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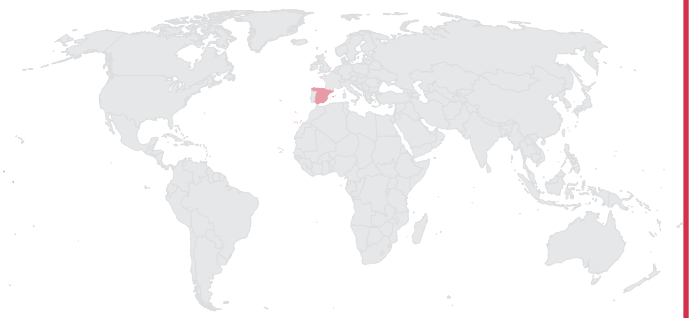
Social Policy Country Briefs

Spain



Antonio Basilicata

The Long-Term Care System in Spain

Global Dynamics of Social Policy CRC 1342

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Contact: crc-countrybrief@uni-bremen.de

Postadresse / Postaddress:
Postfach 33 04 40, D - 28334 Bremen

Website:
https://www.socialpolicydynamics.de

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Antonio Basilicata*

Content

*basilant@uni-bremen.de

1. Country Overview

Source: http://ontheworldmap.com/spain/ (Accessed: November 15, 2020)

- Sub-Region (UN standard): Southern Europe
- Capital: Madrid
- Official language: Spanish
- Population size: 47,329,981 (INE 2020)
- Share of rural population: 19.435% (World Bank 2020; 2019 value)
- GDP: 1.394 Trillion USD (World Bank 2020; 2019 value)
- Income group: High-Income (World Bank 2020)
- Gini Index: 34.7 (World Bank 2020; 2017 value)
- Colonial period: Not applicable

2. Long-term care dependency

a. Population statistics

Table 1. Older population in Spain

	Total number	Share of total population
Population 60+	12,187,447	25.75%
Population 70+	6,836,716	14.44%
Population 80+	2,851,870	6.03%
Population receiving LTC benefits	Approx. 953,924	Approx. 2.05%

Sources: number and share of population 60+/70+/80+ are taken from Instituto Nacional de Estadística (INE 2020) and refer to January 1, 2020; number and share of the population receiving LTC benefits are from Rodríguez Cabrero et al. 2018 and refer to December 2017

b. National definition and measurement of long-term care dependency

In Spain, long-term care (LTC) dependency is usually referred to as *dependencia*, e.g. in the current Spanish LTC law (also: *atención a personas en situación de dependencia*). The law defines the term as follows: "The permanent state in which people find themselves who, for reasons derived from age, illness or disability, and linked to the lack or loss of physical, mental, intellectual or sensory autonomy, require attention of one or more other persons or important assistance to carry out basic activities of daily life or, in the case of people with intellectual disabilities or mental illness, of other supports for their personal autonomy" (Ley 39/2006, Art. 2, sec. 2; translation from Spanish).

There are three grades of dependency (according to the Ley 39/2006 each had two sub-levels, but this further distinction was abandoned in 2012). Each applicant is visited and assessed by a regional professional and trained assessor in regard to several abilities relevant for personal autonomy and their individual requirements for assistance (e.g. eating and drinking, getting dressed, physical condition etc.). Following the national assessment scale for dependency (*Baremo de Valoración de los Grados y Niveles de Dependencia,* BVD), the applicant receives points for each indicator that in sum correspond to one of the three dependency levels:

- *Grade 1*: Moderate dependency (*dependencia moderada);* a person who needs help with basic daily activities at least once a day or periodically and/or limited need of assistance for personal autonomy.
- *Grade 2*: Severe dependency (*dependencia severa);* a person who needs help with basic daily activities two or three times per day but does not need/want permanent help from a caregiver or is in need of extensive support services for personal autonomy.
- *Grade 3*: Extreme dependency (*gran dependencia*); a person who needs help with various daily activities several times a day and/or needs continued assistance from another person. (Ley 39/2006, Art. 26 sec. 1; Blanco-Encomienda and Callejón-Céspedes 2012; Reinhard 2018)

