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Assessing Needs of Care in European Nations

THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN SPAIN

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1. The LTC system in Spain

1.1 Overview of the system

A new citizenship right, known as the "fourth pillar of the welfare system", was established by Act 39/2006 of 14th December on the Promotion of Personal Autonomy and Care of Dependent People, (*Ley de Promoción de la Autonomía Personal y Atención a las Personas en Situación de Dependencia*, or "LAPAD"). The act recognises the universal nature of benefits and the entitlement to access them under equal conditions for all elderly or disabled people who need help carrying out basic daily living activities.[1] The principles underlying this act can be considered as the philosophy of the long-term care system in Spain, whose main goals are to guarantee basic welfare conditions and to forecast required levels of protection for disabled people.

The System for Autonomy and the Care of Dependency (SAAD) is based on the constitutional framework of powers established by statute and also on the collaboration, cooperation and participation of the different public administrations involved. The Territorial Council of the System for Autonomy and Care of Dependency, with the collaboration of the general state administration and the autonomous communities, has as its main functions to agree the framework of inter-administrative cooperation, the scope of the "catalogue of services" (i.e. the list of services that are offered under the umbrella of the dependency law), the conditions and amount of financial benefits, the criteria for the participation of beneficiaries in the cost of the services and the determination of a scale to assess dependency. The SAAD Advisory Committee is a consultative body within the SAAD. It makes proposals on matters of particular interest to the functioning of the system. To ensure the participation of organisations representing people in a situation of dependency and their families, there are three additional advisory bodies: the State Council of Senior Citizens, the National Disability Council and the State Council of Non-Governmental Social Action.

Traditionally, the provision of health care services to dependent people has been a family responsibility, with the administration limiting itself to providing long-term care (LTC) services only when family income was insufficient to provide such care. Changes in family patterns, a higher rate of female labour market participation, and the emerging needs that all of this entails have encouraged the development of the current long-term care system.

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[1] The system is known as SAAD, *Sistema para la Autonomía y Atención a la Dependencia*, or System for Autonomy and the Care of Dependency.

It is expected that more than one million people will benefit from the services of long-term care (LTC) arising from the development and application of the law on dependency in Spain, a country where most of these services are still provided by the family; in other words, a country where LTC is mainly provided as an informal care service (70%). Moreover, it was estimated that the implementation of the act would create 300,000 new jobs in the context of care of elderly people (IMSERSO (2005b), Chapter X), but job creation in this sector, although quite significant, has fallen below these expectations.

The autonomous communities have taken on the responsibility for the provision of benefits and services established by the Dependency Law, within the framework of the so-called Network of Social Services of the Autonomous Communities. These responsibilities include not only the provision of services to dependent people, but also the provision of certain benefits.

According to the Law on Dependency, the service catalogue includes the following in-kind benefits and services:

- Dependency prevention services and the promotion of personal autonomy
- Personal alert system
- Home-help service (addressing the needs of the household)
- Personal care
- Adult day-care centres
- Residential care service

If the competent administrations are unable to offer these services, the dependent person is entitled to receive financial benefits. There are three types of financial benefits: financial assistance to access certain care services, financial assistance for informal caregivers, financial assistance to hire personal caregivers. The amount of these benefits depends on the degree of dependency and the economic situation of each individual.

1.2 Assessment of needs

The Act on the Promotion of Personal Autonomy and Care for Dependent Persons defines the concept of "dependency" as

> the permanent state in which persons that for reasons derived from age, illness or disability and linked to the lack or loss of physical, mental, intellectual or sensorial autonomy require the care of another person/other people or significant help in order to perform basic activities of daily living.

In the case of people with mental disabilities or illness, the concept of "need for support for personal autonomy" is applied in order that they may attain a satisfactory degree of personal autonomy in the community.

The assessment of dependency is carried out by the autonomous administration corresponding to the applicant's residence and is valid for the whole of Spanish state territory, because this is one of the conditions that guarantee equality. The degree and levels of dependency are determined using a scale approved by the Territorial Council of the System for Autonomy and Care for Dependency.

