

# **Long-term care: context, debates policies and prospects**

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Although the political debate on social protection in Spain is mainly related to the future of the public pension system a growing interest on social protection of dependency has been taken place from the last ten years such as scientific as political debate.

Firstly we try here to describe the social phenomenon of dependency in Spain and its main characteristics. Secondly, we analyse present political and scientific debates on how to manage the long-term care programmes. Thirdly, we describe the present policies and programmes that are answering the social problem of dependency. Finally, we will tentatively point out some tendencies concerning of long-term care policies.

## **The context for dependency policies**

The social problem of dependency is not new in Spain because some needs of dependent people are already protected with different social benefits of Social Security –mainly the dependency related to consequences of accidents at work– as we have pointed out in a previous report on dependency in Spain for European Commission<sup>1</sup>. However the dimension of the dependency problem in many senses is new because of the impact of recent demographic and social developments such as the ageing of Spanish population and dramatic changes in the size and dynamic of Spanish family. As has happened with other social changes (for instance, the abrupt declining of fecundity rates and the increasing figures of economic immigrants) the most relevant fact related to dependency is the speed of social change, its impact on very elderly people and its political and scientific importance.

There are three main factors that determine the long-term care policies in Spain: the increasing size of dependent population, the great variety of long-term care policies under a decentralised State and the centrality of informal care and the role of family caregivers. We will analyse now each of these three factors:

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<sup>1</sup> Rodríguez Cabrero, G. (1998) 'Social protection for Dependency in old age in Spain', in Pacolet, J., and Bouten, R., *National Reports of the Social Protection for Dependency in old age in the 15 EU members States and Norway*, Leuven: HIVA Katholieke Universiteit.

- a) The dependency and the need for long-term care go through all social structure of ages. However, the present process of ageing of Spanish population is the main cause that explains the social relevance of dependency and its present impact in terms of social protection policies. We must take into account that while in 1960 the percentage of people being 65 and older was 8% of Spanish population, in the year 2000 was near 17%. Obviously ageing is not the only factor that explains dependency. There are other crucial factors that condition furthermore the rates of dependency such as healthy life, education and professional work that overall define what is known as “life expectancy without dependency”.

We can consider some figures which show the increasing social relevance of dependency. The rates of dependent people higher than 65 years old are roughly 6% of all Spanish population. From 65 age onwards the rates of dependency grow exponentially: 11% in the age group of 65 to 69, 16% in the age group of 70-74, 25% in the age group of 75-79, 34% in the group of 80-84 and 54% in the group of 85 and more (see graphic 1). The total Spanish dependent population –that is, people who need help to carry out personal and instrumental activities of daily life could be estimated according to our own calculations between 1,423,751 (people who suffer three or more handicaps) and 1,113,626 (people with three or more handicaps who can not carry out daily activities or with great difficulty in relation to personal care, mobility at home and management of domestic tasks) (see table 1). If we also take into account all levels of dependency – low, medium and high dependency – the total dependent elderly people is around 1,167,504. This figure related to 1999 survey, analysed by us recently, comes to be similar with former estimations for 2000, made in 1998 which quantify the dependent population in 1,115,444 elderly dependent people<sup>2</sup>.

This dependent population can be characterised by three crucial facts: the predominance of women who are around 67% of total dependent population, the overwhelming percentage of dependent people higher than 65 (around 70%) and the growing dependent population being 85 and more who are now around a third of total elderly dependent population.

Between the population higher than 65 years old of age the rate of dependency is roughly 17%. Between those 30% would be people with moderate dependency, half of all with medium dependency and around 16% people with high dependency<sup>3</sup>.

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<sup>2</sup> Rodríguez Cabrero, G. and Morán Aláez, E. (2001), *La población dependiente: primeros resultados de la Encuesta sobre Discapacidades, Deficiencias y Estado de Salud*. INE. IMSERSO. Forthcoming; Rodríguez Cabrero, G. (coord.) (1999), *La protección social de la dependencia*. Madrid: Ministerio de Trabajo y Asuntos Sociales.

