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Long-term Care in Spain

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Abstract

This paper is part of an international effort to review the characteristics of Long Term Care in many developed countries. The provision of care for older age adults in Spain has greatly developed after the introduction of SAAD in 2007, which has expanded care universally under need criteria alone. As a consequence, LTC expenditure as % of GDP has increased from 0.5% (2003) to nearly 0.9% (2019) where private insurance for LTC plays a negligible role. As other long term care systems, the Spanish system still relies heavily on informal care. Replacing informal caregivers with personal home help services would imply a rise in care expenditure of 2.3%-3.8% of GDP. Caregiving allowances have benefitted about 50% of SAAD beneficiaries. Finally, the majority of caregivers in both the formal (83%) and informal (65%) sectors are women.

JEL code: I18,D14,G22
Keywords: LTC, Spain, informal care, formal care

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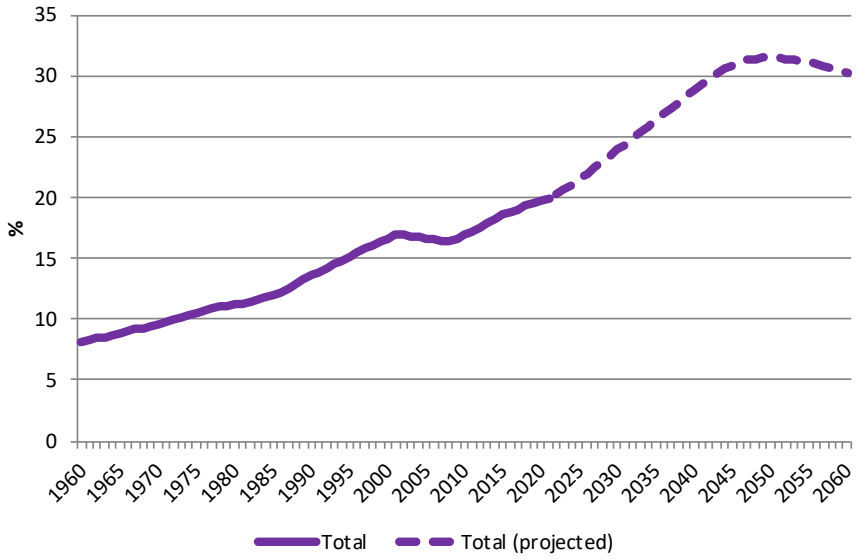
I. Introduction

The rise in life expectancy in Europe and particularly Spain is puting pressure on countries to meet the growing demands of an ageing population. According to OECD statistics, the percentage of people over the age of 65 in Spain will rise to 23.8% in 2030 and 30.3% in 2060, from 19.9% today (Figure 1). Surprisingly, in 2060, slightly more than 27% of the population over 65 (10 percentage points up from 2021) will be 85 or older in Spain (Figure 2).

Individuals over 65 years of age may be susceptible to limitations in activities of daily (ADLs) living at some point in their lives. Indeed, 11% of the population 65+ have two or more ADLs limitations versus 25% for those individuals aged 85+ (according to data from SHARE). This includes help or depend on another to carry out basic activities such as washing, eating or dressing, for example. These number suggest the need to be ready (in terms of services, technology and human capital) for a continuu increasce of the foreseable demand of LTC

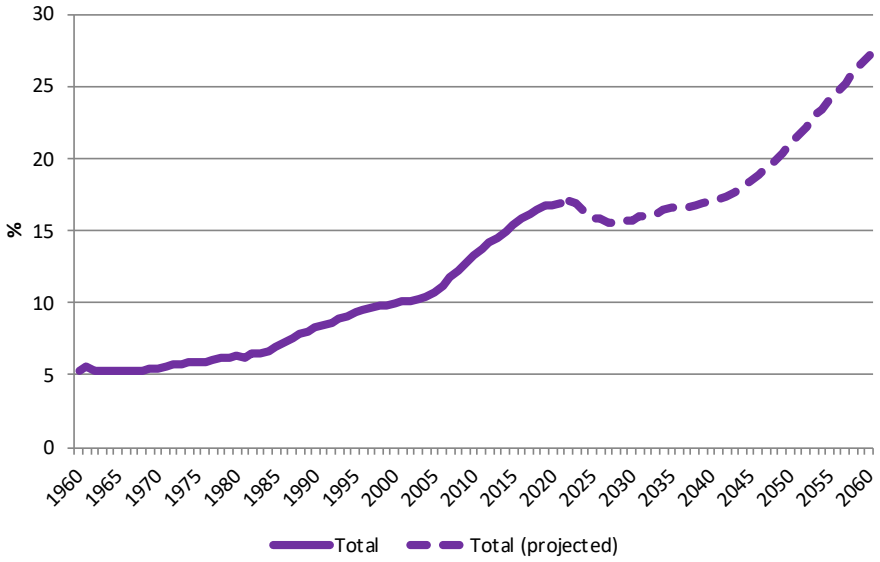
The goal of this chapter is to provide an understanding of how Spain's long-term care system is organised and provided. The following is the paper's structure. We begin with an overview of the LTC's institutional setting in Spain. The overview of demographic facts and trends is then continued (Part I). In the following sections, we will look at nursing homes, formal home care, and informal home care in terms of work hours, demographic composition, and other relevant factors (Part II). In addition, Part III includes the financing and distribution of spending, Part IV analyzes the total cost of the LTC system (value of forman and informal care) and finally Part V reports estimates of the total per capita LTC cost by type of care.

Figure 1: Percentage of population age 65 or older. Spain, 1960-2060.



Source: OECD stat, available at: https://stats.oecd.org/Index.aspx?DataSetCode=POPPROJ#, accessed on September 22, 2022.

Figure 2: Percentage of 65+ population that is age 85 or older. Spain, 1960-2060.



Source: OECD stat, available at: https://stats.oecd.org/Index.aspx?DataSetCode=POPPROJ#, accessed on September 22, 2022.

I.1 Institutional setting

The long-term care system in Spain is funded by central and regional level taxes, and individuals copyaments, though the regional share in the funding of LTC has increses from 50% to about the 60% of the total funding. The system is run by regional governments funded and its regulation and funding is regionally decentralized. More specifically, it is regulated by the Act 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care for Dependent Persons (SAAD), which universalised the access to long term cvare servicies and supports (LTCSS) and devised an effective expansion of public funding for all Spaniards. Before the introduction of SAAD, subsidies were means tested and funded by limited local authority budgets (see figure below to see the evolution of the LTC system in Spain). Disability allowances were only granted in case of disability to a degree higher than 65% and under very strict income thresholds.

The introduction of SAAD universalized the access (not the financing) of care, regardless of age or other demographic characteristics, but co-sharing arranegments designed though implemented heterogeneous by regions. Although initially the system was design to provide a system of home care suppports alone, the final design included a cash subsidy to support household form whom the best care plan was to contnue providing care Individuals were offered either a cash allowancers and a number of hours of home care supports after a needs test assessment that is carried out by an evaluator which follows slightly different criteria by region. Most regins use a ranking scale in their needs assessment to evaluate about 47 tasks grouped into ten activities. Each task is typically assigned a different weight, and a different scale is employed among individuals that suffer a mental disorder or some cognitive disability. Additionally, the care evaluation

considers the degree of supervision required to perform each task. Evaluators interview family mmebers and consider wider social needs.

After a needs test assessment, each applicant receives an 'individual care plan' which determines the support that best matches their wider care and social needs (and includes a consultation with the family). Cash subsidies (allowances) became the chosen option of about 50% of the applicants. However, allowances were incompatible with home care supports. The network of servicies provided by the LTC system includes home care supports, day care and nursing home care. The access to these services is conditioned on the score obtained in a rating scale that considered age, disability status, economic resources, and family situation. Individuals are classified into four scales 'not dependent', 'moderate', 'severe' or 'major dependent' following the official ranking scale defined by SAAD but implemented by regions.

