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# INFORME

## THE SYSTEM FOR PROMOTION OF PERSONAL AUTONOMY AND CARE FOR DEPENDENT PERSONS

### CONCLUSIONS AND PROPOSALS



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One of everyone's main aspirations is to live for as long as possible, with as few limitations and as much autonomy as possible. It is a veritable challenge for the public authorities to support this aim, in the midst of a sharp process of ageing of the population, of increasing chronic illness and the sociodemographic and cultural changes that accompany the demise of the traditional model of care at home. In this context, the creation of the System for Autonomy and Care for Dependent Persons (SADP) was an important milestone for the Spanish system of social protection and should be optimised and reinforced so as to effectively safeguard the right of all persons dependent on care to quality care which is holistic, accessible and provided in equitable conditions.

The serious impact of the pandemic caused by the COVID-19 virus amongst elderly people who are the most vulnerable to the consequences of contagion, has brought to light significant weaknesses in the system of care for dependent persons, as well as new challenges for the future. Aside from the urgent need for solutions and an inescapable requirement for rigorous and independent assessment of all that has happened, it remains essential to recap on the situation of SADP prior to the outbreak of the coronavirus, since this will be the basic reference for all types of comparison in the coming years.

Before presenting the main conclusions which have been extracted from the different chapters of this report, it is necessary to engage in reflection on certain overarching transversal issues or aspects impacting on the provision of care for dependent persons in Spain.

A growing number of people are now reaching what was traditionally considered old age whilst retaining a good bill of health over a longer time period. It is the loss of autonomy rather than reaching a certain age that increasingly acts as the determinant for moving from one phase in life to another. There are important differences in the degree of personal autonomy and in the prevalence of limitations amongst people of the same age, so becoming dependent is not an inevitable consequence of ageing. Dependency, rather, is related to other variables, in some of which there should be intervention, both to delay their onset and to prevent them from becoming more serious.

Preventing the loss of autonomy is essential, though often overlooked, when considering the perspectives of the system of care for dependent persons. It is a social and economic challenge as we look to the future, and it affects many spheres of public poli-

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*Prevention is the priority:  
promoting health and  
personal autonomy  
across the board*

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cies. The creation of the SADP represented recognition of this need, the onset of a new universal right, and the implementation of a system to meet it.

However, the promotion of personal autonomy, that is, the preventive part of the SADP, is one of its least developed aspects, despite the fact it is of vital importance for quality of life and for the economic sustainability of the system itself.

*It is important to augment the provision of care services of a preventive nature, which have to date been very residual, and to reinforce the intensity and the professionalisation of the support mechanisms so that individuals may remain in the family environment; that is to say, those which have a positive impact on guarding against or delaying the institutionalization of dependent persons.*

*The aim of maintaining a good bill of health for the longest possible time, including the policies to promote active and healthy ageing, should be impregnated throughout, in a transversal manner, and with greater intensity right through the different spheres of educational, scientific, economic and employment reality.*

*At the same time, there is a need to align the objectives and resources of the SADP with those adopted in the sphere of healthcare policies and public health, focusing also on improved linkage of social and health strategies, which to date have not been sufficiently developed, as we shall see below.*

However, it is obvious that neither the capacity of the SADP nor that of the health system will be sufficient on their own to enable a response to the need to promote health at all of the stages of life.

One of the first obstacles noted when addressing the situation of care for dependent persons in Spain is a lack of sufficient statistical sources. In particular, this affects the very system for information established as part of the SADP. But, before looking at its specific shortcomings, the lack of consideration of this reality in most of the usual official sources should be pointed out. They do not include it as a topic in itself or with enough disaggregation (as applicable to the statistical classifications of the National Classification of Economic Activities (known by its Spanish acronym, CNAE) and to the National Statistics Institute (in Spanish, INE) data such as the Labour Force Survey (EPA) the Central Companies Directory (DIRCE) or the National Accounts), or they do not do so frequently enough (as with the Survey on Disability and Personal Autonomy or the Survey on the Uses of Time (INE) or the opinion studies undertaken by the Centre for Sociological Research (CIS).

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*Need for assessment  
and for overcoming  
the failings of the  
information system*

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*There is a need for differentiated consideration of the types of care provided for dependent persons throughout the whole of the national system of statistical sources, in line with their status in society as a whole, the economy and social protection.*

In line with the above, it is the ESC's position that in order to undertake any type of improvements in the SADP it is necessary for there to be a mechanism that is permanent, transparent and independent for evaluation of its activity in terms of accessibility, efficiency and quality. This has not yet been rolled out in spite of approval by the Interterritorial Council of common and standard criteria for the quality of services and the publication of a number of evaluation reports drawn up by the Institute for the Elderly and Social Services (IMSERSO) several years ago now.

*The shortcomings of the SADP Information System (SADPIS), which have been outlined throughout the present report, mean that it will be essential to complete a thorough update of its design so that it can provide information on aspects such as coverage, the intensity of services, the profile of beneficiaries, the characteristics of employment, the facilities and internal and jointly-run services of the system, as well as, amongst others, the different sources of funding, the cost of services and the associated expenditure.*

In the months prior to the pandemic, a modification was announced to the contents included within SADPIS, and it is hoped that this will be carried out and will respond to the expectations for improved information indicated here. Although a number of advances have occurred, such as dissemination of information on the impact of the pandemic on the system in terms of estimated deaths (monitoring of daily mortality by Social Services) or the publication of quarterly reports on employment in the Social Services, it is vital to build a real information system and to continue to systematically include more quantitative and qualitative variables so that the situation can be evaluated.