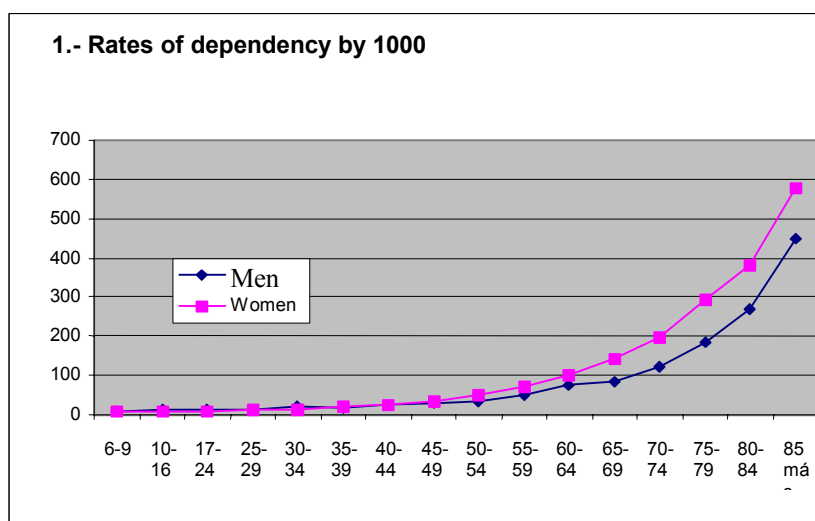
<sup>3</sup> Rodríguez Cabrero, G. (2000), ‘Dependencia y atención socio-sanitaria’, in *Boletín sobre el Envejecimiento: perfiles y tendencias*, no. 2. Ministerio de Trabajo y Asuntos Sociales.

**Table 1: Dependent population in Spain in 1999**

<b>Dependent population with 3 or more disabilities</b>			
	<b>6-64</b>	<b>65 +</b>	<b>Total</b>
Men	199,416	275,579	474,995
Women	235,783	712,973	948,756
<b>Total</b>	<b>435,199</b>	<b>988,552</b>	<b>1,423,751</b>
<b>Dependent population with 3 or more disabilities who can not do 1 daily life activity or with great difficulty</b>			
	<b>6-64</b>	<b>65 +</b>	<b>Total</b>
Men	148,995	236,922	385,917
Women	152,885	574,824	727,709
<b>Total</b>	<b>301,880</b>	<b>811,746</b>	<b>1,113,626</b>

Source: Rodríguez Cabrero, G. and Morán Aláez, E. (2001).

**Figure 1: Rates of Dependency by 1000**



Source: Rodríguez Cabrero, G. and Morán Aláez, E. (2001).

The projections of Spanish elderly population estimated from 1981 to year 2021 indicate clearly the crucial change that will take place in the size and structure of highest ages. For instance the percentage of people being 80 years old onwards that accounted 21% in all elderly population in 1981 will rise to 28% in year 2021 (see table 2). At the same time, between this population the dependent people will increase sharply. The very elderly dependent population, the most frail elderly citizens, being 65 onwards will rise from 1992 to 2010 year 44.7%; also the dependent population being 80 years old onwards will increase 54% during this period of time.

**Table 2: Projections of elderly Spanish population and very dependent old people (%)**

Ages/Years	1981	1991	2001	2011	2021
65-69	34	34	30	27	28
70-74	25	25	27	23	25
75-79	20	20	21	22	19
80-84	13	13	12	16	14
85-89	8	8	8	9	10
90 +			2	3	4
Total	100	100	100	100	100
Very dependent 65 and older	---	10	11.4	13	---
Very dependent 80 and older	---	26.8	25.2	23.2	---

Source: *Projections of Population*, INE. Own calculation on dependent old people (Rodríguez Cabrero G. and Monserrat Codorniu, J., 2002).

b) There is a second factor that explains the dependency in Spain: the crisis of family informal care system. Although the majority of elderly people live independently those who are dependent live with a main caregiver permanently (59%) or temporally (16%). Only 3% of elderly people live under institutional care, half of them in nursing homes. In terms of care 73% of dependent people get all help they need –76% between elderly people-, 8% receive some care and 16% do not demand any personal care. Mainly families (87%) without any monetary compensation take this very wide coverage of informal care (only 20% of caregivers receive some payment). The women are the overwhelming majority of informal carers (83%). Personal social services only protect around 3% of dependent population. The received care by friends, neighbours and private caregivers is simply residual. Private care by economic immigrants, mainly those who coming from Latin America (Peru, Dominican Republic and Colombia) is increasing as main support to many middle and high professional women in big cities as Madrid, Barcelona and Valencia.