Figure 3: The evolution of policy reforms after the Promotion of Personal Autonomy and Care for Dependent Persons (SAAD)

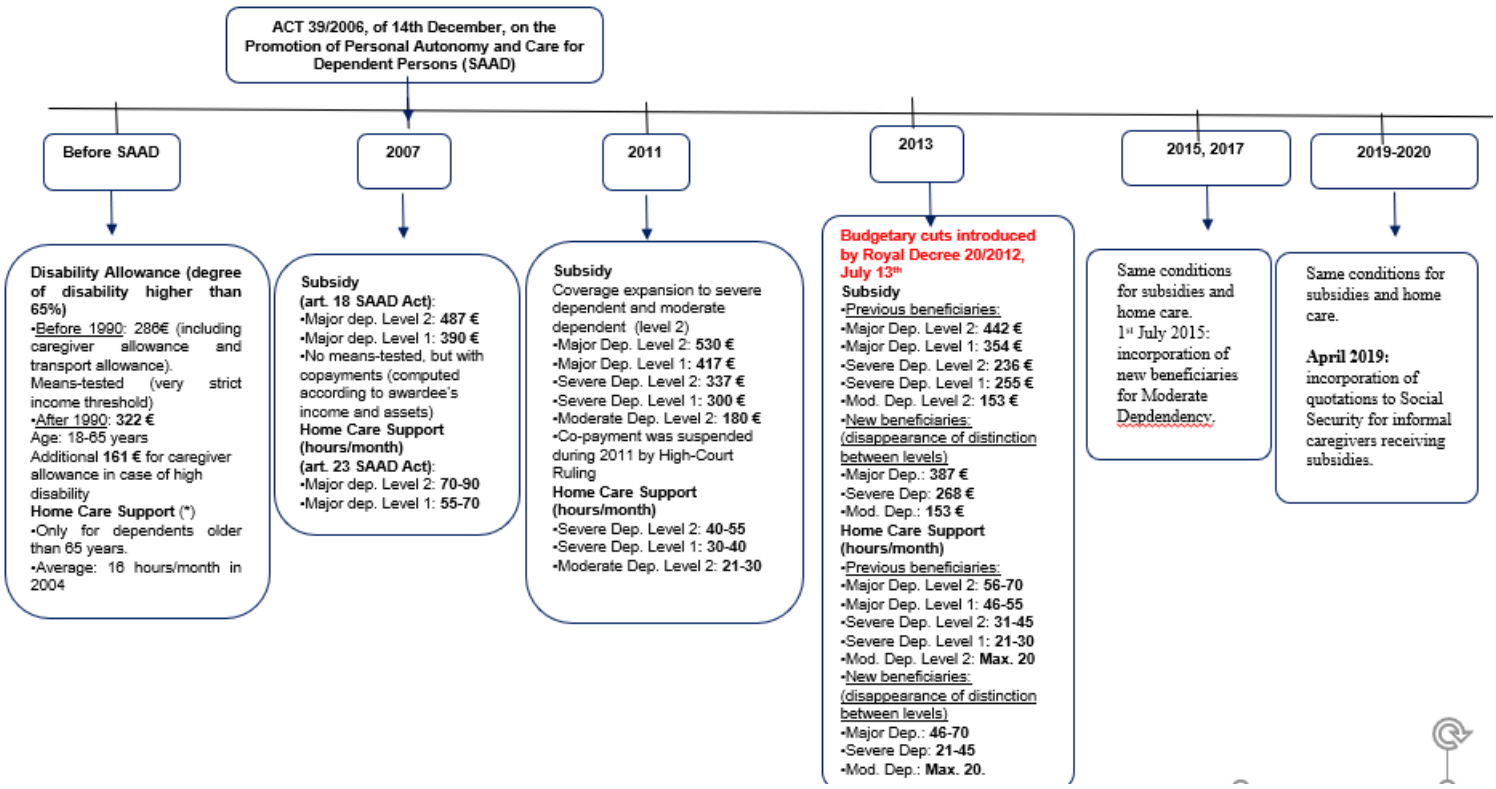


Figure 3 depicts the availability and evolution of allowances (subsidies) and homecare supports. Allowances range between €390/month and €487/month in 2007 (nominal euros) for major dependants and increased to a range between €417 and €530 in 2011. However, the amount fell to between €387 and €442 in 2013 in the wake of the 2012 austerity cuts (Rodriguez Cabrero et al, 2022). Allowances for individuals with severe dependency became available only after 2010, and they ranged between €180 and €300 in 2011, but after the 2012 spending cuts, they were subsumed into one group that

received between €236 and €268 in 2013.[1] Subsidies were always below the minimum wage and were unconditional, that is, the cash was paid directly into the care recipient's bank account. The intensity of homecare support ranges from 70-90 hours/month for major dependency, Level 1, which was four times the average provision before the reform (16 hours/month), and 55-70 hours/month for Level 2. Between 2007 and 2011, the system extended to the lower levels of dependency of severe and moderate. Consistent with the reductions in cash allowances, austerity cuts in 2012 reduced the number of hours of supports too. Between 2012 and 2014, government funding for the SAAD fell by 1,409 million euros. Individuals with 'moderate' care needs were added to the system in 2015, and individuals providing care's social security contributions were taken into account in 2019.

II. Aging, Disability and Well-Being

Sample and Definitions

Table 1 shows the percentage of people aged 65 and up who have limitations in their daily activities. As can be seen, approximately 32.5% of the population 65+ has no limitations at all (neither ADL nor IADL), compared to nearly 20% of those aged 85+. Furthermore, approximately 13% of people in both groups have no ADL limitations but at least one IADL limitation. When we consider the population with severe difficulties, defined as having four to six ADL limitations, 26.2% of the 65+ population and 40.3% of the 85+ population.

Table 1: Share with ADLs by Age. Spain, 2021.

	65+	85+
0 ADLs & 0 IADLs	0.325	0.198
0 ADLs & 1+ IADLs	0.128	0.130
1 ADL	0.105	0.082
2 ADLs	0.129	0.123
3 ADLs	0.052	0.065
4 ADLs	0.062	0.086
5 ADLs	0.094	0.139
6 ADLs	0.106	0.178
Observations	*6938*	*2357*

Source: Data are from the Survey of Disabilities, Dependency and Autonomy (2020). Interviews were conducted between April and August 2021. Respondent weights are used for all calculations ADLs include walking across room, dressing, bathing, eating, going to bed, and using the toilet. IADLs include using a telephone, managing money, taking medications as prescribed, shopping for groceries, and cooking a hot meal. Individuals that report not doing these activities are also included as having difficulty with them.

[1] For a better understanding of the significance of the magnitude of the caregiver allowance, it can be compared with the minimum wage, which was €570.60/month (2007), €641.40 /month (2011), and €645.30 /month (2013) (see Table A7 for further details). Although the reform catered for a caregiving allowance for 'moderate dependency', its implementation was delayed until 2015, and hence, only people with severe and major dependency received support.

Table 2 depicts the distribution of limitations based on the type of IADL or ADL for the 65+ and 85+ populations. In comparison to the other limitations, preparing a meal and using a phone are the most frequently reported problems for those with one or more IADLs. Furthermore, for those with one or more ADL limitations, walking across a room and getting in and out of bed are the most common difficulties, particularly in the 85+ population.

Table 2: Distribution of Limitations with Specific ADLs/IADLs. Spain, 2021.

	65+ All	65+ Conditional	85+ All	85+ Conditional
Panel 1- IADLs:				
IADL – Use a Phone	0.499	0.707	0.666	0.814
IADL – Manage Money	0.306	0.457	0.497	0.626
IADL – Take Meds as Prescr.	0.256	0.458	0.411	0.606
IADL – Shop for Groceries	0.219	0.393	0.365	0.539
IADL – Prepare a Meal	0.478	0.698	0.657	0.817
Observations	6938	3788	2357	1597
Panel 2- ADLs:				
ADL – Use the Toilet	0.305	0.558	0.450	0.670
ADL – Get Dressed	0.306	0.560	0.460	0.685
ADL – Take a Bath	0.338	0.617	0.501	0.745
ADL – Walk Across a Room	0.386	0.706	0.509	0.758
ADL – Eat	0.139	0.254	0.222	0.330
ADL – Get In/Out of Bed	0.395	0.723	0.485	0.721
Observations	6938		2357	1597

Source: Data are from the Survey of Disabilities, Dependency and Autonomy (2020). Interviews were conducted between April and August 2021. Respondent weights are used for all calculations Column 1 shows the share of the sample that report having difficulty with each activity, while Column 2 shows the share of people with at least 1 IADL (panel 1) or at least 1 ADL (panel 2) who report having difficulty with each activity. Individuals that report not doing these activities are also included as having difficulty with them.

Well-Being

Table 3 shows the percentile distribution of household income and wealth for those aged 65 and up and 85 and up. As can be seen, income and wealth are rising along the income percentile distribution (with a slightly increase at 90th percentile). For example, the bottom 5% of the population 85+ has a wealth of 1,067€, while the bottom 5% of those 65+ have a wealth of 5,334€. On the other hand, the top 5% of the sample for those aged 85 and up has a wealth of 470.458€, while those aged 65 and up have a wealth of 579.465€. Similar conclusions can be achieved comparing income instead of wealth

Table 3: Income and Wealth Distribution. Spain, 2019.

	Income		Wealth	
	65+	85+	65+	85+
5th Percentile	3,194	1,567	5,334	1,067
10th Percentile	7,444	2,733	35,197	12,251

25th Percentile	10,560	8,289	87,000	76,898
50th Percentile	16,100	11,690	151,297	135,000
75th Percentile	22,791	16,800	271,149	210,667
90th Percentile	32,760	23,629	444,909	350,800
95th Percentile	41,906	29,718	579,465	470,458
Mean	18,135	13,318	204,345	170,660
Observations	*951*	*209*	*951*	*209*

Notes: Data are from the Survey of Health, Ageing and Retirement in Europe (wave 8; only interviews conducted in 2019). Weights are used to include individuals in nursing homes. All income estimates are post-tax (2019 euros).