3. First public scheme on long-term care

a. Legal introduction

Name and type of law:
Ley 39/2006, de 14 de diciembre, de Promoción de la Autonomía Personal y Atención a las personas en situación de dependencia (Act)

Date the law was passed:
4.12.2006

Date of *de jure* implementation:
01.01.2007

Brief summary of content:
With the so-called "Dependency Act" a universal right to long-term care is established for residents of Spain. The decentralized system includes standards for both public and private service provision and cash benefits under the System for Autonomy and Care for Dependent Persons (SAAD – *Sistema para la Autonomía y Atención a la Dependencia*). It is financed through state funding and co-payments by the beneficiaries (Rodríguez Cabrero and Gallego 2013).

Socio-political context of introduction:
Prior to the law, care was mainly the responsibility of the family, mostly female relatives, and not regulated on the federal level (Garcia-Gomez et al. 2019). Demographic changes due to an ageing population and an increasing participation of women in the labour market put the need for a coherent LTC policy on the political agenda in the early 2000s (Costa-Font and García González 2007). The creation of the actual law was a result of long negotiations between governmental actors (national and regional), societal actors (trade unions and business representatives), institutional actors and NGOs. Particularly the legal independence of the policy was highly disputed and resolved by positioning it outside the existing social security framework (Rodríguez Cabrero and Gallego 2013).

b. Characteristics of the long-term care scheme at introduction

All dependent persons residing in Spain are *covered* by the law. Applicants must have resided at least five years in the country, two of those years must immediately precede the claim for assistance (Reinhard 2018). The degree of dependency is assessed by trained regional officials based on national criteria for the three levels mentioned in Section II b.

The SAAD consists of a network of public and private *service providers* for home-based and residential care. Private providers have to be accredited by regional authorities first. Despite the LTC law, family members and external non-professional caregivers still play an important role in LTC provision (Deusdad, Comas-d'Argemir, and Dziegielewski 2016).

The *financing* method is very complex and includes funding by the federal and regional government(s) as well as co-payments by the beneficiaries. According to the law, the federal state provides each autonomous region with funding for minimum, basic care. For specifying the individual amount of a region's grant, the state takes into consideration e.g. the population size and number of dependent persons (Ley 39/2006, Art. 32). Additional benefits and services that are covered by the law receive equal funding by both the federal state and the respective autonomous region. The latter has to at least match the funding of the federal government (Gutiérrez et al. 2010). Each region can increase its service package but must bear the full costs of services that go beyond the Dependency Act. Finally, Art. 33 of Ley 39/2006 states that beneficiaries have to contribute with co-payments. The amount depends on the type of service and the income level of the beneficiary.

Basic conditions and minimum standards of LTC are *regulated* by the federal government. However, the autonomous regions regulate all other and detailed aspects of LTC such as the actual provision (incl. accreditation of providers) and individual policy designs. This is due to constitutional regulations that also provide regions with competencies in other health-related areas (Rodríguez Cabrero and Gallego 2013). The Territorial Council (*Consejo Territorial del Sistema para la Autonomía y Atención a la Dependencia;* from 2012 onwards *Consejo Territorial de Servicios Sociales y del Sistema para la Autonomía y Atención a la Dependencia*) facilitates the dialogue between the federal and regional level and serves as a board for controlling, monitoring, and evaluating the system.

4. Subsequent major reforms in long-term care

Apart from amendments in the wake of the financial crisis, no major reform has taken place since the Dependency Act was passed in 2006. The 2012 reform (see Section VI) led to retrenchments in services and increased users' co-payments but does not classify as a fundamental change to the system's design.

5. Description of current long-term care system

a. Organisational structure

The system that started with the implementation of Ley 39/2006 still offers universal care for all dependent persons, independent of age. The grade of dependency is assessed on the regional or local level and determines the benefits of the individual claimants. In order to simplify the dependency assessment, the two sub-levels of each dependency grade have been removed (Reinhard 2018). In 2017, 2.05% of the whole population received some kind of LTC benefits (Rodríguez Cabrero et al. 2018). Apart from the minimum standards and services, each autonomous region provides different additional services, which highlights the fragmentation and decentralisation of the system. Consequently, LTC became a separate policy field in Spain, detached from the social security system. However, it is part of the social protection system, i.e. with its legal character it expands and complements existing tasks of the state and the social security system (Reinhard 2018).