This family model of care is progressively becoming in crisis due to three main facts: firstly, a less potential at disposal of family carers<sup>4</sup> because of a decreasing in the number of women in age of care at the time when there is a growing number of elderly dependent people; secondly, a dramatic change in traditional model of family because of growing rates of divorce, single-parent families and the remaining of great figures of young people at home until near their thirties; thirdly, changes in the social role of women related to their incorporation into the workforce that decrease the informal care population and, also, the intensity of time to care.

c) Finally, we must emphasize on institutional factors. As a consequence of before mentioned social changes, a growing demand of social services and cash benefits in

<sup>4</sup> Fernández Cordon, J.A. (1992), *Les personnes âgées en Europe: Rapport national, Espagne*. Brussels: European Commission.

favour of dependent population and their carers is taking place. The traditional family solidarity is still working strongly but demands support to face the new social need (mainly community care services: home help, day centres). We must here detail the deficits in long-term care services. Until today near all social and economic costs of dependency fell on families, that is to say, on women, in terms of direct cost in time, money and opportunity costs. Public spending on dependency –including health and social personal services– is around 0.85% of GDP. Although some cases of dependency are protected by Social Security benefits, those handicaps that are consequences of accidents at work, the present social protection system does protect dependency cases as a consequence of ageing or serious illness. However, being health care a universal social right, the real deficit on social protection of dependency is on personal social services. For instance, the coverage of community care services and nursing homes is very low compared with Northern and central European Union countries. Only 2% of elderly people can access to home help, 0.2% to Day Centres and 2% to Nursing Homes. Thus, the social right to personal social services is a very “weakened social right” because of its social assistance nature. Finally, Regional Governments have full constitutional competence on personal social services and a growing uneven development has been taken place from the last fifteen years in terms of coverage and intensity ratios in spite of policies of equality applied by national plans such as National Plan for Municipal Social Services.

Briefly, the main issues that determine the social protection policies on long-term care in Spain are the growing dependent elderly population, the crisis in the traditional system of informal care and the very limited coverage of public services related to dependency. All of those have transformed a latent need into a new social demand and also a new area of political debate on social protection.

### **Political and scientific debates on dependency**

The political and scientific debate on dependency started in 1991 when the first National Gerontologic Plan was set up for the period 1991-2000. Later, the National Agreement (*Acuerdo Marco de Atención Sociosanitaria*) in 1993 between the Ministries of Health and Social Affairs on care of elderly people stimulated the scientific debate with such intensity that since 1999 it has progressively been a target in the political agenda in Autonomous Communities and Central Government.

- a) The scientific debate started to develop, as we mentioned before, under the support of National Gerontologic Plan and the high influence of scientific societies. The participation of professionals in European debates and applied research show how dependency is a new social problem that must be placed in the political agenda. Applied social research is being crucial in order to justify political proposal.

During the second half of nineties has taken place an important development on social research in order to improve the knowledge on social structure of dependent population, models of care, levels and distribution of social spending and possible long-term care programmes<sup>5</sup>.

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<sup>5</sup> We can mention applied research such as: Rodríguez Cabrero, G. (coord.) (1999) *La protección social de la dependencia*. Madrid: MTAS; Rodríguez Cabrero, G. and Monserrat Codorníu, J. (2002), *Modelos de atención sociosanitaria: aproximación al análisis de costes de la dependencia*. Madrid: MTAS; Casado, D. and López i

However, the impact and influence of scientific debate on public policies has been undermined from the very beginning by monetary policies favouring the containing of social spending and the target of deficit zero, the pre-eminence of public pensions debate and growing influence of privatization ideology that supports private insurance on dependency.

- b) From the point of view of political debate we can mention four main lines of debates on long-term care policies:
1. The initial active role of IMSERSO (Instituto de Migraciones y Servicios Sociales) depending on the Ministry of Employment and Social Affairs, favours a national social insurance programme on long-term care. Following the scientific debate and recommendations of Ombudsman Office, the IMSERSO has supported an universal social insurance policy following another European policies such as in Austria (1993), Germany (1994) and Luxembourg (1998). There was advanced a draft bill on long-term care national insurance in the autumn of 2001 justified as a development of article 41 of Spanish Constitution of 1978. From that date until today the proposal has been paralysed. Also the Ministry of Health supports a national insurance model of long-term care and set up a Long-term care Commission in the National Health System<sup>6</sup>.
  2. There is a second initiative led by Spanish Parliament which has ended in the elaboration of official reports such as Senate Recommendations on social protection and ageing and the mentioned report from Ombudsman Office<sup>7</sup>.
  3. Unions are in favour of long-term care policies although is not a priority in its political agenda. A national insurance policy on dependency should have been placed inside Pact of Toledo. The last agreement between Government and CCOO Union, in April of 2001, has compromised to analyse the possibility of a long-term care policy as a national insurance policy<sup>8</sup>. However the absence of Socialist Union UGT undermines credibility to this political agreement.
  4. Finally, the last position is the privatization option promoted by big private insurance companies and supported by some areas of Government (Ministry of Economy), that in National Budget of 2000 (Law No. 55/1999) compromised to send to Parliament a report on private insurance scheme of dependency. This report elaborated by the General Direction of Insurance (Ministry of Economy) points out that private insurance on long-term care would have very scarce acceptance in Spain (as US experience shows clearly), but it also considers that a national insurance policy is unfeasible in financial terms under a context of social spending restrictions. The ideal model that this report suggests is social assistance insurance for people living under official poverty line, fiscal support to families and caregivers, and private insurance schemes and private management of personal social services in general.