Table 4 shows the distribution of household (HH) income and wealth by ADLs and IADLs limitations. Approximately 10% of those 65 and older with no daily life limitations earn less than 50% of the median HH income. However, the share of the population 65+ with one or more ADLs/IADLs limitations continues to rise: 16.4%, 18.5%, and 22.6% with one, two, or three or more ADLs/IADLs limitations, respectively. In terms of higher income categories, as the number of ADL limitations increases, the population share decreases.

Table 4: Income and Wealth Distribution by Limitations for 65+ Population

Spain, 2019.

	0 ADLs & 0 IADLs	0 ADLs & 1+ IADLs	1 ADL	2 ADLs	3+ ADLs	Total
Panel 1: Income						
<50% Median HH Income	0.096	0.108	0.164	0.185	0.226	0.119
50-100% Median HH Income	0.347	0.460	0.377	0.519	0.478	0.380
100-150% Median HH Income	0.280	0.306	0.344	0.222	0.209	0.277
150-200% Median HH Income	0.118	0.081	0.082	0.037	0.026	0.100
200%+ Median HH Income	0.159	0.045	0.033	0.037	0.061	0.125
Total	0.693	0.108	0.060	0.026	0.112	-
Observations	710	111	61	27	115	1,025
Panel 2: Wealth						
<50% Median HH Wealth	0.180	0.351	0.230	0.185	0.330	0.219
50-100% Median HH Wealth	0.263	0.306	0.328	0.444	0.313	0.281
100-150% Median HH Wealth	0.157	0.198	0.230	0.185	0.209	0.172
150-200% Median HH Wealth	0.126	0.072	0.016	0.074	0.070	0.106
200%+ Median HH Wealth	0.274	0.072	0.197	0.111	0.078	0.221
Total	0.693	0.108	0.060	0.026	0.112	.
Observations	710	111	61	27	115	1,025

Notes: Notes: Data are from the Survey of Health, Ageing and Retirement in Europe (wave 8; only interviews conducted in 2019). Weights are used to include individuals in nursing homes. All income estimates are post-tax (2019 euros).

. Our ADL Index runs from 0-6 and is the number of ADLs that are either difficult or not done from eating, bathing, dressing, using the toilet, walking across a room, and getting in/out of bed. IADLs include using a telephone, managing money, taking medications as prescribed, shopping for groceries, and cooking a hot meal. Each cell reports the share of respondents in the respective ADL category who are in that row's income group.

Finally, in Table 5, we summarise various measures that reflect people's well-being. On the surface, it appears that having multiple limitations (three or more) for daily life activities (and at older ages) has an impact on having good health. However, 9.4% of those aged 65 and over report having good health, while 8.5% of those aged 85 and up report having good health. Individuals with no limitations, on the other hand, exhibit a much higher percentage of people reporting good or better health: 34.3% for those 65 and up, and 20.1% for those 85 and over. Furthermore, the prevalence of depression is quite similar between those with no limitations and those with three or more limitations, particularly among those aged 85 and over: for whom only 35.4% display no limitations and 34.9% for those aged 65 and over with three or more limitations.

Table 5: Well-Being for those 65+ and 85+ by ADL Limitations. Spain, 2019.

	65+	65+, 3+ Lims	85+	85+ 3+ Lims
Reports good or better health status	0.343	0.094	0.201	0.085
Very satisfied with retirement.	0.638	0.398	0.545	0.434
Depressed Much of Time	0.291	0.355	0.354	0.349
Observations	951	256	209	129

Notes: Data are from the Survey of Health, Ageing and Retirement in Europe (wave 8; only interviews conducted in 2019). Our Limitations Index runs from 0-12 and is the number of ADLs/IADLs that are either difficult or not done from eating, bathing, dressing, using the toilet, walking across a room, and getting in/out of bed (ADLs) + using a telephone, managing money, taking medications as prescribed, shopping for groceries, and cooking a hot meal (IADLs). Because retirement satisfaction is only asked of those who are retired, the sample is restricted to those who are retired. The survey asks whether respondents have felt depressed much of the time over the last week.

Care Received

Table 6 reports the distribution of hours of help received depending on informal or formal provider and all together. Hours of help from each helper are limited to 16 hours per day to allow for 8 hours of rest, so the maximum hours per week should be 112 (95% of the cases). Only 5% of the caregivers work less than 7 hours per week for the group of people 65+ and 14 hours per week for the group of 85+.

Table 6: Distribution of Hours of Help Received per Week. Spain, 2021.

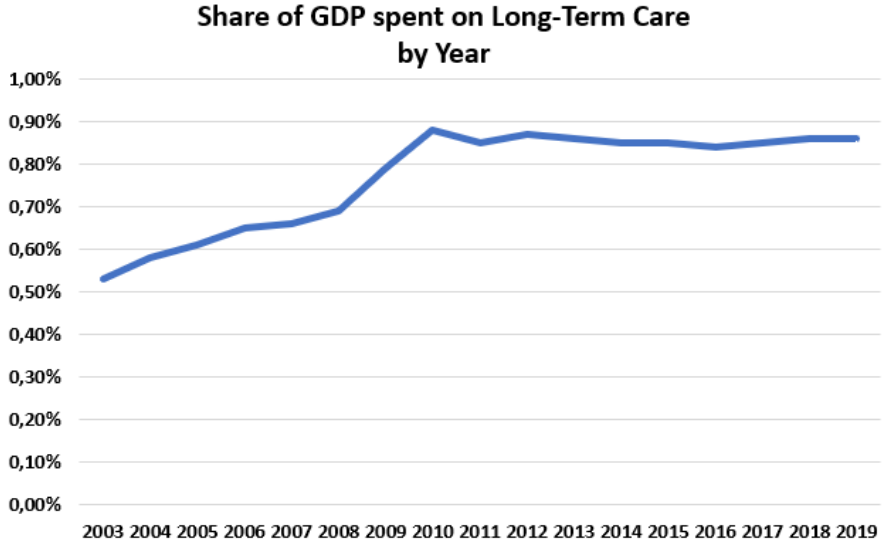
	65+	85+
5th Percentile	7	14
10th Percentile	14	21
25th Percentile	28	35
50th Percentile	77	91
75th Percentile	112	112
90th Percentile	112	112
95th Percentile	112	112
Mean	68	74
1 Hour per Day or Less	0.06	0.03
5 Hour per Day or More	0.68	0.77
Observations	*3882*	*1744*

Notes: Survey of Disabilities, Dependency and Autonomy (2020). Interviews were conducted between April and August 2021. Respondent weights are used for all calculations. Nursing home residents are automatically excluded from all calculations. Hours include both formal and informal care received from helpers who assist with ADLs, IADLs, and managing money because of a health problem. Hours of help from each helper are limited to 16 hours per day to allow for 8 hours of rest.

III. Long-Term Care System in Spain

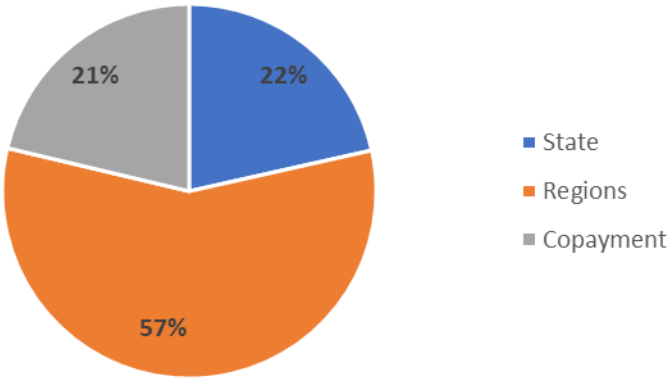
LTC expenditure as % of GDP has increased from 0.5% (2003) to nearly 0.9% (2019). Since 2017, spending on long-term care relative to GDP has followed a slight upward trend, after a period of slow down (Figure 4). Besides, Figure 5 reports a summary of the percent of LTC financing by source. LTC financing is made of the central governments general contribution, contributions from autonomous communities (regions), and contributions from users (cost sharing). The regional contribution is 57%, the central state contribution is 22%, and the percentage attributed to users cost sharing, which is about 21% (see figure 6).

Figure 4: Share of GDP spent on long-term care. Spain, 2003-2019.



