Long-Term Care landscape in Spain

InCARE Short Report

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Supporting INclusive development of community-based long-term CARE services through multi-stakeholder participatory approaches

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InCARE (Supporting Inclusive development of community-based long-term CARE services through multi-stakeholder participatory approaches) aims contribute to the design of a coordinated approach to the development of national long-term care policy and care services at local and regional level, by establishing socially innovative and participatory decision-making processes. We work with care users, care providers and policymakers in Spain, Austria and North Macedonia to design, implement and scale-up innovative care services.

More information on the project's website: https://incare.euro.centre.org/. For updates on our progress and publications please subscribe to our newsletter here or send an email to cc@eurocarers.org.

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1. Overview of country context

Spain has a population of 47.43 million inhabitants on 1 January 2022. People 65+ are 20.2% of total population. People 80+ are 6.2% of total population. There are 4.38 million people with some disability, of whom 2.63 million people are 65+ years old (5.54% of the total population, 59.95% of the people with disabilities) (Instituto Nacional de Estadística (INE) 2022).

Spain is a democratic, law and welfare state, with a market economy. The political form of Spain is a parliamentary monarchy. The system of government is based on national sovereignty, the division of powers and a parliamentary system.

The country territory is divided into 17 Autonomous Communities and 2 Autonomous Cities (Ceuta and Melilla). The 17 autonomous communities have a wide range of competences; social services, and therefore, long-term care is a regional competence. The coordination for displaying social policies between State, -through Ministry for Social Rights and Agenda 2030- and the social departments of each regional government is carried out by the Territorial Council on Autonomy and Support to Dependent Persons.

FIGURE 1. ***POPULATION FIGURES*** (INE 2021b)

STRENGTHS	WEAKNESSES
• Spain is a developed country that complies with all national and international rights of people. • Long-term care system that protects people with fewer resources.	• Different services in different regions.
OPPORTUNITIES	**THREATS**
• The pandemic has highlighted the need to change the system as the residential model has been shown not to work.	• 17 autonomous communities, it is difficult to reach an agreement.

TABLE 1- SWOT ON GENERAL COUNTRY CONTEXT

2. Support-capacity and care needs in the community

Demographics

Average age in Spain in 2020 according to Instituto Nacional de Estadística (INE) is 42.3 years for men and 44.8 years for women (INE 2021a). Life expectancy at birth in Spain grows since 2010, according to INE (2021c) and is higher for women (85,4 years for women compared 80,1 years for men).

According to INE population structure indicators (INE 2022a) People 65+ are 20.2% of total population. People 80+ are 6.2% of total population. Within the population greater than or equal to 65 years of age, the female population has a greater representation with 56,27%. Ageing rate in Spain in 2022 was 132.7% (INE 2022b).

According to AROPE index (At-Risk of Poverty and Exclusion), (Instituto Nacional de Estadística (INE) 2013), older persons and migrants, among others, are below the threshold of 60% of medium household income in Spain, which in 2019 was 9,009 euros. Profile of migrants in Spain in 2019 and first semester of 2020 is: men and women aged between 20 and 34 years from countries such as Morocco (869,661 people), Colombia (290,053 people) and Venezuela (222,890) (Instituto Nacional de Estadística 2021).

Socioeconomic determinants and risk factors

According to continuous survey of households published by INE (2020a) the main household structure of older people between 70-74 years old are couples living without children; secondly, people living in couple and with a child and finally people living alone.

As age increases, there are more women who live alone than those who live with a partner, on the contrary, there are more men who live with a partner compared to those who live alone, this is due to the greater life expectancy of women.

- Pension coverage
  Contributory pensions: are economic benefits of indefinite duration, although not always, which entitlement is generally attached to a previous agreement with Social Security Authority (to demonstrate a minimum quotation period in some cases), and also meet the other requirements.

Non-contributory pensions: these are economic benefits granted to citizens who are in need of protection and have not sufficient incomes to live according to the law, even in the case of inexistence or insufficiency of previous quotations in order to be entitled to contributory level benefits. Non-contributory pensions are managed by each Autonomous Community (region) and provincial department of Institute for Older Persons and Social Services (IMSERSO) in Ceuta and Melilla autonomous cities.

Average income of older people in 2019 was 13,575 euros yearly for men and 13,112 euros yearly for women. (Instituto Nacional de Estadística (INE) 2020b)

Lifestyle is conceptualized under the different current models of aging: active, healthy or successful aging depends on the theoretical model (Petretto et al. 2016).

Daily life is often oriented to the daily tasks of household maintenance and care tasks, although there are large gender differences in the performance of these tasks.

Health, functionality and wellbeing

When older people require help, their main caregiver is usually a woman, normally a wife or daughter (84%), of intermediate age (an average of 52.9 years).