As a consequence of this political debate, national policies on long-term care are delaying year after year while Autonomous Communities have to face the new demands of social protection without any global State policy. That means very different long-term care regional

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Casasnovas, G. (2001), *Vejez, dependencia y cuidados de larga duración*. Barcelona: Fundación la Caixa; Informe del defensor del Pueblo realizado por la Sociedad Española de Geriatria y Gerontología y la Asociación Multidisciplinar de Gerontología (1999), Madrid: Defensor del Pueblo; Documentación Social (1998), 'Envejecimiento', no. 112.

<sup>6</sup> Ministerio de Sanidad y Consumo (2001), 'Bases para un modelo de atención sociosanitaria'. Draft. Madrid.

<sup>7</sup> Cortes Generales, Senado (2000), *Ponencia sobre la problemática del envejecimiento de la población española*. Madrid.

<sup>8</sup> Acuerdo Gobierno-CCOO, 9 April 2001 on Pensions.

programmes that increase the territorial inequalities and then less effectiveness in social protection of dependency.

### **Policies, health and personal social services models and plans to care elderly people**

To analyse the different models of long-term care in Spain is not an easy task because of a very wide diversity of programmes and policies that are at national and regional level. Such diversity can be explained by following reasons:

1. The full competence in health services by the Autonomous Communities. The 1<sup>st</sup> of January of 2002 the transfer of health constitutional competencies finalized;
2. The very deep different degrees of development between Regional Governments in terms of personal social services: there are wide differences in service coverage, ratios of intensity and social rights of accessibility;
3. The inexistence about how to rule the process and finance of long-term care programmes even though there is a general consensus between Regional Governments;
4. Finally, there are very different levels and styles of co-ordination between health system and personal social services.

This institutional complexity allows us to differentiate between two main institutional levels: Central Government Policies and Regional Government Programmes. Between the last one we must differentiate two institutional levels: specific programmes on long-term care and regional general plans for elderly people.

We are now analyzing each of those programmes emphasizing in the problems of co-ordination between Administrations.

#### ***Long-term public policies of central administration***

Long-term term public policies of central administration are a consequence of its constitutional competence on co-ordination and promotion of national solidarity. Under this framework we can mention two main initiatives:

- Ministry of Employment and Social Affairs (MTAS): ‘National Gerontologic Plan 1992-1997’ (Plan Gerontológico Nacional 1992-1997) has promoted the development of long-term care programmes. The report that evaluates this Plan considers as a positive step in social policy the new regional programmes on long-term care such as Plan Andaluz de Atención Integral de Mayores, Plan de Atención Sociosanitaria de Castilla y León, Programa de Vida a los Años de Cataluña, Plan de Salud de Extremadura 1997-2000. The main contribution of National Gerontologic Plan has been its leadership in the promotion of scientific and political debate on social protection of dependency. ‘Action Plan for Elderly People 2000-2005’ supports, between the area of Equal Opportunities, the development of an integral system in order to protect dependent people, the improvement of co-ordination between different plans and asks for the inclusion of dependency risk as a new Social Security contingency. This Plan favours territorial equality in accessibility to benefits and services related to dependency, setting up a basic

national catalogue of long-term care social benefits that could be considered in the future national social rights.

'Plan on Alzheimer and other Dementias 1991-2005' defines a national policy for a population group that is estimated between a maximum of 669,478 persons higher than 65 to a minimum of 334,724, that is, around 10 and 5 per cent of Spanish elderly population.