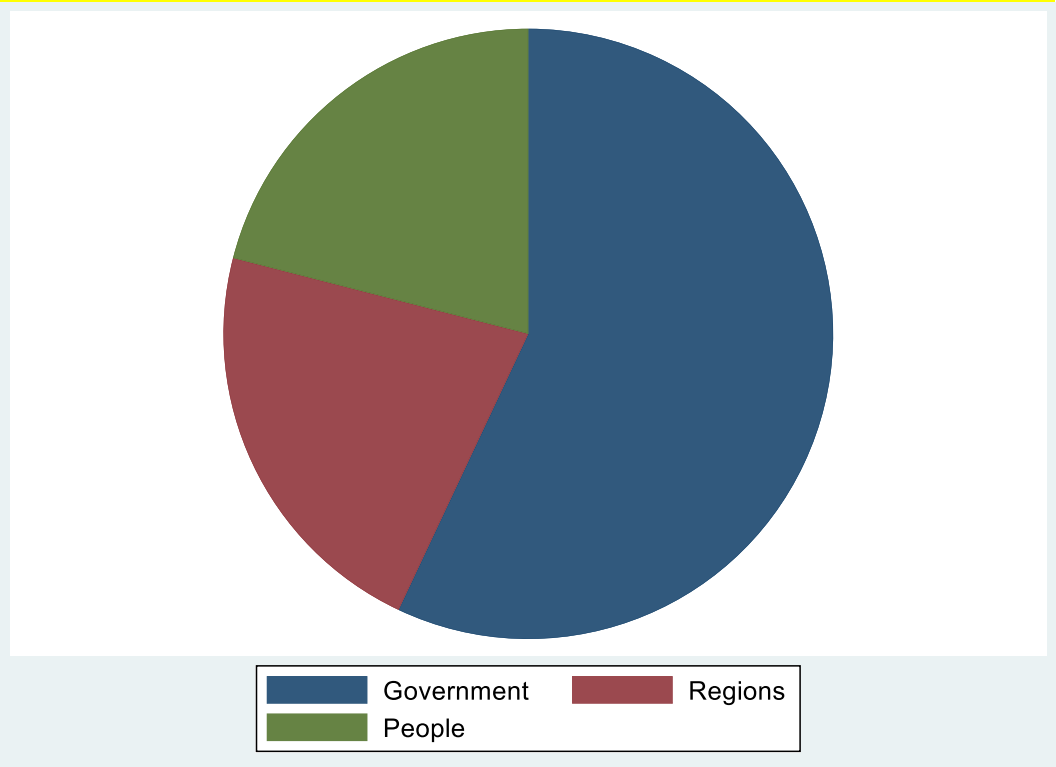
Source: Eurostat.

Figure 5: Percent of LTC Financing by Source. Spain, 2021.



Source: Asociación Estatal de Directores y Gerentes de Servicios Sociales de España, available at: https://directoressociales.com/wp-content/ccaa2021/INFO%20GLOBAL%20XXI%20DICTAMEN%202022%20Def%20%283%29.pdf

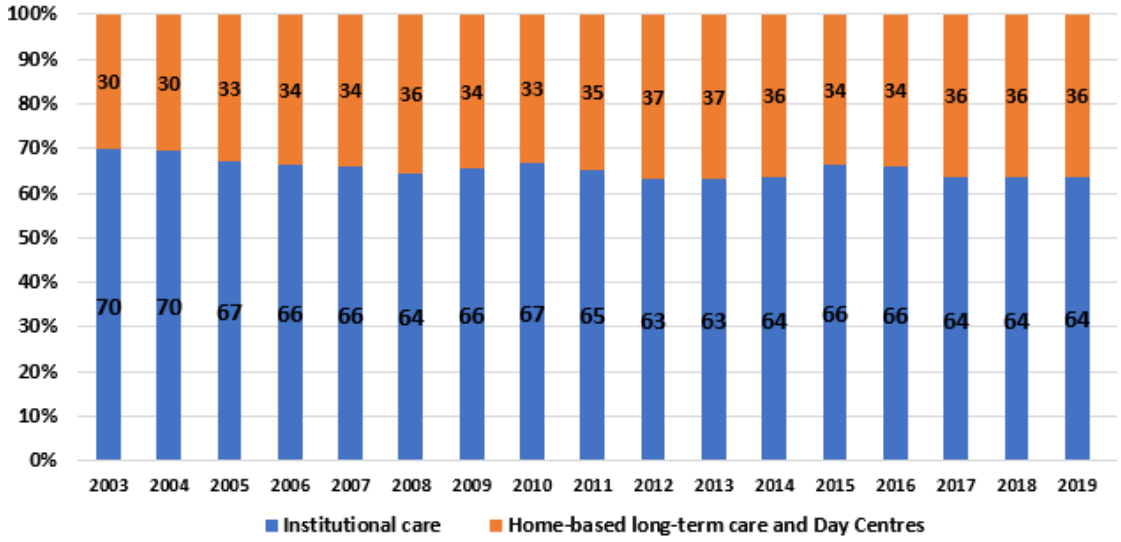
Figure 6. Source of funding of the LTC system (including residential care). 2019



In Figure 7 we show the share of public LTC expenditure[2] aimed at institutional care and home care and day centers. As can be observed, the expenditure on institutional care accounts for 64% although it has been decreasing 6 pp since 2003 and in consequence the share of public LTC expenditure relative to home care and day centers has increased from 30% in 2003 to 36% in 2019.

[2] As we cannot replicate Medicaid spending because the LTC system in Spain is diverse, we opted to replace it for the public LTC by type of care.

Figure 7: Share of public LTC expenditure for institutional care and home care and day centers. Spain, 2003-2019.



Source Eurostat.

Private Insurance

The market for private insurance in Spain for LTC is still underdeveloped. Table 7 reports the number of individuals (of all ages) with private LTC insurance, and as can be noticed it is very low respect to total population, that is, 0.14%. Table 8 (based on SHARE data) reports some descriptive characteristics for both insured and uninsured groups. For example, those individuals with insurance perceive higher incomes and those people uninsured receive more informal help (43.5%) than those insured (23.3%).

Table 7: Population with LTC Insurance- Spain, 2019.

	65 Plus	85 Plus
Population with LTC Insurance	54,024	6,500
Share of 65+/85+ Population	(0.037)	(0.019)
Observations	*951*	*209*

Notes: Data are from the Survey of Health, Ageing and Retirement in Europe (wave 8; only interviews conducted in 2019) All types of long-term care insurance, regardless of whether it covers home care, nursing home care, or both, are counted for the insured indicator.

Table 8: Characteristics by LTC Insurance. Spain, 2019.

	65+ Insured	65+ Uninsured
Total Household Wealth - Mean	177,968	186,721
Total Household Wealth - Median	164,625	13,700
Total Household Income - Mean	26,478	15,954
Total Household Income - Median	20,700	13,740
In Nursing Home (> 100 days)	0.000	0.005
Live with Spouse or Partner	0.542	0.569

Formal Help with ADL/IADLs	0.287	0.190
Informal Help with ADL/IADLs	0.233	0.435
Observations	*56*	*895*

Notes: Data are from the Survey of Health, Ageing and Retirement in Europe (wave 8; only interviews conducted in 2019). All types of long-term care insurance, regardless of whether it covers home care, nursing home care, or both, are counted for the insured indicator. All variables (income, wealth, types of help) are defined as they were in previous tables.

Long-Term Care Receipt

Table 9 displays the share of people 65 and 85+ who receive any care at home in the form of formal or informal help by their number of ADL/IADL limitations. 56.3% of people aged 65+ receive any kind of formal or informal care (30% for people 85+). As expected, the percentage of people who need care increases with the number of ADL limitations: roughly 75% for those individuals 65+ and 40% for people aged 85 or over.

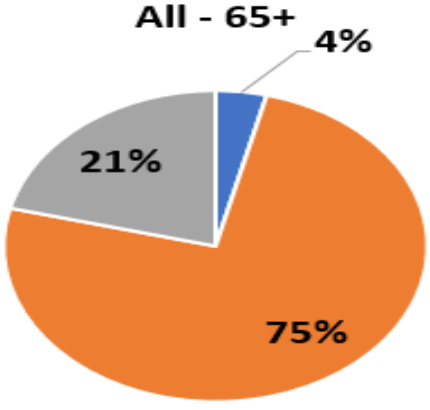
Table 9: Any Care by Age and ADL. Spain, 2021.

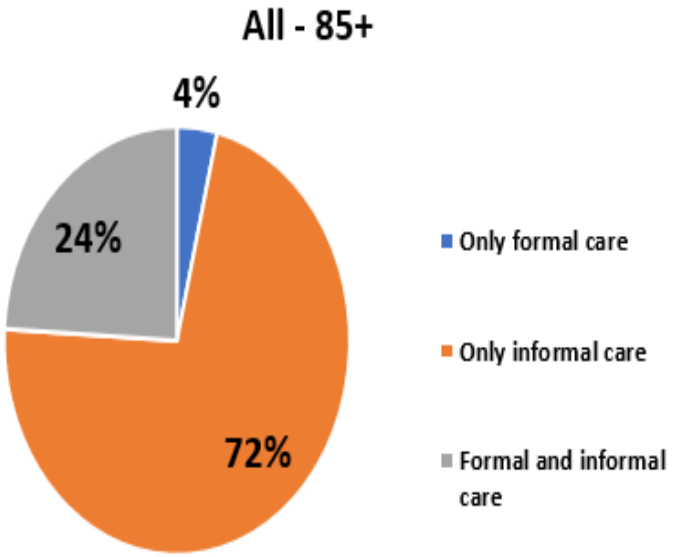
	65 Plus	85 Plus
Full Sample	0.563	0.550
0 ADLs, 1+ IADL	0.066	0.063
1 ADL	0.052	0.040
2 ADL	0.082	0.070
3+ ADL	0.237	0.277
Observations	*6938*	*2357*

Notes: Data are from the Survey of Disabilities, Dependency and Autonomy (2020). Interviews were conducted between April and August 2021. Respondent weights are used for all calculations. The care variable is defined as either having received either formal or informal home help with ADLs, IADLs, or managing money because of a health condition in the last 30 days

Figure 8 and Figure 9 illustrate the classification between formal and informal care for each category of ADL, namely, one, two or three and more limitations. As can be perceived, informal care is predominant in all categories of ADL limitations. Specifically, with one ADL limitation, informal care accounts for 85% in the group of 65+ and 81% in the older group (Jiménez-Martín and Viola, 2020).