Table 1. Ranking scale contained in the dependency law

ACTIVITIES	**AGE**			
1. Eating and drinking	**3-6**	**7-10**	**11-17**	**18 & older**
Using artificial nutrition or hydration	29.1(18.3)	19.3(10.9)	19.3(10.9)	17.8(10)
Opening bottles and cans	NA	0.10	0.10	0.10
Cutting up meat	NA	0.25	0.25	0.25
Using cutlery	0.38	0.25	0.25	0.25
Holding a glass	0.23	0.15	0.15	0.15
Putting a glass to mouth	0.23	0.15	0.15	0.15
Drinking	0.15	0.10	0.10	0.10
2. Control of physical needs	24.2(12.8)	16.1(7.6)	16.1(7.6)	14.8(7)
Go to the appropriate place	0.25	0.20	0.20	0.20
Dressing and undressing	0.19	0.15	0.15	0.15
Adopting the right posture	0.25	0.20	0.20	0.20
Cleaning oneself	NA	0.20	0.20	0.20
Urination control	0.13	0.10	0.10	0.10
Defecation control	0.19	0.15	0.15	0.15
3. Washing	14.5(14.7)	9.6(8.7)	9.6(8.7)	8.8(8)
Washing hands	0.50	0.15	0.15	0.15
Washing face	0.50	0.15	0.15	0.15
Washing lower part of the body	NA	0.35	0.35	0.35
Washing upper part of the body	NA	0.35	0.35	0.35
4. Other personal tasks	NA(NA)	3.2(2.2)	3.2(2.2)	2.9(2)
Combing hair	NA	0.33	0.30	0.30
Cutting nails	NA	NA	0.15	0.15
Washing hair	NA	0.33	0.25	0.25
Brushing teeth	NA	0.33	0.30	0.30
5. Dressing	NA(NA)	12.9(12.6)	12.9(12.6)	11.9(11.6)
Putting on shoes	NA	0.15	0.15	0.15
Doing up buttons	NA	0.15	0.15	0.15
Dressing upper part of the body	NA	0.35	0.35	0.35
Dressing lower part of the body	NA	0.35	0.35	0.35
6. Maintaining health	NA(NA)	3.2(12)	3.2(12)	2.9(11)
Applying therapeutic measures	NA	0.50	0.25	0.25
Avoiding indoor risks	NA	0.50	0.25	0.25
Avoiding outdoor risks	NA	NA	0.25	0.25
Distress call	NA	NA	0.25	0.25
7. Mobility	12(3.7)	8(2.2)	8(2.2)	7.4(2)
Sitting down	0.15	0.15	0.15	0.15
Lying down	0.10	0.10	0.10	0.10
Standing up	0.20	0.20	0.20	0.20
Changing posture from a sitting position	0.25	0.25	0.25	0.25
Changing posture from bed	0.30	0.30	0.30	0.30
8. Moving inside home	20.2(22.2)	13.4(13.2)	13.4(13.2)	12.3(12.1)
Movements related to self-care	0.50	0.50	0.50	0.50
Movements not related to self-care	0.25	0.25	0.25	0.25
Access to all settings of the rooms	0.10	0.10	0.10	0.10
Access to all rooms	0.15	0.15	0.15	0.15
9. Moving outside home	NA(NA)	14.3(14)	14.3(14)	13.2(12.9)
Leaving the house/building	NA	0.42	0.25	0.25
Walking around the house/building	NA	0.42	0.25	0.25
Walking short distances	NA	0.17	0.10	0.10
Walking long distances	NA	NA	0.15	0.15
Using transport	NA	NA	0.25	0.25
10. Housekeeping	NA(NA)	NA(NA)	NA(NA)	8(8)
Cooking	NA	NA	NA	0.45
Shopping (for food)	NA	NA	NA	0.25
Cleaning the house	NA	NA	NA	0.20
Washing clothes	NA	NA	NA	0.10
11. Making decisions	(28.3)	(16.7)	(16.7)	(15.4)
Self-care activities	0.43	0.38	0.33	0.30
Mobility activities	0.29	0.25	0.22	0.20
Housekeeping	NA	NA	NA	0.10
Personal relationships	0.29	0,25	0.22	0.20
Use of money	NA	0.13	0.11	0.10
Use of public services	NA	NA	0.11	0.10

Note: This ranking scale is also applied to the elderly population. Variables in brackets are only applied to patients with a mental illness or cognitive impairment. NA: not applicable. *Source:* www.cofispa.org/legislacion/manualusoBVD.pdf

The law distinguishes between different degrees of dependency, which in turn establish the benefits and services that can be received:

- Degree I. Moderate dependency: when the person needs help to perform various basic daily living activities at least once a day or when the person needs intermittent or limited support for his/her personal autonomy.
- Degree II. Severe dependency: when the person needs help in order to perform various basic daily living activities two or three times a day, but he/she does not want the permanent support of a caregiver or when he/she needs extensive support for his/her personal autonomy.
- Degree III. Major dependency: when the person needs help to perform various basic daily living activities several times a day or, due to his/her total loss of physical, mental, intellectual or sensorial autonomy, he/she needs the continuous support of another person or when he/she needs generalised support for his/her personal autonomy.

Each of the degrees of dependency set out above is classified in two levels, depending on the person's autonomy and on the intensity of care that is required. The first level corresponds to those individuals who can perform the activity without the direct support of a third person; whereas the second level refers to those situations where some type of specific support is required. The ranking scale used for the determination of the degree of dependency is shown in Table 1. There are eleven activities divided into a certain number of tasks. Each activity and task receives a weight according to the age of the applicant and the existence of a mental disability or cognitive impairment. Apart from that, the degree of support required for performing each task is also taken into account (see Table 2). The final score is the sum of the weights of the tasks for which the individual has difficulty, multiplied by the degree of supervision required and the weight assigned to that activity:

$$\text{Score} = \sum \text{Weight of the task performed with difficulty} * \text{Degree of supervision} * \\ * \text{Weight of the corresponding activity}$$

Table 2. Degree of support of the ranking scale contained in the dependency law

Support coefficient	**0.9**	**0.9**	**0.95**	**1**
Dependency Law	Supervision	Partial Physical Assistance	Maximum Physical Assistance	Special Assistance
Informal Support Survey	If the dependent only needs a third person to prepare the necessary elements to perform the activity	When the third person has to participate actively	If the third person has to substitute the dependent individual in the execution of the activity	The dependent individual suffers behavioural disorders that hinder the provision of the task by the third person

Source: www.cofispa.org/legislacion/manualusoBVD.pdf

The intervals for determining the degrees and levels have been established according to what is established in Table 3:

Table 3. Degrees and levels of dependency (score)

Degree	**Level**	**Score**
High dependence	Level 2	90-100
High dependence	Level 1	75-89
Severe dependence	Level 2	65-74
Severe dependence	Level 1	50-64
Moderate dependence	Level 2	40-49
Moderate dependence	Level 1	25-39
Not dependent		0-24

People accredited as dependent persons are entitled to receive care and attention by means of services that are matched to their degree and level of dependency (Individual Care Programme).