- Health Policies. The Ministry of Health has set up four policies related to long-term care during the nineties: 'Planning criteria for elderly health care' in 1995, where is defined as an integral programme of health care for frail elderly people who are in their eighties and also for geriatric patients with different handicaps who are 75 onwards. For the first time 'Social and Health Commissions' (Comisiones Sociosanitarias) were set up in different Health Areas as instruments of planning and evaluation for elderly health care programmes.  
'Strategic Plan of National Health Service' in 1997 that assumes as main policy the strategy of long-term care supporting integrated co-ordination between health system and personal social services, interdisciplinary tools of care and the leadership of Primary Health Care on long-term care.  
'Quality Plan of National Health Service' (1999) that regulates a national catalogue of social benefits and services, some of them related to long-term care.  
Finally, the development of ESAD or Domiciliary Health Teams set up in 1999, to care the very dependent and terminal people.
- Joint Policies of Health and Social Affairs institutions. The General Agreement in 1993 between both institutions created new long-term care tools as Social-Health Area Commissions (Comisiones Sociosanitarias) for planning and evaluation of elderly care programmes integrating personal social and health services. At the same time this policy put an incentive to the development of new services as Day Hospitals, Convalescing Units in Hospitals and Social-Health Residences. Also Home Help and Day Centres services started to grow because of new social demand. In spite of these new policies there have been from the beginning limits to its development such as financial constraints of Central Government and uneven political compromises in Regional Administration.

### ***Programmes on Long-term care and Elderly Plans in Regional Governments***

- Long-term care programmes. We define long-term care or social-health programmes as those that can be characterised to establish a specific net of social-health services to care all dependent people, particularly elderly people, although its main orientation is in some cases on health care (programmes of Catalonia, Castilla y León y Cantabria), in other cases, on personal social services (Basque Country), and a mix orientation in other Regions (Galicia, Cantabria).
- There are also some Elderly Plans that have emphasized either on personal social services policies (such as in Andalusia (Law 6/1999), Castilla la Mancha during 1998-2000 and Madrid in 1998) or on Health Plans (Canarias, D.37/1997, and Andalusia (II Health Plan)).

We can conclude that decentralization of Health Service and Personal Social Services has allowed the growing diversity in long-term care programmes. However this new social policies have not contributed to the implementation of a national catalogue of long-term care benefits. At the same time the possibility of a new national law on dependency is far to be passed. That means, as we say later on, that this very decentralised system is favouring, in



practical terms, the promotion of private solutions to long-term care needs where the role of public policies is subordinated in many senses.

### **The future of long-term care policies**

Very specific crucial issues condition the prospects on long-term care policies in Spain. On the one hand, present economic policies are clearly in favour of social spending containment and extension of privatization in public services management; on the other hand, a low social and political visibility of dependency needs is shown in its very secondary role in political parties and unions programmes; lastly, after the successful policies of privatization in the nineties of big public state corporations (telephone, electricity, gas, banks, air companies, etc) the privatization ideologies have widened influence in social policies in such a way that proposals favouring private insurance schemes and fiscal policies to support informal care of families who take care of dependent members are becoming more and more influential.

Under this economic and political environment Central Government has to choice between four possible policies:

1. Universal public insurance scheme under Social Security institution, financed with general taxes and social contributions. Private insurance schemes would be free and complementary.
2. Compulsory private insurance scheme with a generous fiscal support. Dependent citizens living in poverty would be protected under a social assistance programmes.
3. Social assistance programmes for poor dependants and a free private insurance scheme with some fiscal support.
4. Fiscal policy in favour of families with dependent people independently of income family.

Obviously it is a risky to overview now what long-term care policy could win place in the coming years. Probably a mix policy of programmes and institutions will be sat up. In fact, a 'familistic' (option 4) and 'social assistance' (option 3) alternatives could be established but they clash against the demographic tendencies that we have analyzed above. Social insurance of collective risks are objectively preferable via professional contributions or via pay as you go. But they become in contradiction with present economic policies of social spending containment (option 1) or could face an opposition of citizenship (option 2). Because of these limits the possible political outcome could be a hybrid solution which institutional nature will depend on political equilibrium between political parties competition and the influence of Unions. Furthermore, once Regional Governments strengthen different models of health and personal social services care –and uneven mix of 'assistentialism' in personal social services and 'universalism' in health care– the margin of manoeuvre of Central Government has been decreased progressively and then the political opportunity for a national insurance model of social protection of dependency.

Therefore, as main conclusion, policies on long-term care are running under the initiative of Regional Governments and private insurance companies. Central Government is becoming more and more a political spectator, possibly conscious, that is trying to avoid new financial

compromises and at the same time, is stimulating a silent process of selective privatization on long-term care policies.