Figure 8: Type of Care Received by Age. Spain, 2021.

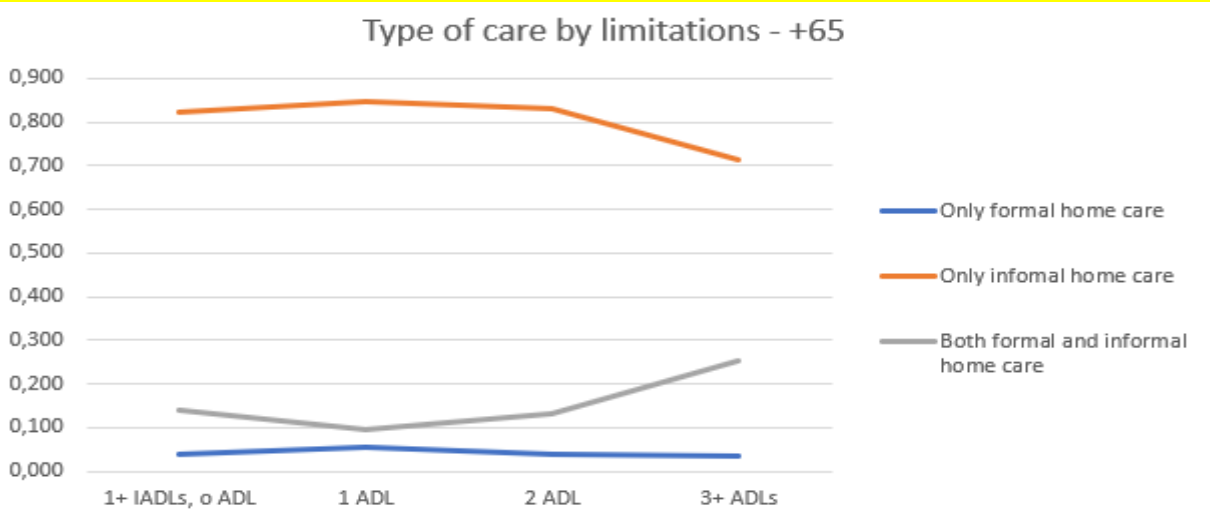


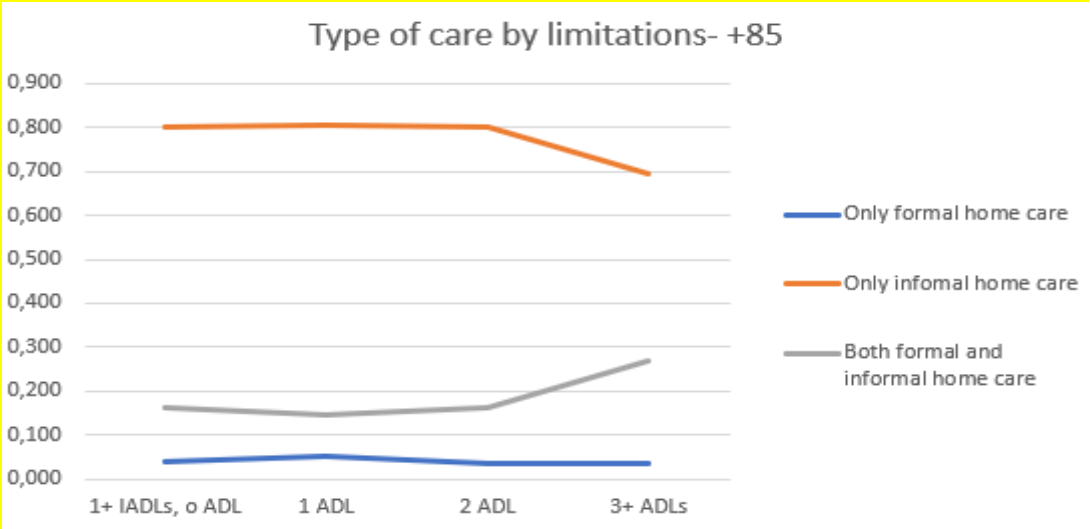


Notes: Data are from the Survey of Disabilities, Dependency and Autonomy (2020). Interviews were conducted between April and August 2021. Help can be with ADLs, IADLs, or managing money due to a health problem. Respondent weights are used for all calculations. Formal care refers to home care (public or private).Informal care refers to care provided by family members.

Figure 9: Type of Care Received by Age and Limitations.

Spain, 2021.





Notes: Data are from the Survey of Disabilities, Dependency and Autonomy (2020). Interviews were conducted between April and August 2021.

Table 10 reports the distribution of hours of help received depending on informal or formal provider and all together. Hours of help from each helper are limited to 16 hours per day to allow for 8 hours of rest, so the maximum hours per week should be 112 (95% of the cases). Only 5% of the caregivers work less than 7 hours per week for the group of people 65+ and 12 hours per week for the group of 85+.

Table 10: Distribution of Weekly Hours Received by Type Spain, 2021.

	65+		85+	
	Formal	Informal	Formal	Informal
5th Percentile	7	7	7	14
10th Percentile	7	14	7	14
25th Percentile	7	28	14	35
50th Percentile	14	70	14	84
75th Percentile	35	112	42	112
90th Percentile	84	112	98	112
95th Percentile	112	112	112	112
Mean	29	67	33	72
Observations	*863*	*3739*	*445*	*1683*

Notes: Survey of Disabilities, Dependency and Autonomy (2020). Interviews were conducted between April and August 2021. Respondent weights are used for all population estimate calculations. Hours include care received from helpers who assist with ADLs, IADLs, and managing money because of a health problem. Hours of help from each helper are limited to 16 hours per day to allow for 8 hours of rest. help is defined as help provided without pay or by a paid relative, while formal help is paid help by a non-relative.

Formal Long-Term Care Supply

Table 11 provides an overview of key indicators related to nursing homes in Spain based on the most recent data available from the Institute for Older People and Social Services (IMSERSO) and data from Jiménez and Viola (2019). In Spain, there are 5,542 nursing homes, the majority of which are private (74.11%). On the contrary, the total number of registered beds in 2019 is 389,031 of which 61.9 percent are public. The

occupancy rate of nursing homes varies by region (Table 13) expressed as the percentage of beds/places occupied in nursing homes. In Spain, the occupancy rate is around 63%. However, there are communities such as Castilla-La Mancha, Madrid, Murcia, Ceuta and Melilla where the occupancy level is well above the national average, reaching full capacity of the nursing homes (99%-100%).

Table 11: Absolute number of nursing homes, beds, and occupancy rate. Spain, 2019.

	Spain, 2019
Nursing homes	5,542
Fraction public nursing homes	25.89%
Fraction private nursing homes	74.11%
Beds	389,031
Fraction public beds	61.90%
Fraction private beds	38.10%
Nursing home residents	247,451
Pop 65+	9,217,464
Occupancy rate	63.61%
Nursing home size	70.2
Coverage	4.2%
Beds per pop 65+	0.042

Source: IMSERSO.
Occupancy rate is defined as the percentage of beds occupied in nursing homes.
Nursing home size is defined as the number of beds per nursing home facility.
Coverage is defined as the percentage of population 65+ who has a nursing home bed.

Table 12: Distribution of nursing homes occupancy rate and beds across states. Public and private nursing home places.

Spain, 2019.