The Public System of Social Services and the Public System of Health (universal and free) are two of the pillars of the Welfare State, but there is a need to develop greater socio health coordination, because at the moment the two systems are independent and poorly integrated.

Regarding to the rights, the Spanish Constitution states that public powers shall guarantee rights of people with disabilities and older people. Especially, public pensions and complimentary social services are mentioned. Moreover, Law 39/2006 on the Promotion of Autonomy and Rights of Dependent People (hereafter Lay 39/2006) develops the Constitution and displayed a rank of benefits for people who need care. Law 39/2006 establishes three degrees of dependency situation, but in all of them people are entitled to receive long-term care services.

Unwanted loneliness is a growing problem in Spain suffered by 11,6 % adults (almost the same for men and women) (European Commission. Joint Research Centre 2021). The main causes of disability are the group of musculoskeletal diseases, circulatory problems, nervous diseases and mental disorders.

STRENGTHS	WEAKNESSES
• Increased migratory flow into Spain. • The pension coverage system in Spain. • Spain has a high life expectancy.	• The percentage of population at risk of poverty or social exclusion is increasing. • Poor socio-health coordination.
OPPORTUNITIES	**THREATS**
• Women are in the labour market, so the old model of female family caregivers must change.	• Jobs are often precarious and without contract. • A lot of people live alone but would prefer to live with another person.

TABLE 2 - SWOT ON SUPPORT CAPACITY AND CARE NEEDS IN THE COMMUNITY

3. Service delivery

Legislation

The Spanish Constitution determines that the State has jurisdiction over basic legislation and economic regime of Social Security, without prejudice to the execution of its services by the Autonomous Communities.

In accordance with the distribution of powers established by the Spanish Constitution the Autonomous Communities may assume competences in matters of “social assistance”. All the Autonomous Communities assumed exclusive competence in their designated statutes of autonomy, matter of social services, repeated competence in the most recent statutory reforms.

As a result of this competency framework, the Autonomous Communities have approved their own social services laws, in which their guiding principles are defined, in addition to the benefits and care services.

According to the laws, a person has the right to be assessed for dependency through the service of assessment provided for the community in which he or she lives. The assessment is standardized by legislation and provides a three-level dependency degree, each one related to different services and benefits options of increasing intensity depending on the intensity of the dependency.

- Dependency degree I. Moderate dependency: when the person needs support to carry out several basic activities of daily living at least once a day or if the person needs intermittent support for his or her autonomy.

- Dependency degree II. Severe dependency: when the person needs support to carry out several basic activities of daily living at least twice or thrice a day but not needs permanent support from a caregiver.

- Dependency degree III. Great dependency: when the person needs support to perform several basic activities of daily living and due to their total loss of physical, mental, intellectual or sensory autonomy, they need the indispensable and continuous support of another person.

Types of services

The service provision is regulated by Law in order to regulate the basic conditions which guarantee equality in the exercise of the citizenship rights to the promotion of autonomy and care for people in a situation of dependency. The number of people entitled to a service or economic benefit is 1.313.437 (IMSERSO 2022). Services and benefits are as follows:

a) Services

- Prevention of dependency.
- Promotion of personal autonomy.
- Telecare.
- Assistance at home.
- Day care centre.
- Night centre.
- Residential care.

b) Services through economic benefits

- Economic benefit of personal assistance
- Economic benefit, in line with the services provided in section a.
- Economic benefit for care in the family environment and support for caregivers

Social services include:

- Support for personal care (e.g., personal hygiene, daily routines, eating)
  Support for basic activities of daily living related to personal care could be provided in different ways depending on the dependency degree, the preferences of the person and, in practice, of the family unit. There are different support options, but the main used are:
    - Services at home (SAD)
    - Personal assistant (AP)
    - Day care centre (CD)
    - Residential care settings (nursing homes).
- Support for household maintenance (e.g., support for cleaning, laundry, household maintenance and errands such as banking, grocery shopping) SAD and AP services offered for personal care are aimed at supporting the instrumental activities of daily living.
- Fitness/strength training (e.g., balance exercises like Tai Chi, yoga, fitness)
  In some autonomous communities, the services for the promotion and prevention of autonomy develop specific preventive and rehabilitative programs of physiotherapy and occupational therapy. The physical exercise, apart from that aimed at medical rehabilitation, is usually out of the standardized services of the law but could be provided from private services.
- Driving and transportation (e.g., delivery of meals/medicines, drop in/out services)
  The main services of transportation are oriented for the transportation of people to day care centre for people with dependency, but there is also a delivery of meals service in several cities that provides support for older people without support network or who lives with someone with dependency.
- Support for social integration (e.g., community clubs, cultural programmes, leisure activities)
  Social integration is mainly aimed at people and families who are in a situation of social exclusion or marginalization and show a willingness and capacity to carry out social inclusion processes. Services are assessment and diagnosis of social exclusion, specialized accompaniment, family intervention, psychological support, insertion programs for drug addicts, programs for people with prison experience, migrants and ethnic minorities. More leisure oriented or formative programmes are mainly provided by NGOs, private or concerted initiatives.
- Social support services (e.g., stress management, conflict resolution, detection of abuse)
  Depending on the town city hall different options for social support services could be provided. Social support services out of the standardized options described by the law could be of minority use and depend on the specific characteristics of the social services of the city.

