenge

The requirement of quality and efficacy of SAAD is regulated by the Dependency Act of 2006, which covers the quality of services, the training of professionals and carers, the information system and the fight against fraud. This regulation was later developed in detail in order to specify the quality requirements in terms of the accreditation of the centres and services, the minimum benefits and the quality of professional work.[9] However, there is no comprehensive analysis that assesses the quality of services and dependency benefits.

In the assessment of quality, it should be noted that there are no evaluations of the gender impact of the feminisation of care, or of the impact of the suspension of the payment of social security contributions for informal home carers by the government since mid-2012.[10]

The care sector creates jobs. Thus, in 2016, the ratio of direct employment to every million euros of public expenditure was 35, according to the Association of Directors and Managers in Social Services (Association of Directors and Managers, 2017). In 2016 (with data as of 31 December), it is estimated that there were more than 197,380 direct jobs

[9] BOE (17.12.2008). On common criteria of accreditation to guarantee the quality of centres and services for autonomy and dependency care, see https://goo.gl/mroLSn Regulation modified in 2015 (BOE 16.11.2015) at https://goo.gl/kkD9Co and 2017 (BOE 30.12.2017) in order to update the professional qualifications and quality care (https://goo.gl/E4mt9o).

[10] Until mid-2012, the government paid the social security contributions for the non-professional home carers of beneficiaries of the cash benefit for informal care at home.

associated with LAPAD in Spain.[11] This is only an estimate, since there is a significant volume of employment in social services associated indirectly with the dependency system (Martín-Serrano Jiménez, 2014).

However, the quality of employment is among the darker aspects of SAAD. The pioneering study by Aragón et al. (2008) assessed LTC employment as a precarious sector, with low levels of remuneration, high psychosocial risk and the need for training. These features seem to have persisted, according to more recent studies (Martín-Serrano Jiménez, 2014; Comisiones Obreras, 2017). According to the latter, the temporary employment rate in the residential sector was 38% in 2008, dropping to 24% in 2013. In community social services, the rate of temporality was higher at the beginning of the implementation of the SAAD (45%) and has tended to decrease over time. With regard to part-time contracts, the rate was 18% for residential services and 39% for community services in 2017 (the rate for the Spanish economy as a whole was 14.7% in 2017).

The challenge for employment in the LTC sector is the set of qualifications required according to the different professional profiles. The inadequate supply of training and the lack of plans for professional accreditation have hampered the goal of having all staff qualifications accredited by 2015. Also non-professional care was regulated in 2009 in order to guarantee the quality of care.[12]

Finally, the quality of LTC also rests on the adequate and efficient coordination of social and health services. Discussion of this topic is prevalent among public managers and professionals. However, the different professional cultures, administrative inertia and the absence of a robust commitment at the state level have impeded the development of this objective, which is nevertheless a practice implemented selectively in the different Autonomous Communities.

2.1.3 Employment challenge

Women are the main informal carers of dependent persons in Spain, comprising around 62.4% of the informal caregiving population. Historically, they have shouldered the burden of care. Despite cultural changes, new attitudes and relative advances in the distribution of the caregiving burden, women continue to assume responsibility for and the bulk of caregiving.

Informal care reduces the opportunities for participation in the labour market. Besides, the demand for employment in companies remains insufficient to provide for older female carers, who find themselves obliged to accept part-time jobs. As noted in the Spanish report 'Work-life balance measures for persons of working age with dependent relatives' (Rodríguez Cabrero et al., 2016), the most significant problem is the lack of labour activity for women caring for family members due to cultural reasons, because there is a lack of public services for dependent persons or an inability to pay for them. The proportion of women not in active employment is high, reaching nearly half the female population (46%). Nearly 14% of women regularly care for dependent family members.

A crucial problem remains the existence of informal work in the dependency sector, which usually employs women migrant workers who are primarily engaged in domestic

[11] There is no specific heading in the National Code of Economic Activities (CNAE) identifying the activities of LTC. They fall under two more general headings: assistance activities in residences and social services without accommodation. Obviously, LTC employment is a part of employment in social services.

[12] BOE (27.11.2009): Agreement of Inter-territorial Council of the System for Autonomy and Care for Dependency on common criteria for training and information of non-professional care. Available at: https://goo.gl/TMDgjr; BOE (16.3.2010): Agreement of Inter-territorial Council of the System for Autonomy and Care for Dependency to improve the quality of monetary benefit for family carers. BOE (17.12.2008) On common criteria of accreditation to guarantee the quality of centres and services for autonomy and dependency care Regulation modified in 2015 (BOE 16.11.2015) and 2017 (BOE 30.12.2017) in order to update the professional qualifications and quality care.

work and in accompanying lonely and dependent persons, but who do not have the required training for care.

2.1.4 Financial sustainability challenge

Spain belongs to the group of EU countries with LTC systems characterised by medium coverage, which are mainly financed by general revenue, with a significant weight of the informal care support sector.