1.3 Available LTC services

What services?

Assessment of the situation of dependency is performed by means of a decision issued by the autonomous administration that corresponds to the applicant's residence, which is valid throughout the state territory. The services that assess the situation of dependency, the prescription of services and benefits and the management of the financial benefits are assessed directly by the public administrations and may not be the object of delegation, hiring or subsidising private entities. In the event of a change of residence, the autonomous community of destination cannot change the assessment of the dependency situation, but on the basis of its network of services and benefits may modify the Individual Care Plan.

The individual care programme can be reviewed: at the request of the interested party and of his/her legal representatives; on an official basis, in the form and at the intervals foreseen in the regulations issued by the Autonomous Communities and on the occasion of a change of residence to another Autonomous Community (LAPAD, Chapter IV: Right recognition, Article 28).

The catalogue of services includes:

1. "Services for the prevention of situations of dependency and for the promotion of personal autonomy" are services whose purpose is to prevent the onset or aggravation of illnesses or disabilities and their side-effects, by means of the coordinated implementation by the social and healthcare services of initiatives to promote healthy living conditions, specific preventative and rehabilitation programmes aimed at older and disabled persons and those affected by complex hospitalisation processes.
2. The "personal alert system" provides assistance to beneficiaries by means of the use of communication and information technologies, with the support of the necessary personnel resources, in immediate response to emergencies, danger, loneliness and isolation. This service may be independent or complementary to the home help service and is provided to people that do not receive residential care services and whose individual care programme provides for this.
3. The "home help service" is made up of a set of initiatives that are carried out in the home of the dependent person in order to cater for his/her everyday needs, provided by entities or companies that have been accredited for this function. It includes:
    a. Housework and services related to attending to domestic or home needs: cleaning, washing, cooking or others.
    b. Personal care and related services in performing daily living activities.
4. The "day and night centre service" offers comprehensive care during the day or night to the dependent person, with the aim of improving or maintaining the highest possible level of personal autonomy and supporting families or carers. In particular, from a physical-psycho-social perspective, it covers the needs of counselling, prevention, rehabilitation, guidance for the promotion of autonomy, enablement or assistance and personal care, and includes:
    a. Day centres for older persons.
    b. Day centres for persons under the age of 65 years.

c. Day centres with specialised care.

d. Night centres are adapted to the requirements and ages of the dependent persons.

5. A "residential care service", may be provided on a permanent or temporary basis when a person requires a temporary stay for the purposes of convalescence, during holiday periods or at weekends or if the non-professional carers are ill or availing of a rest period. It includes:

   a. Residence for dependent older persons.

   b. Centre offering care for dependent persons, according to the type of dependency, degree of dependency and the intensity of care required by the person.

When the competent administrations are unable to offer these services, the dependent person is entitled to receive financial benefits (see Table 4 for 2011 benefits amounts). There are three types of financial benefits:

1. "Financial benefit linked to the service", received on a regular basis, is only granted when access to a public or subsidised care service is not available, and depends on the degree and level of dependency and on the beneficiary's economic status, in accordance with the terms of the convention held between the general state administration and the autonomous community in question. This personal financial benefit cannot in any case be linked to the acquisition of a service. The competent public administrations supervises, in any case, the purpose and use of these benefits to verify compliance with the purposes for which they were granted.

2. "Financial benefit for care in the family setting and support for non-professional carers." A financial benefit for family care is supposed to be granted on an exceptional basis, when the beneficiary is being cared for in the family setting and as long as the home meets requirements regarding co-habitation and habitability. The carer must comply with the rules on affiliation, registration and contributions to social security that are laid down in the regulations.

3. "Financial benefit for personalised care". The purpose of the personal assistance financial benefit is to promote the autonomy of the severely dependent persons. Its objective is to contribute to the hiring of a personal assistant, for a number of hours, in order to provide the beneficiary with access to education and employment, as well as a more autonomous life in the exercise of basic daily living activities.

Table 4. Amount of financial benefits in 2011 (euros/month)

	Financial benefit linked to the service	Financial benefit for care in the family setting for non-professional carers		Financial benefit for personalised care
		Monthly amount	Quotation to Social Security and Vocational Training	
High dependence Level 2	833.96	520.69	164.54 (163.04+1.50)	833.96
High dependence Level 1	625.47	416.08	164.54 (163.04+1.50)	625.47
Severe dependence Level 2	426.18	337.25	164.54 (163.04+1.50)	Not available
Severe dependence Level 1	401.20	300.90	164.54 (163.04+1.50)	Not available
Moderate dependence Level 2	300	180	82.27 (81.52+0.75)	Not available
Moderate dependence Level 1	Not implemented yet			

In addressing dependent people's needs the act prioritises services such as remote care, home help, adult care centres and residences over financial benefits. However, the actual situation is radically different, since more than 45% of the benefits are of a financial nature (*Prestaciones Especiales para Cuidados de Familiares* or Special Benefits for Family Care).[2]

Who is eligible?

An individual care programme determines the services or benefits that best match the applicant's needs. This programme is established with the participation of the beneficiary through consultation and opinion-seeking, and, where applicable, with his/her family or the supervisory entities that represent him/her.