Regarding to the Health System, the Autonomous Communities may draw up their own service catalogues that, as a minimum, must include the common one of the National Health System: Public health benefits, Primary care, Specialized care, Urgent care, Pharmaceutical services, Ortho-prosthetic services (surgical implants, external prostheses, orthotics, wheelchairs and special orthotics), provision of dietary products (complex diet therapy and home enteral nutrition) Provision of medical transport and Preventive care (e.g. annual check-ups, influenza vaccination, mental health risk assessment, counselling services for lifestyle, eye/ hearing exams). The catalogue of common services established in this standard aims to guarantee equity and accessibility to adequate health care in the National Health System, considering the principles established in the Spanish Constitution.

Primary care.

- Vaccinations in all age groups and, where appropriate, risk groups, according to the current vaccination schedule approved by the Interterritorial Council of the National Health System and the competent health administrations.
- Activities to prevent the appearance of diseases acting on risk factors (primary prevention) or early diagnosis (secondary prevention).
- Mental health care in coordination with specialized care services.
- Preventive care is mainly provided in the primary care centres organized by the general practitioner and the nurse. Check-ups, vaccination, primary health risk assessments, diet counselling, and screenings are firstly administered in the primary care centres. The general practitioner decides to refer people to specialist practitioners.

Specialized care

Establishment of a care plan that includes preventive measures, instructions for the correct follow-up of treatment, hygienic-dietetic recommendations, control of symptoms and general care.

Promotion and education for health.

Regarding Promotion and education for health, it includes activities aimed at modifying or promoting habits and attitudes that lead to healthy lifestyles, as well as promoting a change in behaviours related to risk factors for specific health problems and those aimed at promoting self-care, including:

- Information and advice on behaviours or risk factors and on healthy lifestyles.
- Group health education activities and in educational centres.

Follow up services.

Follow-up services post hospitalization (e.g. post-discharge care, medicines reconciliation, nursing (home) care services, secondary prevention) comprises the diagnostic and therapeutic activities that must be carried out in a coordinated manner by primary and specialized care as a consequence of procedures initiated at the specialized care level and that both levels, by consensus, agree that they can be facilitated at home in such a way as to guarantee continuity in the care provided to the user after hospital discharge, in accordance with the special programs established and the organization of each health service. Follow-up after hospitalization is organized with the hospital itself through visits to specialists who control the case until discharge is received and monitoring continues to be carried out by the general practitioner.

Rehabilitation

Basic rehabilitation

- Prevention of the development or progression of musculoskeletal disorders.
- Physiotherapeutic treatments for symptom control and functional improvement in chronic musculoskeletal processes.
- Recovery from acute mild musculoskeletal processes.
- Physiotherapeutic treatments in neurological disorders.
- Respiratory physiotherapy.
- Orientation / health training to the patient or caregiver, where appropriate.

Rehabilitation in patients with recoverable functional deficit.

Includes the rehabilitation of conditions of the musculoskeletal system, the nervous system, the cardiovascular system and the respiratory system, through physiotherapy, occupational therapy and speech therapy.

Rehabilitation care since 2010 is usually provided by dedicated hospitals, but some primary care centres provide continuity of care through physiotherapists, either staff primary health care physiotherapists or as an outreach service provided by hospital rehabilitation professionals (Bernal et al. 2018). While at home hospitalizations have increased is uneven through AC in the numbers of patients benefiting, also in the intensity and frequency per patient.

- outpatient and inpatient departments. End-of-life services (e.g., hospice services, pain management, advanced care planning)

<u>**Palliative care for terminally ill patients.**</u>

It includes comprehensive, individualized and continuous care, it is provided at the patient's home or in the health centre, if necessary, establishing the necessary mechanisms to guarantee continuity of care and coordination with other resources and in accordance with the protocols established by the corresponding health service. It includes:

1. Identification of terminally ill patients.
2. Comprehensive assessment of the needs of patients and caregivers and establishment of a written care plan that includes preventive measures, hygienic-dietary recommendations, symptom control and general care.
3. Frequent assessment and control of physical and psychological symptoms, carrying out the necessary diagnostic tests and procedures and indicating the pharmacological and non-pharmacological treatment of pain and other symptoms.
4. Support for people linked to the patient, especially the main caregiver.