The following organisations and agencies are the most relevant actors in the LTC sector of Spain:

- Territorial Council of the SAAD (administration, monitoring, evaluation),
- Ministry of Health (federal government),
- Governments of the autonomous regions, incl. their health departments,
- Advisory bodies such as the "*Comité Consultivo*", the "*Consejo Estatal de Personas Mayores*" etc. (advisory bodies usually include members of the federal and regional governments, business associations, unions etc.).

b. Service provision

Both formal and informal care are provided in Spain. Since the introduction of Ley 39/2006 the formal care sector is expanding and maintaining basic standards for training, service provision etc. Nonetheless, as Triantafillou et al. (2011) point out, informal care still plays a crucial role for dependent people, e.g. in smaller towns. Additionally, it seems that formal care is mostly used when the demands of the beneficiary exceed the capacities of informal caregivers (Triantafillou et al. 2011). Table 2 shows that informal care has actually increased and only 15.8% of the beneficiaries received solely formal care in 2013. However, it must be considered that most of the benefits for Grade 1 dependency (moderate) were not implemented until 2015 (Reinhard 2018).

Care is delivered by the SAAD network, which consists of public and private providers on the regional level. Private companies are accredited by the autonomous regions before participating in the system. The main places for formal care provision are the homes of beneficiaries (home-based care), residential facilities and day-/night-care centres (Table 3).

Table 2. *Informal and Formal Care in Spain before and after Ley 39/2006*

Combination of Care Provision	2006 (share of total LTC beneficiaries in percent)	2013 (share of total LTC beneficiaries in percent)
Informal care, from household member only	32,3	24,2
Informal care, from external caregiver only	20,1	25,1
Informal care, from household member and external caregiver	6,3	8,5
Informal care, from household member + formal care	11,5	8
Informal care, from external caregiver + formal care	9,4	12,5
Informal care, from household member and external caregiver + formal care	3,2	6
Formal care only	17,3	15,8
Total	*100*	*100*

Source: Spijker and Zueras 2018

Table 3. *Beneficiaries and Benefits*

Type of benefit	Number of benefits (July 2017)	Share of benefit in the LTC system (in percent)
Prevention of dependency and promotion of personal autonomy	42,250	3.78
Teleassistance	176,428	15.77
Home-based care	178,737	15.98
Day-/night centres	88,827	7.94
Residential care	153,483	13.72
Special benefits linked to service	97,906	8.75

Type of benefit	Number of benefits (July 2017)	Share of benefit in the LTC system (in percent)
Special benefits for family carers	375,309	33.55
Special benefits for personal assistance	5794	0.52
Total	1,118,734	100
Absolute number of beneficiaries (July 2017):	909,973	
Benefits per beneficiary ratio:	1.23	