1.4 Management and organisation (roles of the actors/stakeholders)

The system is configured as a network for public use that integrates public and private centres and services on a coordinated basis. The SAAD network of services is made up of public centres and services in the autonomous communities and local entities, the state centres of reference for the Promotion of Personal Autonomy and Care for Dependent Persons, as well as the recognised (chartered) private centres and services.

Unchartered private centres must obtain an accreditation for providing services to dependent persons. The Territorial Council is expected to agree on quality criteria for the centres and services and quality indicators for the assessment, continuous improvement and comparative analysis of the centres and services in the system. The act supports the quality of the System for Autonomy and Care for Dependency with the aim of ensuring that services are effective, without detriment to the competences of each of the autonomous communities. Essential quality standards have been established for each of the services that are included in the catalogue regulated by this act, following agreement by the Territorial Council of the System for Autonomy and Care for Dependency.

Residential centres for dependent persons must have internal regulations governing their organisation and operations, including a quality management system and establishing the participation of users in the form that is determined by the competent administration.[3]

Specific attention has been paid to quality in employment and to promoting professionalism and reinforcing training in entities that aspire to managing benefits or services that are part of the System for Autonomy and Care for Dependency. Basic and ongoing training is provided to the professionals and carers that attend to dependent people. In this regard, the public powers determine the professional qualifications that are required for the exercise of the functions that correspond to the Catalogue of Services.[4]

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[2] See (http://www.imsersodependencia.csic.es/documentos/estadisticas/indicadores/saad/2011-10/estadisticas-saad-oct-2011.pdf).

[3] Resolution of the Ministry of Social Policy, Families and Care and Disability Secretary, 2 December 2008, which publishes the agreement of the Territorial Council of the System for Autonomy and Care for Dependency, on criteria for common accreditation to ensure quality of facilities and services of the System for Autonomy and Care for Dependency.

[4] November 4, 2009, Resolution of the General Secretariat for Social Policy and Consumer Affairs, which publishes the Territorial Council Agreement of the SAAD on common accreditation criteria for training and information of carers.

1.5 Integration of LTC

Integration within the LTC system

The Ministry of Labour and Social Affairs, via the competent body, has established an information system in the System for Autonomy and Care for Dependency that guarantees the availability of information and reciprocal communication between the public administrations, as well as compatibility and articulation between the various systems.[5]

The system contains information on the catalogue of services and encompasses, as essential data, details referring to the protected population, human resources, network infrastructure, results obtained and quality in the provision of the services.

This information system specifically contemplates the drawing up of statistics for state purposes on the subject of dependency, as well as supra-community general interest statistics and those that are derived from commitments with supranational and international organisations. The Ministry of Labour and Social Affairs, by means of the preferential use of the common infrastructure of the communications and telematic services in the public administrations, will place at the disposal of the System for Autonomy and Care for Dependency a communications network that facilitates and provides guarantees regarding the protection of the exchange of information between its members. The use and transmission of the information in this network remains subject to compliance with the terms of Organic Law 15/1999, of 13th December, on the Protection of Personal Data, and to the requirements regarding electronic certification, electronic signature and ciphering, in accordance with existing legislation. The aforementioned network is used to exchange information on the infrastructure in the system, the situation, degree and level of dependency of the beneficiaries of the benefits, as well as any other derived from the need for information in the System for Autonomy and Care for Dependency.

Integration with social services

The text of the Spanish constitution, under Articles 49 and 50, refers to the care of disabled and older persons and to a system of social services promoted by the public powers for the welfare of citizens. If in 1978 the fundamental elements of this model of the welfare state focused on health care protection and the social security system for all citizens, the social development of Spain since then has placed increasing importance on social services, mostly organised by the autonomous communities, in special collaboration with the third sector, as the fourth pillar of the welfare system in the care of the dependent population.

Before the SAAD, the needs of older and dependent people were catered for essentially at autonomous community and local levels, and in the context of the Concerted Plan on the Basic Benefits in Social Services, in which the general state administration also participated, and at state level, the Action Plans for Disabled and Older Persons. On the other hand, the social security system took responsibility for some elements of care, both in the care for older persons and in situations linked to disability: major invalidity, third-party benefits in non-contributory invalidity pensions and family benefits for dependent children, as well as social service benefits in re-education and rehabilitation for persons with a disability and care for older persons.

Social and health care services collaborate in providing the services to the users of the System of Autonomy and Care for Dependency that are laid down in the SAAD Act and in the

[5] Resolution of 4 November 2009 of the General Secretariat for Social Policy and Consumer Affairs, which publishes the Territorial Council Agreement on common objectives and content of the information system information of the SAAD.

appropriate regulations issued by the autonomous communities and those that apply to the local entities.

The System of Care for Dependency is one of the fundamental instruments for improving the situation of social services in Spain, responding to the need for care in situations of dependency and the promotion of personal autonomy, quality of life and equal opportunities. Consequently, benefits in kind are provided by the social services networks of the autonomous communities, in the scope of the competences that they have undertaken.

2. Funding

Between 2007 and 2015, the period calculated for the gradual implementation of the System for Autonomy and Care for Dependency, the general state administration will contribute almost 13,000 million euro, and a similar amount will be contributed by the autonomous communities. The SAAD's budget has grown steadily since the commissioning of the law on dependence in 2006.[6] The only reliable information available to date is about the contributions made by the general administration of the state, but it is not possible to obtain comparable data on the financial contributions made the autonomous regions and local authorities to finance the SAAD.