Palliative services are provided in specific hospital units, with coordination between the hospital, nursing home or at home with the guidance of primary hospital professionals, beds in not-for-profit or for-profit hospitals, purchased or not by the public system, out-of-pocket services or services provided in the context of the Dependency Care System (Sistema de Atención a la Dependencia, SAAD).

In Spain, Health services are based on the principles of universality, of public and free access, equity and financial fairness, however private options are available. Three statutory systems coexist: Universal National Health System, Mutual Funds for the civil servants, and Collaborating Mutualities focused on accidents and occupational diseases. National Health services are organized in two levels: administrative (national and regional) and in care provision (Primary Health and Secondary Care). The primary care is the core of the national health services and is mainly provided through the general practitioner and the nurse professional, which serve as first contact point and gatekeepers for more specialised services: specialized care, inpatient care, day care and emergencies (Bernal et al. 2018).

Design of long-term care: Assessments and service catalogues

Even though every autonomous community assesses each situation of dependency, there is a scale of assessment that establishes the common measurement of the dependency degree in Spain. Each region is responsible for the assessment which is carried out by the administration or in collaboration with different entities.

In the field of health, the Ministry of Health articulates the catalogue of common services and benefits of the National Health System which aims to guarantee equity and accessibility to adequate health care in the National Health System, considering the principles established in the Spanish Constitution.

The Autonomous Communities may draw up their own service catalogues that, as a minimum, must include the common one of the National Health System: Public health benefits, Primary care,

Specialized care, Urgent care, Pharmaceutical services, Ortho-prosthetic services (surgical implants, external prostheses, orthotics, wheelchairs and special orthotics), provision of dietary products (complex diet therapy and home enteral nutrition), Provision of medical transport and Preventive care (e.g. annual check-ups, influenza vaccination, mental health risk assessment, counselling services for lifestyle, eye/ hearing exams).

Provider organization and care settings

Spain has a health system oriented to primary and acute care, but rehabilitation, convalescence and terminal illness coverage is still considered a challenge, the Spanish Government is currently working to change the model of long-term care to a person-centred care model, to deinstitutionalisation and to promote social health coordination.

Depending on the needs of the person after a medical intervention there are three main options for inpatient patient recovery, usually provided in specific units of the hospitals or in support hospitals (private hospitals with a contract agreement with the regional health system (Jimenez 2021):

- Continuing Care Units: Aimed at patients with established severe functional disability, without criteria for rehabilitation, who require medical and/or nursing hospital care (for example prolonged intravenous treatments or extensive pressure/vascular ulcers with poor evolution), patients with disabling chronic pathology that requires frequent clinical controls and cannot be insured at home (exacerbations of respiratory diseases such as COPD or cardiac diseases such as heart failure), elderly patients with moderate-severe dementia, with behavioural disorders or other complications that alter family coexistence, for their control after assessment, patients with severe functional disability who are admitted due to overload, claudication or illness of the main caregiver (family respite), patients who require prolonged hospital convalescence, which cannot be offered in assisted residences, before undergoing rehabilitation.
- Functional Recovery Units: mainly focused on the rehabilitation and functional recovery of traumatological (fractures/hip prosthesis) and neurological (stroke) pathologies, as well as acute functional deterioration of different causes (prolonged hospitalization).
- Palliative Care Units: oriented to patients at the end of life and with difficulty in controlling their symptoms at home, as well as those who do not want to or may die at home, who require predetermined periods of rehabilitation and convalescence and for rest for the main caregiver (family respite).

Apart from medium and long-stay hospitals, home rehabilitation is scarce and leaves a gap that is usually continued by social services, primary medicine and dependency care in the framework of chronicity.

- Community based centres, day care centres, small community groups.

Community care organized through centres is mainly developed by day care centres owned by associations, cultural centres or centres for retired people in the municipalities and neighbourhoods.

- Day care services in residential institutions and support services in primary care facilities

Day care services are mainly developed in the Day Centres which are one of the services provided by the law (Boletín Oficial del Estado 2006). These services can be provided in dedicated premises or within a residential building, often located in the first floor to facilitate the daily access of the people. There are no day care centers within the premises of the health care facilities (primary Health care or hospitals) being these Day hospitals oriented to medical care without hospital stay by night.