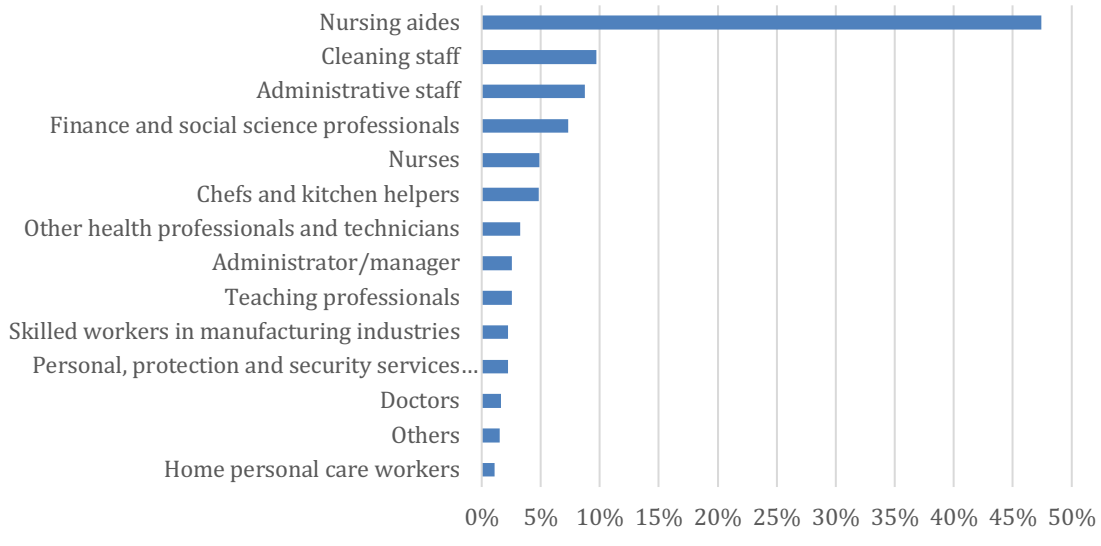
REGION	NH places	NH users	Occupancy rate
Andalusia	45.543	21.919	48,1%
Aragon	19.318	6.817	35,3%
Asturias	15.204	5.987	39,4%
Balearic Islands	6.573	5.334	81,2%
Canary Islands	9.994	9.498	95,0%
Cantabria	6.444	4.401	68,3%
Castile and León	48.089	42.501	88,4%
Castilla-La Mancha	28.695	28.428	99,1%
Catalonia	65.379	44.746	68,4%
Valencia	27.248	16.657	61,1%
Extremadura	14.855	10.211	68,7%
Galicia	21.704	8.674	40,0%
Madrid	52.882	52.830	99,9%
Murcia	5.395	5.395	100,0%

Navarre	6.664	5.339	80,1%
Basque Country	21.765	14.819	68,1%
La Rioja	3.235	1.926	59,5%
Ceuta	199	199	100,0%
Melilla	231	227	98,3%
Spain	399.417	250.708	62,8%

Source: IMSERSO and Jimenez-Martin and Viola (2022)
Note NH users: Aragon, Canary Islands and Extremadura, data 2016. Galicia, data 2017.

Figure 10 depicts the division of staff in nursing home facilities by type of occupation (according to the National Classification of Occupations 2011). As can be seen, nursing aides account for the vast majority of workers in nursing homes (47%), followed by cleaning staff (10%) and administrative staff (9%). Furthermore, nurses (5%) and doctors (2%) make up 7% of the total.

Figure 10. Percent distribution of nurses, aides, and social workers at care facilities. Spain, 2021.



Source: Economically Active Population Survey - EPA. Notes: Administrative staff includes legal and social services support professionals. Nursing aides includes auxiliary technicians of pharmacy and health emergencies.

Training requirements for formal home care workers in Spain are based on professional certifications. Home help assistants must certify the professional qualification of Social and Health Care for People at Home, established by Royal Decree 295/2004, of 20 February, establishing certain professional qualifications that are included in the National Catalogue of Professional Qualifications, as well as their corresponding training modules that are incorporated into the Modular Catalogue of Vocational Training[3].

For this purpose, the following are diplomas and certificates of professional qualifications:

[3] Order SCB/429/2019, of 1 April, amending Order SAS/2287/2010, of 19 August, which regulates the requirements and procedure for the accreditation of the centres, services and private entities, subsidised or not, that act in the field of personal autonomy and care for dependent persons in the cities of Ceuta and Melilla.

- Title of Technician in Auxiliary Nursing Care established by Royal Decree 546/1995, of 7 April, which establishes the title of Technician in Auxiliary Nursing Care and the corresponding minimum education, or the equivalent titles of Clinical Auxiliary Technician, Psychiatric Auxiliary Technician and Nursing Auxiliary Technician established in Royal Decree 777/1998, of 30 April, by which certain aspects of the organisation of vocational training in the field of the educational system are developed, or, where appropriate, any other qualification published with the same professional effects, which takes 1400 hours

- Diploma of Technician in Care of People in a Situation of Dependency, regulated by Royal Decree 1593/2011, of 4 November, establishing the Diploma of Technician in Care of People in a Situation of Dependency and setting its minimum teachings, or the equivalent diploma of Technician in Social and Health Care, established by the then Royal Decree 496/2003, of 2 May, establishing the Diploma of Technician in Social and Health Care and the corresponding common teachings, or, where appropriate, any other diploma that may be published with the same professional effects, which takes 2000 hours

- Title of Higher Technician in Social Integration, established by Royal Decree 1074/2012, of 13 July, establishing the title of Higher Technician in Social Integration and setting its minimum teachings, or the equivalent title of Higher Technician in Social Integration established in the then Royal Decree 2061/1995, of 22 December, establishing the title of Higher Technician in Social Integration and the corresponding minimum teachings, for those professionals who, on the date of publication of the Agreement of 19 October 2017, were working in the professional category of home help assistant, which takes 2000 hours

- Certificate of Professionalism in Social and Health Care for Dependent Persons in Social Institutions, regulated by Royal Decree 1379/2008, of 1 August, which establishes two certificates of professionalism of the professional family Socio-cultural and community services that are included in the National Directory of certificates of professionalism, or, where appropriate, any other certificate that is published with the same professional effects, which takes 450 hours

- Certificate of Professionalism of Socio-sanitary Care of People at Home, regulated by Royal Decree 1379/2008, of 1 August, or the equivalent certificate of professionalism of the occupation of home help assistant, regulated in the then Royal Decree 331/1997, of 7 March, by which the certificate of professionalism of the occupation of home help assistant is established, or in its case, any other certificate that is published with the same professional effects" , which takes 600 hours

Exceptionally, individuals who, on 31 December 2017, could accredit experience of at least 3 years, with a minimum of 2,000 hours worked in the previous 12 years in the corresponding professional category, or who, without reaching the minimum experience required, had worked and had a minimum of 300 hours of training related to the professional competences they wish to accredit in the previous 12 years, are eligible for the qualification of 'home help assistants,' or 'geroculturists,'

Table 13 displays earnings for full-time employees based on administrative data from the Spanish Continuous Sample of Working Life (Muestra Continua de Vidas Laborales). A worker in a nursing facility (1,473 euros) earns approximately 50 euros more per month than a worker in home care (1,424 euros). According to percentiles, 10% of nursing facility workers earn less than 847 euros per month and 626 euros in home care (percentile 10), while only 10% of nursing home workers (percentile 90) earn more than 2,238 euros per month and 2,542 euros per month in home care.

Table 13. Pay for full-time care workers at nursing facilities and in home health care. Spain, 2018.

CARE TYPE	P10	P50	P90	Wage Euros/month
Nursing facilities	846.94	1,323.33	2,237.6	1,472.576
Home care	625.57	1,207.57	2,541.59	1,424.273

CARE TYPE	SKILL	P10	P50	P90
Nursing facilities	Low education	1,082.81	1,770.095	3,082.19
	Inter. Education	822.73	1,288.45	1,904.24
	High education	731	1,193.72	1,649.71
Home care	Low education	822.33	1,722.04	3,108.22
	Inter. Education	712.94	1,305.92	2,720.6
	High education	472.41	964.87	1,392.87

CARE TYPE	SKILL	Wage Euros/month
Nursing facilities	Low education	1,928.629
	Inter. Education	1343.865
	High education	1207
Home care	Low education	1,846.593
	Inter. Education	1,553.243
	High education	964.5872

Source: Spanish Continuous Sample of Working Life (2018).

Who are the Caregivers?

Table 14 reports estimates of the total number of individuals providing ADL/IADL-related help. Around 81% of people helping individuals over age 65 were informal caregivers and if we focus on the group of 85+ the fraction is almost the same (79%).

Table 14: Home Care Provision – Population Estimates. Spain, 2021.

	65 Plus	85 Plus
Formal Helpers - ADL/IADLs	328,363	163,796
Relative to 65+/85+ Population	(0.035)	0.018)
Relative to 18-64 Population	(0.011)	0.006)

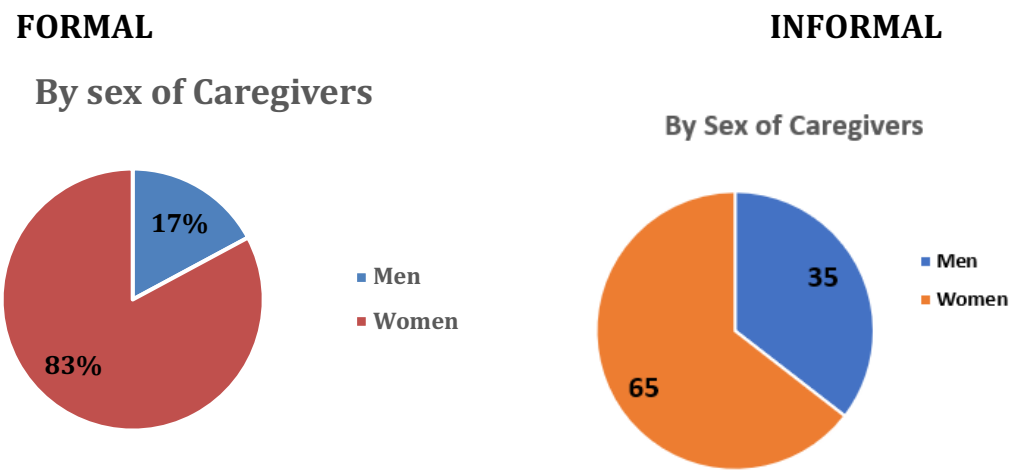
Informal Helpers - ADL/IADLs	1,405,925	621,406
Relative to 65+/85+ Population	(0.152)	0.067)
Relative to 18-64 Population	(0.047)	0.021)
All Helpers - ADL/IADLs	1,734,288	785,202
Relative to 65+/85+ Population	(0.187)	0.085)
Relative to 18-64 Population	(0.058)	0.026)
Observations	*3,882*	*1,744*