Chapter V in Title II of the LAPAD regulates the funding of the system and contributions of beneficiaries. Article 32 states that SAAD funding should be sufficient to ensure compliance with the obligations incumbent on the competent public administrations. Such funding should be determined annually in the budgets. It also emphasises that the general administration of the state should fully finance the costs derived from a guaranteed minimum level of assistance, while the autonomous communities should each year provide an amount at least equal to the amount provided by the general state administration.

In the context of inter-administrative cooperation stated in Article 10, the general state administration and each of the administrations of the autonomous communities may determine bilateral agreements where the obligations of each of the parties for the funding of services and system benefits may be stated. These conventions, which may be annual or multi-criteria for allocating resources, should take into account the dependent population, geographic dispersion, insularity, returnees and other factors, and may be reviewed by the parties. There is an additional fund in the framework of administrative cooperation that aims to offset income differences among the dependent population by region, based on household disposable income and the average pension for those dependent people with level III of dependence.

Additional levels of care service provision may be established by the autonomous communities, and should be fully funded by them. All autonomous communities develop systems of public-private cooperation through indirect management of certain services and agreements for the provision of services. In general, tele-assistance services and home care are managed through the councils at different levels of participation of local authorities.

Article 33 provides that beneficiaries must contribute financially to the funding of services by means of a co-payment. The dependent person's income level and also that of their relatives and the cost and nature of the care service provided are considered to determine this private level of contribution. The LAPAD established that no citizen can be outside the scope of the system due to a lack of economic resources.

Criteria determining the amount of co-payments to be paid have recently been defined and have not retroactive characteristics, but mandatory. It has been decided that those who already

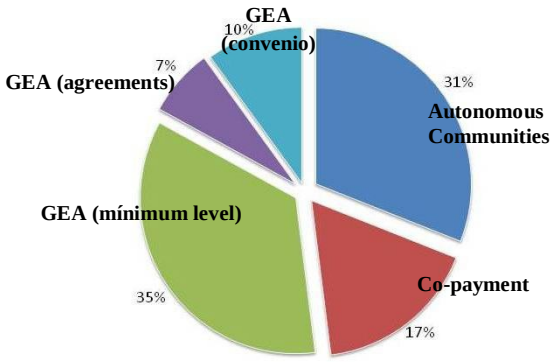
[6] Fund designed to SAAD by the general administration of the state amounted to 400 million euro in 2007, whereas it will amount to 1,500 million euro in 2010.

receive a benefit or service derived from the rights recognised in the dependency law shall pay the co-payment if and only if, by doing so, they are better off with respect to the situation prior to the definition of these principles. Co-payments are not defined equally for all the services provided:

- Old people's homes: the resident pays 90% of the cost for as long as possible within his/her income levels, so that nobody pays more than 90% of their income or less than 70%. Furthermore, all users should have at least 60 euro per month for their personal expenses after they make the co-payment.
- Day care centres: regarding this service, the co-payment is a percentage that varies depending on the dependent person's income level. Co-payment should be within a range of between 10% and 65% of their income.

Funding from the general state administration to the SAAD is quite transparent because it is determined annually in the budgets (59% in 2009). However, the disparity between models, the opacity of the data and the lack of a unified financial tracking system make any real understanding of regional financing impossible. Meanwhile, the average user input to the system (co-payment) amounts to around 17% of total SAAD expenditure in 2009. It allows us to estimate the funding from the autonomous communities[7] as a residual.

Figure 1. Sources of funding, 2009



Source: Asociación Estatal de Directores y Gerentes en Servicios Sociales.

3. Demand and supply of LTC

3.1 The need for LTC (including demographic characteristics)

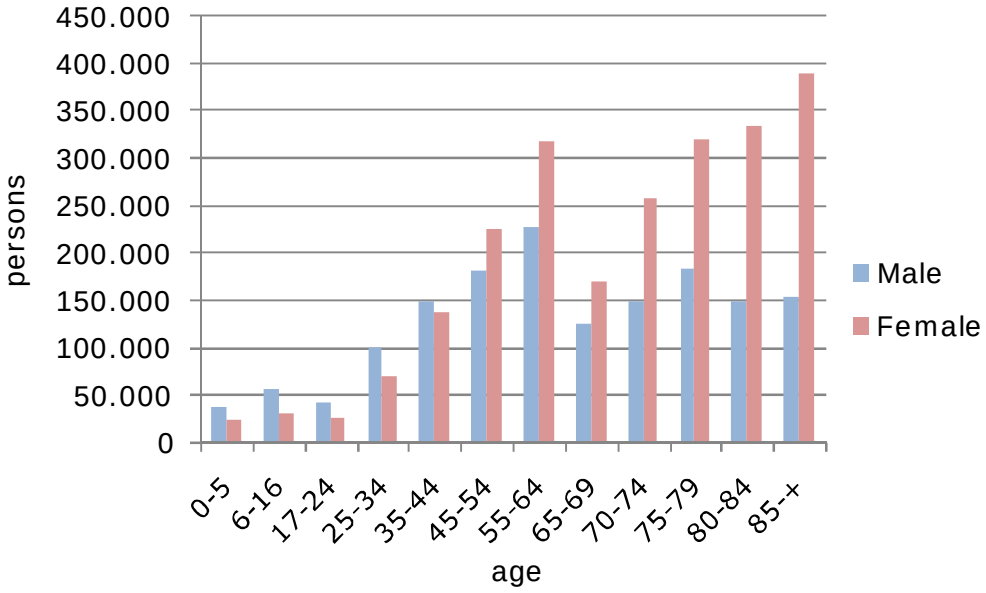
Demographic and social changes are leading to a gradual increase in the number of dependent people in Spain. On the one hand, the significant growth in the population aged over 65 years, which has increased from 7,3% of the total population in 1950 to 16,5% in 2008, is expected to