Expenditure on LTC varies depending on whether we consider only expenditure on social services or if we add up the health expenditure associated with dependency. In the case of Spain, it is estimated that public expenditure on social services for dependency was around 0.9% of GDP in 2013 (European Commission, 2015). According to other sources, such public expenditure was around 0.7% of GDP in 2016 (Association of Directors and Managers, 2017). The financing of the SAAD was distributed as follows: 63% by the Autonomous Communities, 17% by central government and 20% by co-payments. This estimate is generally shared by the different experts (Montserrat, 2014; Prada Moraga and Borge González, 2015; Oliva Moreno, 2014).

These studies emphasise the need not only to recover the expenditure lost during the period 2012-2015, but also to make a financial effort to respond to the growth in the dependent population, and to the challenge of improving the quality of care and the quality of employment. Otherwise, the cost of care will fall on households – and the burden of care primarily on women. This requires new institutional commitments and improvements in the coordination of LTC policies between the central administration and the Autonomous Communities. This should translate into public spending of around 1-1.5% of GDP, which means recovering the level of complementary financing agreed between the central administration and the Autonomous Communities but suspended in 2012, the purpose of which is to carry out investment in services.

Improvement in efficiency and effectiveness is still lacking, due to the limited scale of the development of home care and community-based services; deficits in the coordination between social and health services; and the dispersal of some of the existing LTC innovations – especially the models and practices of comprehensive and people-centred care, which are undergoing broad development in Spain (Spanish Society of Geriatrics and Gerontology, 2017; Rodríguez Rodríguez, 2013).

2.2 Assessment of the recent or planned reforms and how they address the challenges in LTC

The LTC system was modified in 2011, 2012 and 2014.[13] The measures introduced since July 2012 have contributed to the strengthening of the financial sustainability of the system, but at the expense of coverage and the intensity of protection. The Association

[13] In 2011, the Royal Decree 20/2011 established that moderately dependent people (Degree I) should wait until 2013 (level 2) or 2014 (level 1) to be incorporated into the system. A new reform arrived barely 7 months later, with the Royal Decree 20/2012 that included, among other measures, a reduction in the minimum level of funding, a reduction of 15% in the amount of the monetary benefit for home care, a new delay in the incorporation of individuals with moderate dependency (Degree I) within the LTC system until July 2015, a reduction in the number of hours for home assistance and the suspension of payment of social security contributions for home carers. According to the 2014 National Reform Plan, these measures represented expected savings of EUR 2.278 billion between 2012 and 2014 (EUR 1.183 billion for the central government, and EUR 1.095 billion for the regions). The changes introduced since January 2014 further elaborated on some of the restrictive measures proposed in the reform of July 2012, including the following: a new information system and an LTC expenditure justification system for Autonomous Communities; a reduced intensity of services and greater incompatibilities between economic benefits and services, and between different types of services (except tele-assistance); and changes in the fiscal transfers from the central government to the regions to give priority to services rather than monetary benefits. A positive aspect was the extension of the allowance for a personal assistant for all degrees of dependence (before 2014 this was only allowed for Degree III dependent people).

of Directors and Managers in Social Services (Association of Directors and Managers, 2017) estimates that central government has adjusted SAAD expenditure by EUR 3.774 billion since July 2012. As noted above, this had a negative impact on SAAD coverage and on the extension of services and benefits between 2012 and 2015. For example, from the approval of the reform in July 2012 to April 2015, the number of LTC beneficiaries decreased by 37,405. Concerning the quality of life of carers, the suspension of government-paid contributions to social security for non-professional home carers in July 2012 has led to a regression of the rights of carers. On the other hand, the extension of the allowance for a personal assistant to all degrees of dependence has had a positive, albeit moderate, impact on the provision of quality LTC and on personal autonomy.

In order to analyse the sustainability and the current financing mechanisms of LTC, a Commission for the Analysis of the Situation of Dependency was set up in February 2017.[14] It has prepared a technical report[15] for the examination and adoption of the necessary agreements. The report provides recommendations to improve SAAD funding, including a review of the financing system and of the amounts contributed by all administrations. However, no concrete measures have been proposed, apart from the recovery by 2020 of the amounts of the *minimum* level of funding that were affected by cutbacks during the crisis.[16]

2.3 Policy recommendations to improve the access and adequacy, quality and sustainability of the LTC system

The Spanish LTC system has fostered a positive development of the social protection system. Its implementation coincided with the economic and financial crisis and, as a consequence, the fiscal consolidation policies implemented between 2012 and 2015 have hindered its expansion and financing. The social demand for dependency benefits will continue to grow in the coming years. SAAD must therefore take the path of strengthening its institutional development and improving its financing. In view of the latter, it is recommended that the following measures be implemented to improve and refine the current system:

- In general, recover the lost investment effort in LTC, especially on the part of the central administration, and clarify the current system of co-payment, given its diversity and opaqueness.
- Reduce the waiting lists for access to services significantly and expand the supply of home and community services, which are in high demand and are very cost effective.
- Implement person-centred care models that allow for the integration of social and health care, institutional and family care, with a greater participation of dependent persons.
- Improve the quality of services, especially the quality of formal employment. Home-based care (almost 33% of all dependency benefits) should be monitored for its quality, and carers should be able to access training services. Strengthening social policies and benefits to reconcile the care of dependent persons with formal employment remains a challenge in Spain.