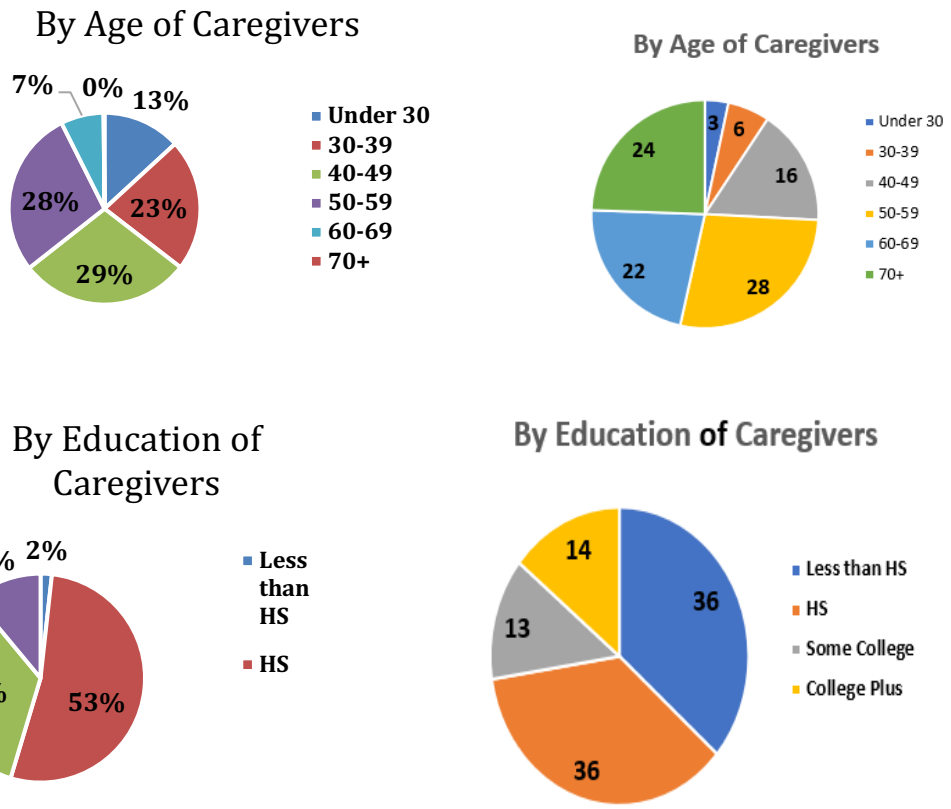
Notes: Survey of Disabilities, Dependency and Autonomy (2020). Interviews were conducted between April and August 2021. Respondent weights are used for all population estimate calculations Respondent weights are used for all population estimate calculations. Those providing help to nursing home residents are automatically excluded from all calculations. ADLs and IADLs are defined as before. Informal help is defined as help provided without pay or by a paid relative, while formal help is paid help by a non-relative.

In terms of the demographic composition of formal and informal home care workers, Figure 11 shows that the majority of caregivers in both the formal (83%) and informal (65%) sectors are women. Caregivers in the formal sector are mostly between the ages of 40 and 59 (57%). On the contrary, caregivers in the informal sector are older than those in the formal sector because people aged 50 to 69 account for 50% of caregivers, and people aged 70 or older account for 24%. Furthermore, 53% of total formal care workers have a high school diploma (HS), followed by 34% who have a college diploma or something similar. The informal sector seems to be less qualified thus having 36% of informal workers less than a high school degree and 13% with some college degree.

Finally, Figure 12 depicts the informal caregivers' relationship to the care recipient. As can be seen, over 60% of informal caregivers are spouses, 18% are children, and 8% are mothers.

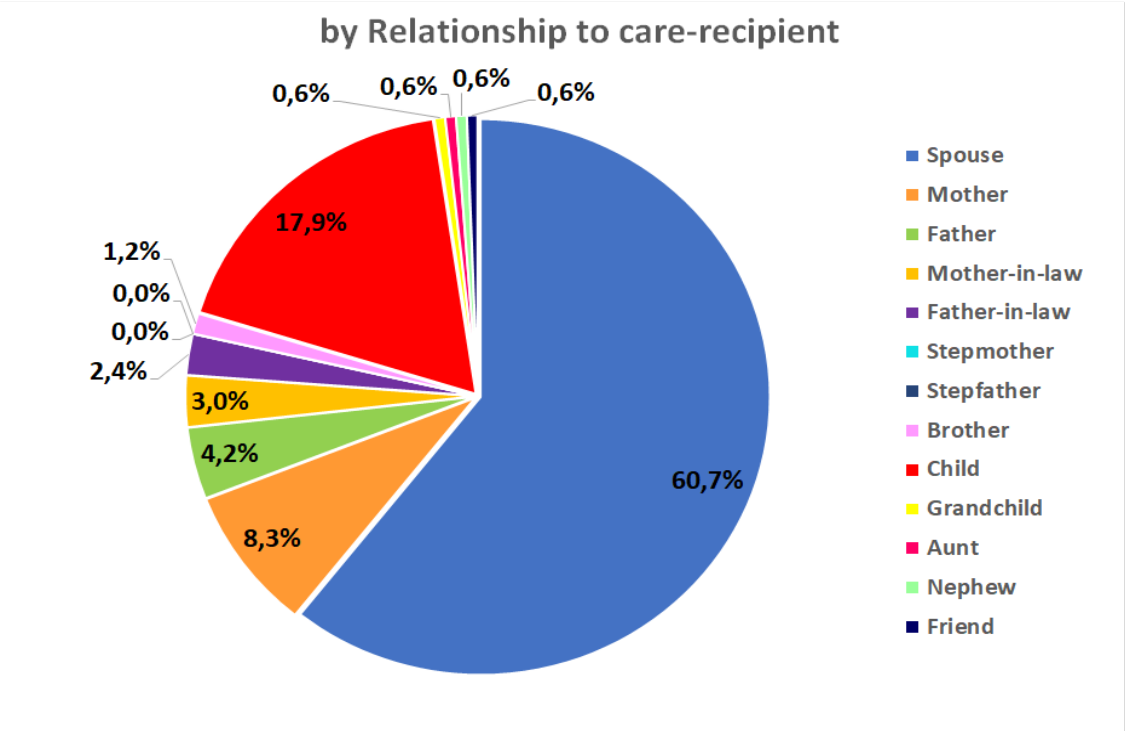
Figure 11: Demographic composition of Formal and Informal Caregivers.. Spain 2021





Notes: Survey of Disabilities, Dependency and Autonomy (2020) and Economically Active Population Survey – EPA. The Survey of Disabilities, Dependency and Autonomy was conducted between April and August 2021.Respondent weights are used for all population estimate calculations.

Figure 12: Informal Caregivers by Relationship to Care Recipient. Spain, 2020.



Source: National Health Survey (2020). Interviews were conducted between July 2019 and July 2020.

IV. The Cost of Long-Term Care

Public insurance entitlement and benefits

In Spain, everyone is entitled to have access to LTC. LTC funding, on the other hand, comes from national and regional budgets, as well as from individuals themselves through income-based cost sharing. As mentioned, prior to the implementation of SAAD, public assistance was limited to means-tested allowances provided by underfunded local authority budgets, as well as means-tested disability allowances granted only for a degree of disability greater than 65%.

Eligibility for LTC benefits does not depend on an individual's age or other socioeconomic/demographic characteristic, and its only conditioned on individuals undergoing a needs test as defined in section 0.I. That is, a needs test determinants individual care needs, and gives rise to a specific care plan. However, the system faces significant waiting times which vary significantly across regions, and some share of applicants pass away before they get to benefit from SAAD.

Care plans defined the care that best matches each individual needs, which include inputs not just of an individual's personal care needs but consider wider availability of care in the household. Individuals are classified into four tiers of care needs, namely 'not dependent', 'moderate', 'severe' or 'major dependent', pursuant to SAAD's official ranking scale.[4] The final decision on the content of the 'individual care plan' lies with the regional department of social services. Since its implementation in 2007, the subsidy has increased the social security entitlements of informal caregivers below the official retirement age.

The administrative procedure giving rise to the care entitlement is initiated at the request of citizen, and it can be either directly requested by individuals themselves of their legal representatives or guardians. Requirements to apply for it:

1. Spanish (or European nationality).
2. Be regarded in a situation of dependency needing care in one of the degrees spatulated by SAAD.
3. Have Spanish residency for more than five years. Of these, two must be immediately prior to the date of submission of the application.
4. The law does not establish a minimum or maximum age for receiving aid.