- Residential long-term care facilities (health and/or social services) & nursing/care homes

In case of developing dependency (29.6% over 65 years of age in Spain) (Ministerio de Sanidad 2021) and needing daily support, when ageing at home is not possible, or is not the desired option, nursing homes are one of the most extended living options. Cognitive impairment or dementia, number of chronic conditions, 3 or more activities of daily living dependencies, urinary incontinence, behavioural disturbances or a poor social network are the main predictors of nursing home admission (Banaszak-Holl et al. 2004; Friedman et al. 2006; Pinzón-Pulido et al. 2016).

In Spain the Residential Care Services provide housing and food for people with dependence on a permanent or temporary basis. In Spain there are 6,116 centres with a total of 399,046 vacancies, and a coverage rate of 4.29. Of the 242,667 users, 70.8% are women and 79% are over 80 years of age. The residential care services most in demand are the Residential Centres, whose vacancies account for 97.7% of the vacancies analysed, and the Homes for the Elderly (Instituto de Mayores y Servicios Sociales 2021).

- Home care

According to data from IMSERSO there are 246,904 people receiving benefits for caring at home, however the number of people in receipt of some form of long-term care is however substantially larger, as services are also provided outside of the national long-term care system (SAAD) (Zalakaín y Davey 2020).

According to Zalakain et al. (2020) as previously said, people requiring support within the community should have the options of: home care, day care services, cash benefits to family caregivers, cash benefits for personal assistance services, or cash benefits for the independent purchase of home care, as well as other complementary and preventive services. Home care is mainly administered in two forms:

a) For people who are eligible to receive services, according to the national evaluation criteria, the service known as Servicios de Atención a Domicilio (SAD) is provided. Home care within this category is subject to a reference range in hours per month, per dependency level (3 levels). Falling under the national long-term care provision, SAD is co-funded by the autonomous administrations, local authorities (in some regions) and the central government.
b) As preventative services (Servicios Sociales Preventivos or SAD social) for people who do not yet meet the official criteria of being dependent, funded entirely by local authorities and is provided solely at the discretion of the regional or municipal authorities.

According to Zalakain et al. (2020) the preventative services covered near to 70% of the SAD provided locally, decreasing during the practical implementation of the law. However, in this case, probably the term preventative is in relation to a rapid support for people with dependency needs in a situation of inefficient administrative management, but not preventative in terms to avoid dependency or fostering the capabilities to live autonomously.

- Hospice (end-of-life care) and palliative care

Comprehensive health care and the improvement of well-being is the basis of the National Health System and the System for Autonomy and Dependency Care (SNS and SAAD). The current organization of the health system is aimed at the acute patient and focused on hospital care, however, the current health needs of the population are care for patients with chronic diseases, outside the hospital, in Primary Care and whenever possible at the patient's home. The Ministry of Health works on addressing chronicity, publishing in 2012 the Strategy for Addressing Chronicity of the National Health System (Ministerio de Sanidad Servicios Sociales e Igualdad 2012). It is therefore a strategy not only aimed at addressing chronicity, but also at preventing dependency.

Formal and informal carers

In terms of formal and informal long term care workers, last year in Spain there were a total of 62.706 informal caregivers in Spain adhering to the special agreement for non-professional caregivers of people dependent on the General Treasury of Social Security and 535.476 social service workers affiliated with Social Security: professional carers who work in residential care settings and at home in different regimes (Ministerio de Inclusión Seguridad Social y Migraciones 2021). However, there are other carers of a disabled person who are not included in the previous statistics because they are working without a contract, such as people who receive support with daily tasks (such as Service for support the dependency SAD), telecare services, day care centre or people who care and do not receive any administrative support for different reasons.

Support services for informal carers are provided for in the law, however there are also services provided by the community (associations, informal support in the neighbourhood) and by the market. There are training programmes for informal carers for providing care, personal assistance and respite care. Informal carers who provide care for a person in the family mainly receive support through the services described in the law 39/2006, however formative or training programmes are not mainly implemented in the support system. There are programmes developed in the municipalities through the town city halls in collaboration with private enterprises, support by NGOs, voluntary action, and associations. Personal assistance is mainly given through the support with daily care (SAD), Personal Assistant or by means of respite care in day care centres or residential respite.

Regarding staff, the professionals who carry all the weight of the social intervention are the social workers, they provide the services designed by law. In the case of health services, primary medicine, composed of the general practitioner and the nurse, provide basic services and serve as a gateway to specialized services.

These nurse case managers coordinate from the health system with social services (basic and specialized care social workers), but the direct support at home is given by home services or personal assistant, whom have different professionalization degrees.

In case of residences, nurse assistants are the main profile. Care is a feminised and "ethnicised" sector in which a large population of migrant origin is employed (Duque, Ballano y Pérez 2013; Vidal-Coso y Miret-Gamundi 2014).
In Spain, each Autonomous Community has regulated the requirements to be met by staff working in formal long-term care services differently. According to the collective agreement on care services for dependent persons and development of the promotion of personal autonomy., there are four professional groups that work on LTC services. These groups are established, according to the level of qualification, knowledge or experience required for entry. The working conditions such as salaries, number of hours, functions, holidays, etc. are determined by the professional group.