Source: Reinhard 2018

c. Financing

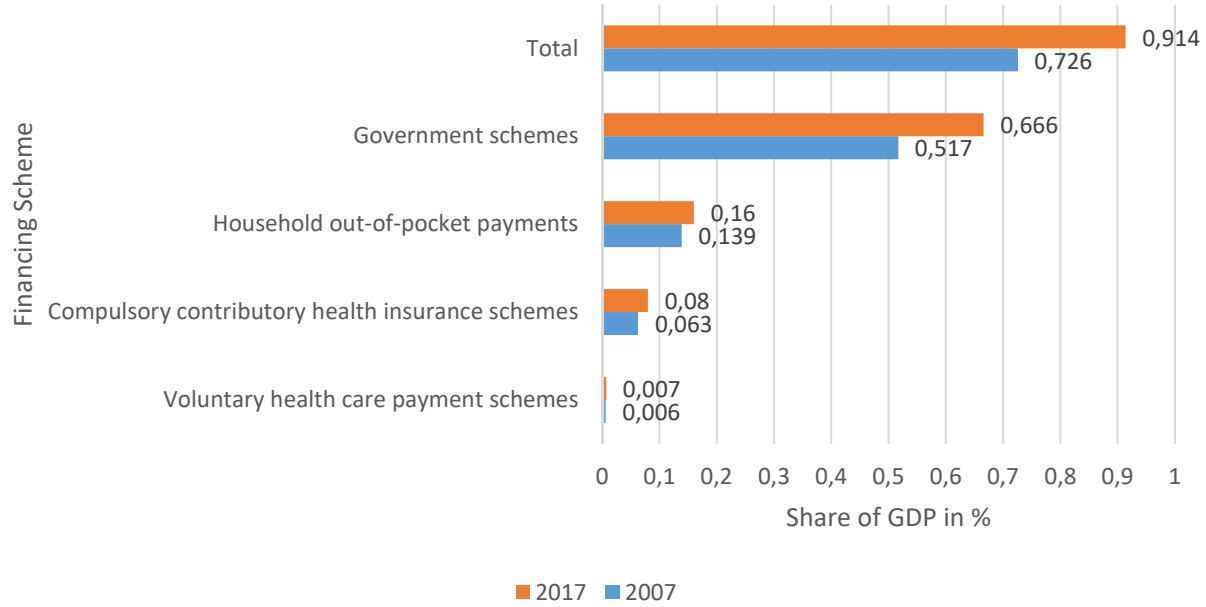
Most of the LTC system in Spain is financed by the state, following a three-level model:

- Basic benefits: Funding from the federal government (since 2017 the individual calculation is based 50% on the inhabitants of the respective region and 50% on the number of dependent people receiving benefits under the scheme.)
- Additional benefits covered by the law: Financed equally by the federal government and the specific regional government.
- Additional benefits not covered by the law: Funding by the regional governments. (Costa-Font, Gori, and Santana 2012; Reinhard 2018)

As a percentage of the GDP, LTC expenditure was 0.726% in 2007, increasing to 0.914% in 2017 (OECD 2020). Furthermore, beneficiaries must contribute with co-payments based on their income level and the services they apply for. According to Marbán Gallego (2014), only people who do not exceed the Public Income Index (IPREM) are exempted from co-payments. Others must pay, depending on their income, the required service, and regional regulations, up to 90% of the costs since the 2012 reform (Marbán Gallego 2014).

Up to 60% of the system is financed by the respective autonomous region, 20-30% by the federal government, and 10-20% by means of co-payment (Marbán Gallego 2014). According to OECD estimates, in 2007, when the system started, approx. 19.97% of total expenditure were financed from private sources (both voluntary schemes and out-of-pocket payments) while public expenditure accounts for the remaining 80.03% (OECD 2020).

Figure 1. LTC expenditure Spain in 2007 and 2017



Source: OECD 2020

d. Regulation

As described in Section III b, the federal state and autonomous regions are responsible for the regulation of the LTC system. While the federal state sets basic conditions and minimum standards of LTC in Spain, it is the responsibility of the autonomous regions to create individual policy frameworks for their respective territory. As such, they regulate service provision, assess dependency grades, and create additional benefits. The dialogue between the different governmental levels is facilitated by the Territorial Council of the SAAD.

6. List of additional relevant laws

Royal Decree Law (RDL) 20/2012:

- Administrative change of the Territorial Council: It is now affiliated to the Federal Ministry of Health and in addition serves as a forum for Social Services ("*Consejo Territorial de Servicios Sociales y del Sistema para la Autonomía y Atención a la Dependencia*").
- Financial benefits for informal care by family members are reduced and social insurance for family members working as caregivers is no longer mandatory (voluntary insurance, i.e. it is not paid by the state).
- It is possible to claim for LTC benefits retroactively, but the regional authorities may take up to two years to process each application (before: authorities had to process an application within six months).
- The three dependency grades lose their two sub-levels. From now on dependency is classified as moderate, severe or extreme dependency.
- The implementation of benefits for Grade I dependency (moderate) is postponed until 2015 (before: implementation scheduled for 2013).
- Many services are no longer compatible with each other, except for services pertaining to the prevention of dependency and the promotion of personal autonomy or teleassistance. For instance, a person cannot receive benefits for home-based care and day-care centres at the same time. (RDL 20/2012; Vilá Mancebo 2013; Rodríguez Cabrero et al. 2018)

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