[7] *"Financiación y costes de la ley de promoción de la autonomía personal y atención a las personas en situación de dependencia"*, Asociación Estatal de Directores y Gerentes en Servicios Sociales (October 2009).

reach 30,8% by 2050. On the other hand, we have to add the demographic phenomenon known as the 'ageing of ageing', i.e., the increase in the sector of the population aged over 80 years: from 1% in 1950 to 4,6% in 2008, with demographic forecasts of an increase to 11,1% by 2050. (Source: INE).[8]

The process of ageing in Spain has been driven by an increase in life expectancy[9] and by a reduction in fertility rates.[10] According to the 2008 Disabilities, Personal Autonomy and Dependency Situations Survey, 8,5% of the Spanish population has some disability or limitation that has caused, or may cause, dependency in activities of daily living or a need for support towards personal autonomy under equal conditions. This percentage increases to 31,2% for people between 65 and 79 years and 26,7% for people older than 80 years. The total number of persons in need of care in 2008 amounted to 3.276.500 (Figure 1).

Figure 2. Total number of persons in need of care, in 2008 by age and sex



Source: Encuesta de Discapacidad, Autonomía personal y situaciones de Dependencia 2008.

It is necessary to distinguish 'disability' from 'dependency'. As the Ageing Report 2009 remarks in its Chapter 8, the former refers to some "functional impairment" of the individual, whereas the latter refers to the "share of the population having some disability that requires the provision of a care service".

[8] The Spanish population was 28,117,873 in 1950 and 44,687,483 in 2008. Population projections estimate that the total population of Spain will be around 53,159.991 by 2050.

[9] Life expectancy in 1975 was 73,5 years (70,7 for men and 76,3 for women). In 2005, it was 80,23 years (76,96 for men and 83,48 for women), source: National Institute of Statistics (www.ine.es).

[10] The birth rate (number of births per 1000 inhabitants) decreased from 18.76 in 1975 to 11,38 in 2008. The average household size decreased from 3.36 people in 1991 to 2.74 in 2007, source: National Institute of Statistics.

It is also essential to differentiate the concept of functional dependence, which has been analysed here, from the concept of old age dependency, which shows the balance between the inactive elderly and the economically active (employed) population, known as the old age dependency ratio. According to the Ageing Report 2009 carried out by the Working Age Group (WAG), the economic old age dependency ratio – defined as the ratio of inactive population aged 65 and over to the population aged 15 to 64 – was 36 % in Spain in 2007. They expect that this ratio will increase slightly in the first period of projection to 37% but the expected increase will be bigger by 2020 (projections estimate that this ratio will reach around 79% by 2060). Even if it is not necessarily true that people over 65 years old need long-term care, this figure can be used as an upper bound proxy of the future demand for long-term care services in Spain.

3.2 Informal and formal care in LTC (and the role of cash benefits)

Demand and supply of informal care

An informal carer is considered to be a person such as a family member, friend or neighbour, who provides regular and sustained care and assistance to a person requiring support, usually on an unpaid basis. It is hard to obtain reliable data about informal carers. According to OECD health data in 2009, there are around 2,709,305 informal carers in Spain, 77% of whom are women.

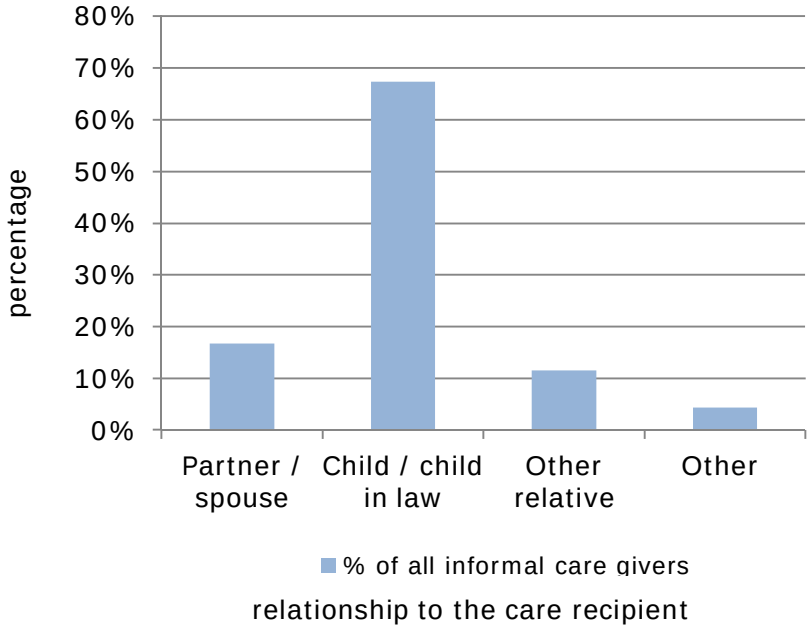
Nearly 70% of Spanish older people with dependency receive family care exclusively. According to a recent study of caregivers ("Informal aid to the elderly") by the *Centro de Investigaciones Sociológicas* (CIS, www.cis.es) in 12.4% of Spanish homes there is a person who provides informal support to an elderly person. In Spain, the responsibility for caring lies mostly with one person (47,20%). Informal carers are usually women, of an average age of 52 years and related to the dependant: generally, mothers, daughters or wives (see Figure 2). Carers are generally people with little education, on low income, do not receive any remuneration and are not included in the employment statistics. The proportion of immigrant female caregivers (household employees) has also increased significantly.[11] However, the patterns of care in Spain are expected to change significantly due to the ageing process and social change.[12.] Changes in family models and the gradual incorporation of almost three million women into the job market over the last decade introduce new factors into this situation,[13] which mean that it is crucial to review the traditional care system to ensure adequate capacity to care for the people in need of such assistance.