Funding

In relation to funding, long-term care is funded by the Spanish State, the Autonomous Communities and users. The part of the General State Administration (AGE) is the following:

- The Minimum Level of protection, which is calculated based on the number of dependents who receive benefits and their degree of dependency. The calculation is made on a monthly basis, the amount corresponding to each autonomous community is determined based on the number of dependent persons and transfers are made according to the calculation. So, it varies depending on the dependent people and their degree of dependency.

- The Agreed Level, which is a determined annual amount that is distributed among the Autonomous Communities according to established criteria (territorial dispersion, demography, economic capacity...). From 2013 to 2020, there has been no distribution at the agreed level, but the agreed levels of protection increased from €283,197,420 in 2021 to €483,197,420 in 2022. In 2021 the overall financing of the SAAD increased by 40.53% to €563 million and is expected to increase significantly in 2022 (Ulla 2022).
- Additional level of protection. Decided and financed by the Autonomous Communities for their own budgets.

Care users also contribute to the cost of services according to their economic capacity. Each Autonomous Community has different formulas for calculating the co-payments for the different services according to economic capacity and the rest of the services and benefits that the person receives, as well as to determine the amount of economic benefit that they will receive.

When an economic benefit of family care has been granted, the beneficiary is paid an economic benefit determined according to the economic capacity of the beneficiary, their degree of dependency and the existence of other services or benefits that they receive. Social Security contributions are paid to the caregiver by the General State Administration, provided that they sign the special agreement for non-professional caregivers with the General Treasury of Social Security.

The autonomous communities prepare their own budgets. On the part of the users, the co-payment for dependency services depends on the CCAA and is determined differently in each of them, generally the economic capacity of the dependent person and the different benefits received are considered.

In July 2022, an agreement has been approved in Spain on common and quality criteria for the centres and services of the System for the Autonomy and Care to Dependency establishing minimum conditions on these issues:

- Material resources and equipment must guarantee the provision of the service adapted to the needs and preferences of dependent people, to their environment, to the intensity of support required, to safety and to universal accessibility.
- Staffing: the requirements and standards for staffing and quality of employment, in terms of number of professionals, their qualifications, training and working conditions, are a fundamental pillar to ensure adequate provision of services and care.
- Ensuring the dignity of treatment and the exercise of the rights of care users: mechanisms and requirements are established to guarantee participation, autonomy and empowerment in the decision-making process. Also, the preservation of the rights and mature treatment of care users, as well as the personalisation of the support they receive.

This new agreement is based on the principles of the person-centred model in line with the European Care Strategy.

STRENGTHS	WEAKNESSES
• The Public System of Social Services and the Public System of Health are two of the pillars of the Welfare State.	• Institutionalisation is currently being over-promoted. • A lot of bureaucracy to receive dependency benefits. • Spain has a model care with a higher percentage of informal care (women and immigrants).
OPPORTUNITIES	**THREATS**
• People want LTC services to help people stay at home and live in community.	• The person-centred model of care is difficult to implement, attention must be paid to its correct application.

• Advancing new technologies and incorporating innovation in the provision of services.	• Overburdening of family caregivers.

TABLE 3 - SWOT ON SERVICE DELIVERY

4. Performance

Long-term care services coverage

Considering the use of formal long-term care services, Spain is categorised as low use, as only 6% of the respondents or someone close to the respondent has used nursing home care, home help or personal care, or home nursing care in 2016 (Eurofound 2019). In Spain, more than 50% of people aged 65 or older with activity limitations reported a lack of assistance related to personal care in the 2014 European Health Interview Survey. This percentage is a bit slower regarding lack of attendance in household activities. Among those who lack or need more professional home care, costs are the prevailing known reason for unmet needs for 69% in Spain (2016), followed by the non-availability of services for 9% of those with care needs in their household. It can be even larger in rural areas.

Based on the data from European Union Statistics on Income and Living Conditions (EU-SILC) 2016, financial barriers do not seem to be a high burden for formal long-term care at the point of use for two out of three people using this type of facilities in Spain. In this sense, 65% is free of charge for the user and 35%, partially funded by them. However, almost 50% of respondent reported a moderated to high level of difficulty in affording professional home care services (Eurofound 2019)

Quality of care for older people

According to OECD report (OECD y European Observatory on Health Systems and Policies 2021) Life expectancy in Spain is among the highest in Europe, but it declined significantly in 2020 due to the impact of the COVID-19 pandemic. On average, the Spanish population spends more time living in good health compared to other EU countries, but risk factors such as alcohol consumption have increased.

