Spain

Long-term Care

18 May 2011

Highlights from *Help Wanted? Providing and Paying for Long-Term Care*, OECD Publishing, 2011.

- The share of the population aged over 80 years -- at 5% in Spain in 2010 -- is projected to more than double by 2050, placing Spain among the o oldest populations in the OECD. The working-age population, as a share of the total Spanish population, will be the fifth smallest in the OECD.

- Spain's public LTC expenditure as share of GDP is projected to about triple and could even grow by 6 times by 2050.

- Spain has one of the highest shares of the population providing informal care to old or disabled people across the OECD. Half of these carers provide more than 20 hours of care per week, second only to Korea.

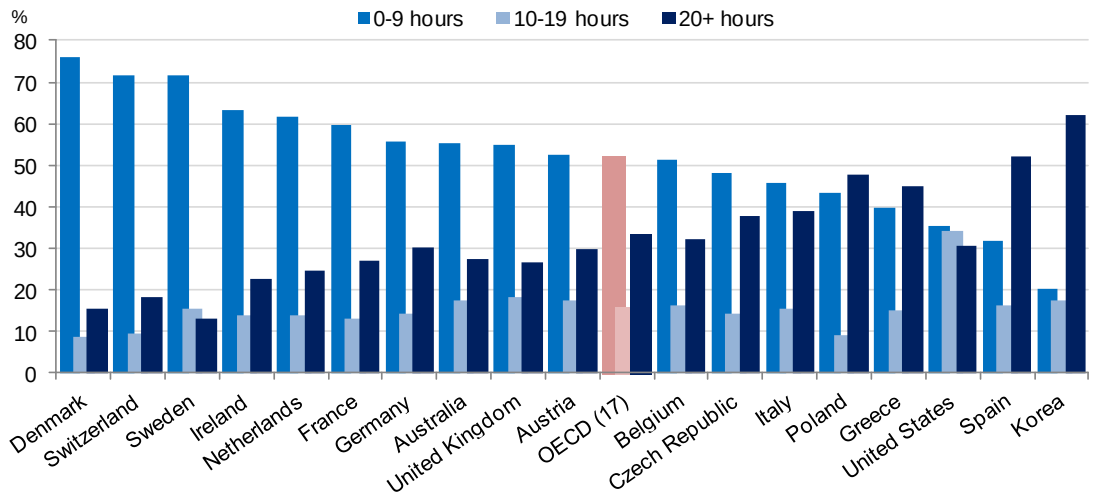
- Spain could enhance measures to help carers reconcile caring duties with work. High-intensity caring reduces employment and hours of work in Southern Europe more than in other parts of Europe. The provision of leave for care reasons is less frequent in Spain than in other European countries except for Austria.

- Considerations should also be given to providing work permits for foreign-born carers in numbers commensurate to the extent of labour needs. As options for legal entry for lower skilled jobs are limited, irregular inflows exceed the regular one in Spain.

- Despite the intention to train more care workers, the size of the LTC workforce remains one of the lowest compared to the number of those in need for care within the OECD. Despite qualification requirements for workers in institutions, the LTC workforce consists mainly of low-qualified workers.

- The 2006 LTC law improved access to care as well as support for family carers, however, the actual cost exceeded initial forecast. In light of the tight fiscal environment facing Spain, it will be important to grant benefits to those with the severest care needs, and continue to apply a means-test to determine the amount of the support provided to all eligible care recipients.

Spain has the second highest percentage of family carers providing intensive care



Source: *Help Wanted? Providing and Paying for Long-term Care* © OECD 2011

OECD (2011), *Help Wanted? Providing and Paying for Long-Term Care*, Paris,
www.oecd.org/health/longtermcare and www.oecd.org/health/longtermcare/helpwanted

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Key Facts

- About 17.2% of the Spanish population is over the age of 65 years (OECD average 15%) while 4.9% is over the age of 80 (OECD average 4%).
- Spain spent 0.6% of its GDP on public expenditure for long-term care in 2008, half of the OECD average of public LTC spending.
- The overall (public and private) expenditure on long-term care is estimated at around 0.5% of GDP for institutional care, and 0.3% for care services received at home.
- In 2009, 0.3% of the population over the age of 65 years received long-term care in institutional settings and medical facilities, while 1.2% of this population group received care at home.
- Spain reported 4.2% formal long-term care workers per person aged 65 years and over in 2009.
- The latest data available on long-term care beds in nursing homes is 21.3 per 1000 population aged 65 years and over for 2006 (OECD Health Data, 2010).

Background

Prior to the Law 39/2006 of December 2006, LTC needs were partly met through the basic social services provided by regions and local authorities, and by programmes towards people with disability benefits. The Social security system provided assistance in the form of benefits for those with a high degree of disability, allowances within the non-contributory disability pension and family benefits for those with disabled children.

The supply of social services has been scant and marked regional differences. To palliate limited supply, there has been a large expansion of privately provided services since the 1980s and the public administration has been slow to implement quality controls.

The new legislation aims at establishing a system of long-term care services. Policy priorities focus on encouraging formal care capacity and training of caregivers, for example in order to reduce the burden on informal caregivers, increase the quality of care and distribute the burden of LTC financing across society as a whole. The cost of the new system was forecasted upon design of the new legislation at an additional 1% of GDP but they might underestimate projected needs.

The system, which includes services and cash allowances, is to be implemented incrementally, starting from January 2007 with provisions for those with the severest (Degree III, see below for definitions) level of dependency, with the aim to expanding provisions to those with Degree 1 by the end of 2014. Difficulties have already appeared linked to the unequal implementation across regions, both in terms of service availability and dependency assessment.