[11] In 2004, 30% of household employees of dependent people older than 65 years were immigrants. (Source: Informal Support Survey, IMSERSO).

[12] The divorce rate (number of divorces per 100 marriages) has increased from 4.7 in 1980 to 69.01 in 2007. On the other hand, the number of households composed of a single individual older than 65 years has increased from 712,800 in 1991 to 1,420,600 in 2007, source: National Institute of Statistics.

[13] Female labour participation has increased from 28.76% in 1976 to 51,51% in 2009 (3rd term), source: National Institute of Statistics.

Figure 3. Percentage of informal caregivers by relationship to the care recipient



Source: Encuesta de Discapacidad, Autonomía personal y situaciones de Dependencia 2008.

3.3 Demand and supply of formal care

Introduction

The benefits and services laid down in this act are part of the social services network of the respective autonomous communities in the scope of the competences that they have undertaken. The network of centres is expected to be formed by the public centres belonging to the autonomous communities, the local entities, the state reference centres for the promotion of personal autonomy and care and attention to situations of dependency, as well as accredited, subsidised private centres.

The autonomous communities establish the legal regime and the operating conditions for the subsidised private centres. Particular attention is to be paid to those that belong to the third sector (private organisations arising from citizen or social initiatives, under various modalities that meet solidarity and general public interest criteria and are not for profit) in the process of incorporation into the network. Unsubsidised private centres and services providing services to dependent persons must be in possession of the appropriate accreditation from the autonomous community in question. Finally, public powers are expected to promote the voluntary collaboration of the public with the dependent people, by means of participation in voluntary organisations and entities belonging to the third sector.

Institutional care

Institutional care is a long-term care service provided in residential centres adapted to the type of dependency, degree of dependency and the intensity of care required by the dependent person. This service may be provided on a permanent basis, when the residential centre becomes the person's usual residence, or temporarily, when the person requires a stay for the purpose of convalescence, during holiday periods or at weekends, or if the non-professional carers are ill or

have a respite period. The residential care service is provided by the public administrations in public and subsidised centres.

It is hard to obtain data on institutional care workers since care is frequently provided by health professionals who are not specifically included in the statistics exclusively as long-term carers. There are around 5,000 residential centres for the elderly in Spain (80% are private), mostly placed in Cataluña, Castilla y Leon, Andalucía and Madrid.

Regarding the characteristics and number of dependent persons receiving institutional care (see Table 5), most of them are older than 80 (62%) and for the most part, women (66%). They start to receive this service at age 81, four years later than the average man.

Table 5. Institutional long-term care: dependent persons living in institutions

	65 to 79 years	older than 80
Residential homes	50847	157355
Homes for disabled if 65+	3689	716
Nursing homes	4991	4923
Total, institutional care services	**59527**	**162994**

Source: Encuesta de Discapacidad, Autonomía personal y situaciones de Dependencia 2008.

Home Care

The home-help service is made up of a set of initiatives that are carried out in the home of the dependent person in order to cater for his/her everyday needs, provided by entities or companies that have been accredited for this function: services related to attending to domestic or home needs (cleaning, washing, cooking or others) and services related to personal care.

Table 6 presents the population receiving home care by region. More than seven million people received home care services in Spain in 2008, which amounts to 9.4% of the population older than 65 years. 52.2 % of them were attended by SAD (Home Care Service) and the others by telecare services.[14] The average person receiving home care services is a woman (67%), aged 79 (51% are older than 80), living with somebody else (only 31% live alone).[15]

[14] Telecare or tele-assistance services include all means of responding to emergency situations, insecurity, loneliness or social isolation at a distance, for example by phone.

[15] IMSERSO, 2008.

Table 6. People receiving home care by region

Region	Population older than 65	Users attended	Coverage ratio
Andalucía	1196354	46924	3.92
Aragón	262113	11316	4.32
Asturias	235428	10712	4.55
Baleares	145675	4738	3.25
Canarias	263027	9251	3.52
Cantabria	107342	3826	3.56
Castilla y León	570559	27624	4.84
Castilla-La Mancha	362087	28111	7.76
Cataluña *	1196294	57034	4.77
C.Valenciana	813214	22305	2.74
Extremadura	207081	20506	9.90
Galicia	602986	10018	1.66
Madrid	895583	71343	7.97
Murcia	194003	4699	2.42
Navarra	107020	3660	3.42
País Vasco	401688	21891	5.45
La Rioja	57187	3001	5.25
Ceuta	8640	828	9.58
Melilla	7526	291	3.87
España	**7633807**	**358078**	**4.69**

(1) Coverage ratio: (users served/population older than 65)*100.