- Effectiveness: Spending on health per capita remains lower in Spain than the EU average. Mortality from preventable and treatable causes are lower in Spain than the EU average due to effective public health and prevention policies. However mortality rates from lung disease and colon cancer are high (OECD y European Observatory on Health Systems and Policies 2021)
- Accessibility: generally rated as good with low unmet needs (with exception to dental care). Access to health services was disrupted during the first wave of the pandemic but access continued through teleconsultations (OECD y European Observatory on Health Systems and Policies 2021).

- Resilience: despite the severe impact of the COVID-19 specific measures were taken to mitigate the impact. Vaccination rate is higher than the European average being 70% of the population vaccinated (two dose) and 78% (on dose) in August 2021.

The overall quality ratings given to long-term care services in Spain is slightly higher than 6, in a rate scoring from 1 (very poor quality) to 10 (very high quality). However, when people are asked about their average satisfaction, the score is higher (8.1). Some aspects of care provision in long-term care services

analyzed independently show that the quality of the facilities is scored as 7,7, and personal attention provided is scored as 8.3 (Eurofound 2019).

The gradual ageing of the population, together with the changes that are taking place in family models and roles, are increasing the demand for services that provide long-term care. This growing need is accompanied by expectations of high-quality care. In the report on Putting quality first. Contracting for long-term care (European Social Network 2021) assesses the role of public procurement of these services, as well as the quality of these services.

The complexity of the structures that regulate and finance care systems in different countries, together with the heterogeneity of the entities providing long-term care services, has led to a diversity of regulations, approaches and market rules that have an impact on the quality of the care provided and, consequently, on the quality of life of people in need of long-term care.

In Spain, more than 50% of people aged 65 or older with activity limitations reported a lack of assistance related to personal care in the 2014 European Health Interview Survey. This percentage is a bit lower regarding lack of attendance in household activities. Among those who lack or need more professional home care, costs are the prevailing known reason for unmet needs for 69% of the people with care needs in Spain (Social Protection Committee 2021). Followed by the non-availability of services for 9% of those with care needs in their household. It can be even larger in rural areas.

Spending on health per capita remains lower in Spain than the EU average. Mortality from preventable and treatable causes are lower in Spain than the EU average due to effective public health and prevention policies.

The gradual ageing of the population, together with the changes that are taking place in family models and roles, are increasing the demand for services that provide long-term care. This growing need is accompanied by expectations of high-quality care (European Social Network 2021).

In terms of shared decision-making with care users, the legislation indicates the obligation to develop the Individualised Care Programme which includes the participation of the user and families in deciding on the care and services they receive.

STRENGTHS	WEAKNESSES
• Most people have easy access to health and social services, which are affordable.	• Regional inequalities (different ways of assessing the quality of services).
OPPORTUNITIES	**THREATS**
• LTC's users are satisfied with the care they receive so if the system is improved they will be even more satisfied.	• Although legislation protects user choice, decision-making is often not shared.

TABLE 4 - SWOT ON PERFORMANCE

5. System enablers

Cross-sectorial governance

Most of the powers in social and health matters correspond to the Autonomous Communities, although leadership in improving the quality of the health and social systems is a shared responsibility between National and Regional Administrations. All administrations carry out actions that reveal an explicit commitment to this model of care, both at the state and regional level. Although it is true that the degree of development and the pace of implementation of specific measures is different from one Autonomous Community to another.

Currently, the main objective of social health care is to provide comprehensive care and meet the needs of the patient throughout the integration of care. The person becomes the axis on which the organization and operation of the services pivots, leaving aside the assistance models, which are based on the typology of the service. The new model allows health and social care to be flexible, personalised and seamless in terms of time and content. This new approach requires learning and recognising the motivations and needs of the users, placing the relationship between care user and organisation at the centre of all actions to be carried out. In short, it seeks to guide services to demand, that is, social and health care must be based on individual needs and on all the diversity that this may entail and requires autonomy and responsibility in the care that is provided.

The COVID-19 pandemic has been a turning point in terms of population health needs and health policy priorities. The experience has emphasised the need for social services to offer attention, protection, and care to people in a particularly vulnerable situation. Therefore, the Spanish Government aims to guarantee the quality of care and reinforce care at home and in the immediate environment for the elderly, promoting and encouraging a new model of care centred on the person, making it easier for the elderly to live in their own home. On the other hand, it is also a priority to promote the exchange of information between the different levels of Social and Health Services in the public system, as well as to promote the professionalization of the care sector, defining new professional profiles and activities to offer a more effective and efficient service.