Benefits and Eligibility Criteria

Benefits are universal for all Spanish nationals or who have been residents for at least 5 years, of which at least the last 2 before filing the claim. Eligibility depends on an assessment of the degree of dependency, evaluated on the basis of the Scale of Dependency (Royal Decree 504/2007). Three degrees of disability exist, with 2 sub-levels within each grade. The definitions are as follows:

- Degree I (Moderate Disability): the individual requires help for several basic activities of daily living at least once a day, or needs help on a sporadic basis or limited to personal autonomy.
- Degree II (Severe Disability): the individual needs help for several activities of daily living, two or three times a day but does not need permanent help from a carer nor extensive help to ensure personal autonomy.
- Degree III (High dependency): the individual needs help for several activities of daily living several times per day, and because of total loss of physical, mental, intellectual or sensorial autonomy, s/he needs permanent help from a carer or needs generalised help to ensure personal autonomy.

Individuals with a score below 25 on the eligibility scale are not entitled to services or allowances.

Responsibility for assessing the degree of disability and benefit entitlement lies with the regions (autonomous communities). The assessment is followed by the elaboration of an individual plan by social services which includes a list of appropriate services. The legislation (Royal decree 727/2007) establishes nevertheless a criterion for determining appropriate services for each degree and level of disability and entitlement to allowances.

Cash benefits and allowances

Three types of allowances are available:

1) *Allowance for the care recipient to hire services.* This allowance is meant for the care recipient to hire services through private centres (with accreditation), when public services are not available. Benefit levels range from 400 Euros/month for degree II level 1, to 831 Euros for degree III, level 2, in 2009.

2) *Allowance for the care recipient receiving informal care.* To receive the allowance, the informal carer needs to be a relative of the dependent person, except when services are unavailable in the area, in which case the informal carer must be a neighbour residing in the same municipality (or nearby). The allowance is meant to compensate the service provided by the informal carer. Benefit levels range from 300 Euros/month for degree II level 1, to 519 for degree III, level 2, in 2009.

3) *Allowance for personal assistance.* This allowance is meant for individuals having a high degree of disability (III) to hire personal help in order to promote personal autonomy, access to work and education and help in daily activities. Hiring expenses for the carer must be documented and the carer needs to have appropriate professional qualifications (state certifications). Benefit levels range from 609 Euros/month for degree III level 1, to 812 for degree III level 2, in 2009.

All cash allowances are means-tested and depend on cost, or on hours of care for the allowance towards informal carers. Benefit levels will be proportionally decreased if the person receives other allowances for people with disability. In all cases, the remaining allowance cannot be lower than 40% of the original allowance for personal assistance and services, and 75% of the allowance for informal care. All benefits are tax-free.

In-kind benefits

Subsidies may also be received in-kind through prevention services, tele-assistance, home care, day or night care or institutional care. The decision between in-kind or cash is done in consultation with the family after the needs' evaluation. In-kind services are also means and assets-tested. In the case of residential care, wealth is calculated using the value of the house owned if there are no other dependents residing in that house. So far it seems that system developments have focused more on extending allowances rather than on building more public in-kind services.

Institutional and day care services

The following in-king benefits are available:

- Facility-Based (Institutional) Long-Term Care Services: Institutional care includes regional centres, municipal centres and privately provided institutions. Institutions are required to have minimum ratios of workers per care recipient by type of worker for carers and geriatricians; for other categories it will be agreed by 2012. Most institutions are private with only 24% of residences publicly-owned (although 22% additional residents receive a public subsidy to be placed in a private centre). There are large regional disparities in the distribution of places, prices and services offered.
- Day care centres are also mostly private (65%) but publicly subsidised at 60% and have seen large increases (36,000 new places between 2002 and 2007).

Different norms have so far been established throughout the regions for means-testing or co-payments for residential care, i.e. regions set the minimum guaranteed. Co-payment is required for food board and

lodging services. Co-payments cannot exceed 90% of the reference cost indicator, which is set in each region using the prices of private residences that have agreements with the social security

Home and Community-Based Services

Home-care services include prevention and promotion of personal autonomy, help with personal care and with instrumental activities of daily living. All persons below minimum income are guaranteed home care. Co-payments cannot exceed 65% of the reference cost indicator (this is also the case for day or night care centres).

Funding and Coverage

According to cost projections for the implementation of the new system, recipients are expected to pay one-third of total costs of services. Cost-sharing measures and financing might have to be re-designed in light of costs being far greater than initially forecasted. In 2009, extra financing amounted to 2,050 million Euros instead of the 1,958 originally planned.

The system is tax-based and financed by funds from the central government and regions. The central government provides funds to regions based on the number of dependents according to the degree ofdisability. Regions determine whether to set additional funds for additional services.

Workforce Issues

All formal workers must obtain minimum professional qualifications; this holds for carers, home carers, personal assistants and directors of institutions. The formal workforce has expanded by around 170% between 1996 and 2006, and was expected to grow by between 160,000 and 262,000 jobs between 2005 and 2010. 56% of workers have low or no qualifications. There is no allowance directly directed to family carers directly as the allowance is directed to the care recipient. Informal carers have special pension rights and other social contributions. Support and respite care for informal carers will be developed in the future.

References

OECD 2009-2010 Questionnaire on Long-Term Care Workforce and Financing

OECD (2010) *OECD Health Data 2010*, Paris.

OECD Social and Labour Demographics Database 2010