Table 7 describes the number of home care hours received by month has been established according to the grade and level of dependency:

Table 7. Home Care (Hours/month)

Intensive Home Care	High dependence. Level 2 High dependence. Level 1 Severe dependence. Level 2 Severe dependence. Level 1 Moderate dependence. Level 2 Moderate dependence. Level 1	70-90 hours/month 77-70 hours/month 40-55 hours/month 30-40 hours/month 21-30 hours/month 12-20 hours/month
Not intensive Home Care	High dependence. Level 2 High dependence. Level 1 Severe dependence. Level 2 Severe dependence. Level 1	Up to 45 hours/month Up to 35 hours/month Up to 28 hours/month Up to 20 hours/month

Source: SAAD.

Average home care intensity according to IMSERSO data was around 17 hours/month in 2008. However, there are significant disparities between regions not only in home care intensity (average home care intensity ranges from 28 hours/month in Galicia to 8.39 hours/month in Andalucía) but also in the public prices of home care services (it ranges from 6.8 €/h in Extremadura to 22.77 €/h in Navarra).

Semi-institutional care

The day or night centre service offers comprehensive care during the day or night to the dependent person, with the objective of improving or maintaining the highest possible level of personal autonomy and supporting the families or carers. In particular, from a physical-psycho-social perspective, it covers the needs of counselling, prevention, rehabilitation, guidance for the promotion of autonomy, enablement or assistance and personal care. There were around 63,500 vacancies in public (39%), semi-public (25%) and private day or night centres (36%) in 2008.

There are day centres for persons under the age of 65 years, day centres for older persons, centres that are specialised in the specific nature of the care they provide, and night centres, which are adapted to the peculiarities and ages of the dependent persons. Vacancies in day care centres have tripled: 14,925 new places were provided each year during the period 2002-08.

An additional formal care service is the accommodation of older people in residential apartments, in sheltered housing and under foster care. Almost all autonomous communities have sheltered housing. In January 2008 there were 850 sheltered homes supervising a total of 7285 beds, of which 78% were in the Communities Castilla-La Mancha (1,504), Catalonia (2,065), Galicia (943) and the Basque Country (1,167). Only five autonomous communities provide residential apartment services and only six provide foster care services. Galicia ranks first in both.

4. LTC policy

4.1 Policy goals

The text of the Spanish constitution under Articles 49 and 50 refers to the care of disabled and older persons and to a system of social services promoted by the public powers for the welfare of citizens. The main aim of the system is to guarantee the basic conditions and predict the levels of protection. It serves as a common ground for the collaboration and participation of the public administrations and to optimise the available public and private resources. Thus, it confers a subjective right that is based on the principles of universality, equality and accessibility.

4.2 Integration policy

The act establishes a minimum level of protection, which is defined and financially guaranteed by the general state administration. Moreover, as a second level of protection, the act foresees a regime of cooperation and funding between the general state administration and the autonomous communities, with conventions for the development and application of other benefits and services that are covered by the act. Finally, the autonomous communities are responsible for the development of an additional third level of protection for citizens, if they deem it necessary.

The very purpose of this act requires the commitment and combined action of all of the public powers and institutions, which means that coordination and cooperation with the autonomous communities is a fundamental element. Therefore, the act establishes a series of mechanisms for cooperation between the general state administration and the autonomous communities, including the creation of the Territorial Council of the System for Autonomy and Care for

Dependency. It is responsible for developing, by means of agreement between the administrations, the functions of agreeing on a framework of inter-administrative cooperation, the intensity of the services in the catalogue, the conditions and amount of the financial benefits, the criteria for the participation of the beneficiaries in the cost of the services or the scale for assessing the situation of dependency, aspects that should allow for the system to be deployed at a later stage through the corresponding agreements with the autonomous communities.

4.3 Recent reforms and current policy debate

During the period 1st January 2007 to 31st December 2015 and with the purpose of promoting the progressive implementation of the system, the general state administration establishes in its budgets credits for entering into conventions with the administrations of the autonomous communities on an annual basis.

After the first three years of progressive application of the act have elapsed, the Territorial Council of the System for Autonomy and Care for Dependency assesses the results of the latter and proposes any changes that it deems to be necessary in the implementation of the system. Moreover, the government is authorised to issue any provisions that may be necessary for the implementation and enforcement of this act.

The right to dependence aid is taking effect progressively from 1st of January 2007, according to the following table:

Table 8. Schedule of recognition of the different degrees of dependency

Access to benefits			**Years**							
			2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
All	High dependency	Level 2	**X**							
		Level 1	**X**							
All but financial benefit for personalised care	Severe dependency	Level 2		**X**	**X**					
		Level 1			**X**	**X**				
All but residential care and F.B. for personalised care	Moderate dependency	Level 2					**X**	**X**		
		Level 1							**X**	**X**

4.4 Critical appraisal of the LTC system

During the brief performance of the System for Autonomy and Care for Dependency, several shortcomings have been revealed. First, there is no predetermined benchmark that defines the necessary investment to guarantee the catalogue of services offered to dependent people. Second, there is a lack of harmonisation with respect to the participation of the beneficiary. Autonomous communities have legislated different thresholds of cost-sharing according to the economic capacity of the dependent individual.

Third, public and private prices of social services are very different across autonomous communities. This implies that depending on the community cash benefits may or may not be enough to purchase the required amount of formal help. Finally, the implementation of a third level of protection, which has already started in certain communities, may increase regional disparities and contravene the principle of equal opportunities for all dependent people.

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