[4] The ranking scale evaluates 47 tasks grouped into the following ten activities of daily living: eating and drinking, control of physical needs, bathing and basic personal hygiene, other personal care, dressing and undressing, maintaining one's health, mobility, moving outside the home, and housework. Each activity of daily living is assigned a different weight, and there is a different scale for individuals with mental illness or cognitive disability. Additionally, the evaluation considers the degree of supervision required to perform each task. The final score is the sum of the weights of the activities of daily living for which the individual has difficulty multiplied by the degree of supervision required. The degree of dependency is determined as the result of the sum: not eligible (less than 25 points), moderate dependency (25 to 49 points), severe dependency (50 to 74 points), and major dependency (above 74 points). Spain's Royal Decree 504/2007, of 20 April, approved the dependency rating scale established by Act 39/2006, of 14 December, *Promoción de la Autonomía Personal y Atención a las Personas en Situación de Dependencia.*

The care need is determined by applying the scale agreed by the Territorial Council of the System for Autonomy and Care for Dependency, approved by the Government by Royal Decree 504/2007 of 20 April as follows:

1. Grade I Moderate dependency
   The person needs help to carry out some basic activity of daily living, at least once a day, or has intermittent or limited support needs for personal autonomy.
2. Grade II Severe dependency
   Needs help to perform several basic activities of daily living two or three times a day but does not require the permanent support of a caregiver or has extensive support needs for personal autonomy.
3. Grade III Severe dependency
4.
   Needs help to perform several basic activities of daily living several times a day and, due to total loss of physical, mental, intellectual, or sensory autonomy, requires the indispensable and continuous support of another person or has extensive support needs for personal autonomy.

Benefits

Article 14 of the Law for the Promotion of Personal Autonomy and Care for Dependent Persons states that the benefits of care for dependency may take the form of cash allowances or care supports and are intended, on the one hand, to promote personal autonomy and, on the other hand, to meet the needs of people who have difficulty performing basic daily activities.

Except for telecare and a network of supports including publicly funded homecare supports provided by professional caregivers, receiving a cash allowance (or subsidies) is incompatible with any form of home care support. Each regional authority establishes quality standards, and professional services are accredited by regional authorities. In addition to home care assistance. SAAD also includes funding for day and night care centres, as well as residential care.

Regional governments set the requirements and conditions for receiving a cash allowance. The legislation established a link between cash benefits and service delivery. Personal and periodic cash allowances were designed to be granted only when access to a public or subsidised care service is not possible. That is, when the beneficiary is being cared for by his or her family environment and the appropriate cohabitation and habitability conditions of the dwelling are met. This allowance is designed to help highly dependent people gain independence. Its goals are to contribute to the hiring of personal assistance for a set number of hours in order to facilitate the beneficiary's access to education and work, as well as a more autonomous life in the performance of basic daily activities. Although it was intended to be an exceptional benefit, it quickly became popular, with approximately 40-50% of SAAD LTC beneficiaries receiving a care allowance.

Residential care is primarily provided by the private sector, with new nursing home centres opening in the aftermath of SAAD. However, the system's financing is still primarily in the hands of the public sector, which contracts out the majority of nursing home beds. Municipalities typically manage public home care services, which are roughly funded by various government levels. Individuals must be in need of care and have a dependency level of 2 or 3 in order to access both public and subsidised home care

centres. To be assessed, applicants must apply through the region, and the individual care plan must specify the need for access to a nursing home. Once a care plan is issued, individuals are included in waiting list until vacancy becomes available.

Finally, there are also home and community-based services, typically regulated and funded by the regional social service department but provided by public or private centers and services that are subsidised and duly accredited. These services commonly unclde the following:

1. Services for the prevention care needs, which refer to actions to promote healthy living conditions, specific preventive and rehabilitation programs aimed at the elderly and people with disabilities and those affected by complex hospitalisation processes. Persons who have been awarded Grade I of moderate dependency will benefit from the following services for the promotion of personal autonomy:
    - Habilitation and Occupational Therapy.
    - Early intervention.
    - Cognitive stimulation.
    - Promotion, maintenance and recovery of functional autonomy.
    - Psychosocial habilitation for people with mental illness or intellectual disability.
    - Personal support and care in special accommodation (sheltered housing).
2. Tele-care, namely assistance to beneficiaries through the use of communication and information technologies, with the support of the necessary personal resources, in immediate response to emergency situations, or situations of insecurity, loneliness and isolation. It can be an independent or complementary service to home help. This service will be provided to people who do not receive residential care services and whose Individual Care Programme so establishes.
3. Home Help Service, which is the most popular HCBS, which refers to actions carried out in the home of the dependent person in order to meet their daily living needs, provided by entities or companies accredited. They refer to both, *care to meet the household needs* such as services related to domestic or household needs: cleaning, washing, cooking or others, and *personal care*: services related to personal care in the performance of activities of daily living.

4. Finally, the system considers day and night care, both general and specialized.

Value of formal and informal care

Table 15 shows the total costs in formal care. In 2021, in the nursing home sector, the total number of users was 347,694 with a spending of 1.742 million euros. Regarding formal home care, spending on this sector is much larger of 4.010 million euros for 244,116 users.

The value of informal care is computed assuming the minimum wage to be the time equivalent or replacement costs of informal caregivers for not working caregivers, and the home care wage for working caregivers. Table 16 provides alternative valuation assuming medium wave too.

Table 15: Formal care costs, annual. Spain, 2021.

Types	Number of users	Total spending (million €)
Nursing home	347,694	1,742
Home health agency	244,116	4,010

Source: https://directoressociales.com/wp-content/uploads/2021/10/N-Prensa-financ.-Depend-4-10-21.pdf estudio_evaluacion_saad_completo.pdf (mdsocialesa2030.gob.es)

Table 16: Informal Care Valuation. Spain, 2021.

	Working caregiver (€/day)	**Non-working caregiver (€/day)**	**Average (€/day)**	**Cost (Million €/year)**
Number of daily caregiving hours	7,53	10,08		
Percentage with respect to total caregivers	37.83	62.17		
Valuation of informal care				
Workers (min. wage), non-workers (zero)	58,88	0	22,28	10.960
Workers (home care wage), non-workers (zero)	105,42	0	39,88	19.622
Workers (min. wage), non-workers (min. wage)	58,88	74,89	68,84	68.862
Workers (home care wage), non-workers (min. wage)	105,42	74,89	86,44	77.523
Workers (min. wage), non-workers (home care wage)	58,88	141,12	110,01	120.061
Workers (home care wage), non-workers (home care wage)	105,42	141,12	127,61	128.723

Source: Survey of Disabilities, Dependency and Autonomy (2020). Interviews were conducted between April and August 2021. Number of receivers of informal care from Survey on Disability, Personal Autonomy and Dependency Situations (EDAD, 2020).
Minimum wage: 950 €/month.

Finally, Table 17 report valuations of public cost by type of care combining the results in Table 15 and 16. It makes clear the notorious difference between the the two valuation methods.

Table 17: Total Costs by Type of Care and Source. Spain, 2021.

Care Type	**Source**	**Cost I**	**Cost II**
Nursing Home	Public	1742	1742
Home Care	Public	4010	4010
Informal Care	Public	10.960	128.723
Total	Publie	16712	134475

Informal care valuation in Cost I: minimum wage for workers and zero for non-workers.
Informal car valuation in Cost II: home care wage for workers and non-workers.

V. Conclusions

The provision of care for older age adults in Spain has substantially developed after the introduction of SAAD in 2007 which has expanded care. We focus on the study of the relationship between age, disabilities and wellbeing. We also try to analyse the characteristic of the workforce and the caregivers.

Based on the estimates reported in this chapter, we can reach the following conclusions:

- LTC expenditure as % of GDP has increased from 0.5% (2003) to nearly 0.9% (2019), mostly due to the introduction and development of the SAAD.

- As other long term care systems, the Spanish system still relies heavily on informal care replacing informal caregivers with personal home help services a rise in care expenditure of 2.3%-3.8% of GDP. Caregiving allowances have benefit about 50% of SAAD beneficiaries.

- Private insurance for long term care plays a negligible role.

- LTC spending increases with need and with individual income, however, need explains mainly use of publicly funded care, income drives privately funded care.

- The percentage of people who need care increases with the number of ADL limitations: roughly 75% for those individuals 65+ and 40% for people aged 85 or over.

- Having multiple limitations (three or more) for daily life activities (and at older ages) has an impact on having good health. However, 9.4% of those aged 65 and over report having good health, while 8.5% of those aged 85 and up report having good health. Individuals with no limitations, on the other hand, exhibit a much higher percentage of people reporting good or better health: 34.3% for those 65 and up, and 20.1% for those 85 and over.

- Furthermore, the prevalence of depression is quite similar between those with no limitations and those with three or more limitations, particularly among those aged 85 and over: for whom only 35.4% display no limitations and 34.9% for those aged 65 and over with three or more limitations.

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