[14] Ten working sessions took place between March and July 2017. The Commission is formed of representatives of social services and finance from the central administration and of the social services ministers from seven regions.

[15] Available on http://www.dependencia.imserso.es/dependencia_01/evo_doc/co_si_dep/index.htm

[16] This minimum level is assumed exclusively by the central state administration to guarantee similar minimum levels of care throughout the state. It is estimated that the reduction in the minimum level has entailed a lowering of SAAD financing by EUR 820 million since 2012.

- Improve substantially coordination between the central administration and the Autonomous Communities and between the latter and the municipalities. The differences in performance between the Autonomous Communities are excessive and generate inequalities in the coverage and intensity of social protection.

3 Analysis of the indicators available in the country for measuring long-term care

3.1 Access and adequacy indicators

The Information System of the System for Autonomy and Care for Dependency (SISAAD) (Order SSI/2371/2013)[17] includes information on the requests for assessment, the assessments carried out, the claimants entitled to benefits and those actually receiving benefits (in absolute values, as a percentage of the total population of Spain, of each region and by type of benefit), the number of benefits per beneficiary and the profile of the beneficiaries, broken down by degree of dependency, age and gender. This information has been disaggregated monthly from 2007 to the present. The statistics are compiled using the data provided by the regions and are published on the IMSERSO website.[18] We highlight the following coverage indicators:

- SAAD beneficiaries as a proportion of the total number of persons entitled to benefits in SAAD (in %)[19]
- Number and percentage of beneficiaries receiving LTC in-kind and/or cash benefits
- SAAD beneficiaries as a proportion of the total national population (and the total population of each region) (in %)[20]
- SAAD beneficiaries aged 65+ as a proportion of the total Spanish population aged 65+ (in %).

The last two indicators reflect those persons who receive care as a proportion of the total population and the population aged 65+, but not as a proportion of the total population potentially in need of care. For this reason, in order to measure the degree of real coverage of the system, it would be advisable for SAAD to make strides in quantifying the potentially dependent population, in order to use a better indicator, such as the number of persons receiving benefits in SAAD as a proportion of the total potentially dependent population (for the general population and for persons over 65 years of age).

3.2 Indicators of sustainability

The main indicators are the following:

- Public expenditure on long-term care as a percentage of GDP
- Public expenditure on long-term care as a percentage of total government expenditure.

In Spain, there are no official statistical and accounting sources yet that allow the precise determination of the volume of public resources allocated to LTC (Gómez et al., 2012).

[17] Order SSI/2371/2013, 17 December. Available at: http://goo.gl/TBNwVI

[18] Institute of Social Services and the Elderly (Instituto de Mayores y Servicios Sociales – IMSERSO). Available at: https://goo.gl/eLaJhR

[19] The rate in SAAD is currently 75%. The remaining 25% would be on waiting lists. Persons entitled to benefits in SAAD refer to persons who have been assessed as being in need of care by the Individualised Care Plan.

[20] Some 2.05% of the population receives SAAD LTC benefits in Spain (December 2017).

For the calculation of these indicators, it is necessary to use estimates, since public expenditure on LTC is assumed by central government, by the regions and partially by the local authorities, and its calculation is thus complex. According to the Commission for the Analysis of the Situation of Dependency, there remain some differences between public administrations in relation to the criteria for allocating expenditure on the services and benefits associated with SAAD. In addition, most Autonomous Communities do not have an analytical accounting system that separates social services expenditure from specific expenditure on LTC (Prada Moraga and Borge González, 2015; Montserrat, 2015a; Court of Auditors, 2014 [21]). These expenses only partially include the co-payment of users, given the differing budgetary treatment by the regions, which makes it difficult to accurately assess the effort made by the administrations. Concerning co-payments, official data are not yet available. The SISAAD does not yet have up-to-date data on the contributions made by beneficiaries (Court of Auditors, 2014). The estimation of co-payments at the national level is complex, because there are as many models of co-payment as there are Autonomous Communities in Spain.

3.3 Employment indicators

The most common indicators are the number of jobs created in LTC and the percentage of jobs in LTC out of the totality of jobs. However, the accurate calculation of job creation associated with LTC is complex. The main official sources of information used, such as the Labour Force Surveys (LFS) and social security data on affiliates, do not disaggregate information on employment in sufficient detail to distinguish specific employment in LTC from employment in social services in general. The Commission for the Analysis of the Situation of Dependency itself has recognised the technical difficulties of assessing the economic reality surrounding the economic management of SAAD. One of the most widely used indicators in the research of experts on LTC to estimate the economic returns of LTC expenditure in terms of employment is to estimate the direct employment ratio per million euros of public expenditure (Díaz and García, 2015).

[21] The 2014 Report of the Court of Auditors, at: http://goo.gl/JNQCCT

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