The system for the promotion of personal autonomy and care for dependent people annually carries out an evaluation, where the forecasts and progress in the care of care dependent people are collected. Commission reports are also produced for the analysis of the current situation of the long-term care system, its sustainability and the current financing mechanisms, to evaluate its adequacy to the needs associated with dependent people.

Information and communication technology (ICT)

Regarding to the Information and Communication Technology (ICT), the guiding principles from the Digital Health Strategy are:

- The Digital Health Strategy aims to promote the values of the National Health System: equity, cohesion, participation, integration of actions, sustainability, transparency and accountability.
- It aims to increase the autonomy and decision-making capacity of patients and the development of NHS professionals, based on the recognition that health protection is a shared task that requires communication between the different actors, sectors, levels and professional profiles.
- It seeks to prioritize innovative actions that provide, with greater evidence, positive health outcomes. Within its framework, the initiatives that comprise it must accompany

the circumstances, proposals and needs of the autonomous communities, to achieve a systemic development of the digital transformation.

Regarding the use of technologies, many of the instruments that are used appear to be promising in the field of social and health coordination. Some Autonomous Communities have opted for the development of electronic medical records, electronic records of dependency in social services, benefits management system, home telecare, information systems to identify patient needs, multi-channel platforms for relations with citizens, etc. These advances are very positive, since adequate information will allow the specific needs of the different groups and subgroups of patients to be correctly identified in order to offer them standardized care adapted to their profile of needs.

One of the objectives pursued with these initiatives is the development of a shared or at least compatible information system between social and the health care, which takes advantage of the existing information, and facilitates the planning of the necessary intervention in the future.

In any case, the opportunities that technology offers, both in the field of information systems and in the provision of prevention services and continuous care to people with the most intense needs, allow us to imagine a different, more efficient, future system, more accessible and safer.

The new formulas and strategies must be based on investment in innovation and the use of ICT as a support element that endows the system with efficiency and sustainability.

However, there is a lack of shared information systems at a general level and several initiatives at different levels, crystallizing some experiences at the level of Autonomous Communities. There is a general consensus that having an information system that provides reliable and updated data would allow the determination of priorities and the establishment of an evaluation system of public policies for an efficient allocation of resources. However, this is not yet a reality at the level of the whole State.

STRENGTHS	WEAKNESSES
• Formalized structures have been created to promote coordination, in some cases with representation and involvement of various agents who participate in the care process.	• More funding is needed. • The role of caregivers is not professionalised.
OPPORTUNITIES	**THREATS**
• If an action works in a region it should be replicated in other regions. • The 'Dependency Law' must to be modified so that it helps more to promote the personal autonomy.	• Low collaboration between administrations (low information exchange).

TABLE 5 - SWOT ON SYSTEM ENABLERS

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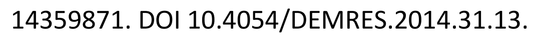

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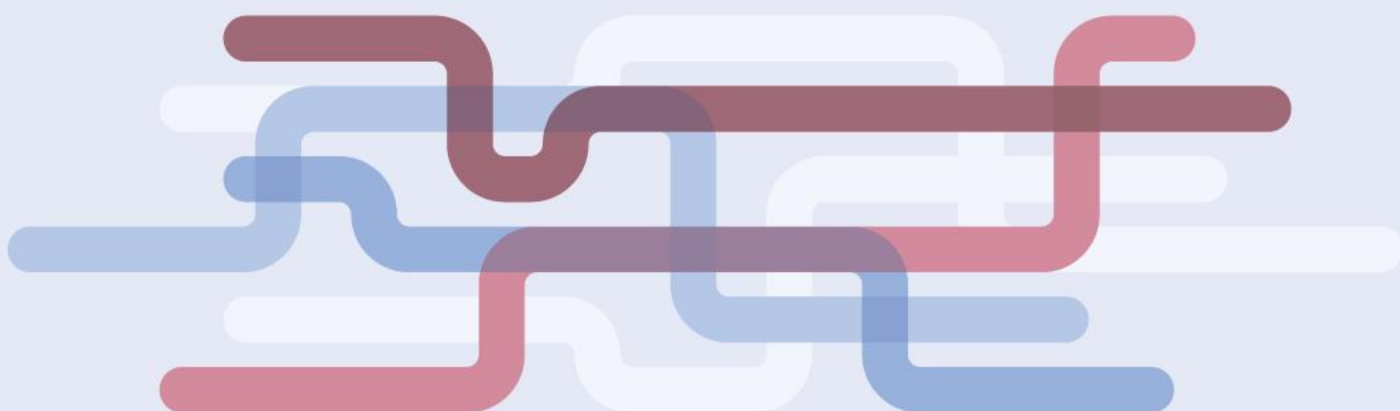

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