In addition, throughout the report it has been noted that the system for care for dependent people in Spain has an obvious gender component. Women account for a large proportion of the beneficiaries of the system, and this will remain the case in view of women's longer estimated lifespan as well as their worse bill of health at older ages. In addition, women represent a majority of carers, whether in formal or informal roles.

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*The reinforcement of care for dependent persons has to include a gender perspective*

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As a result, the deficiencies of the system, as revealed in this report, both those of a structural nature and those that arose in the context of the pandemic, affect women more severely. All efforts focusing on improving care according to the principles behind the dependency act (known by its Spanish acronym, LAPAD), especially the professionalisation of care and the primacy of services as opposed to economic benefits, will have positive repercussions for equality between women and men.

Improving access to care and the quality of care services thus amount to an inescapable challenge of vital importance, not just to guarantee the social right to care for dependent persons, but also to avoid situations of inequality and promote a form of economic and

social development that is more equal, in which the provision of care is compatible with women's full personal, family and career development.

*Specific consideration should be given to the gender impact in the adoption of every one of the measures in the SADP.*

## 1. Dependency and the provision of long-term care

### THE CHALLENGE FOR PROVISION OF LONG-TERM CARE IN THE EUROPEAN CONTEXT

The challenges faced by the Spanish system for care for dependent persons have to be analysed in terms of the closest comparative context, that is, of other European countries. Our neighbours are facing the same sociodemographic trends as our country and are equally exposed to the more recent challenges that SARS-Cov-2 has brought about for care for dependent persons.

The so-called “care crisis” has thus become one of the most important challenges for systems of social protection. Community care, in the framework of the broader concept of “long-term care” (LTC), has become more important over the last few years, to the extent that it became recognised as an essential subjective right for European citizens in the European Pillar of Social Rights.

Among the many models of care and treatment of dependent persons, a number of common trends can be observed, such as the expansion of care services focusing on domiciliary care; similar criteria for defining situations of dependency; privatization of services and convergence towards mixed models for financing. It also seems to be common for countries to have institutional structures that are divided, both vertically (territorially) and horizontally (health services and social services), generating significant challenges in terms of system coordination. In this respect, the European Union highlights the need to improve the governance of the different LTC services by means of proper social and health care integration.

In its most recent institutional documents, the European Union calls on the member states to safeguard the universal *accessibility*, *quality* and *sustainability* of long-term care, emphasising the need to develop adequate and comparable indicators to measure the situation and also encouraging the exchange of good practices.

The community policy is oriented towards prioritising care services in the home, which clashes with the loss-making and insufficient nature of the provision of this type of service in most European countries, particularly for people with higher dependency levels. The service is often provided via organizations from the third sector, and informal care remains frequent, largely delivered by women in the family environment and sometimes delegated to other women, many of whom are of immigrant origin.

As an alternative to care homes, the rise of non-traditional models for care has been observed, especially in northern Europe, in particular for adults with moderate-level

dependency, based on the approach known as the “home model”. However, the development of this type of solutions is still in its early stages in most of the countries.

The increase in the demand for LTC generates extra pressure for ensuring its quality, in a context of a lack of suitably qualified staff as well as the very low social esteem in which these professions are held, exacerbated by unattractive working conditions in most of the countries.

*In any event, reinforcing domiciliary care, as called for by community bodies, without creating an even larger burden for family networks, would require a greater responsibility on the part of the public authorities in most of the countries, including our own, if the aim is to ensure that care and treatment for dependent persons is a real social right.*

The onset of the SARS-CoV-2 crisis revealed the structural deficiencies of the systems for provision of care to dependent persons and the need to put them right. The community response to combat the serious economic and social effects of the pandemic constitutes an opportunity for the member states to strengthen their policies for care and treatment of dependent persons and to take steps to make them a veritable social right.

#### **SOCIODEMOGRAPHIC CHANGES, DEPENDENCY AND CARE PROVISION IN SPAIN**

Spain is one of the countries that will be most affected by ageing of its population in coming years because of its large generation of baby boomers. According to the INE 2020-2070 Projections, the peak for the process of ageing of the population is likely to be reached in around 2050, after which it will begin to decline. Although it is too early to estimate the impact of the pandemic on all demographic phenomena, the INE has anticipated a temporary reduction in life expectancy, which will pick up again in 2021. Considering only the nearest horizon of the next fifteen years, which will be crucial for development of the SADP, account should be taken of the fact that between 2020 and 2035 the volume of people aged over 65 will increase from 19.6 percent of the population in 2020, to 26.5 percent in 2035. Within this group, the over-70s will increase from 14.4 percent in 2020 to 19.4 percent in 2035, and the over-80s will rise from 6 percent to 8.1 percent in the same period. In sum, those who are over 65 but under 80, in other words the majority of the baby boomers, will continue to be the biggest group in both of the reference years. In this first phase, the biggest rises in the volume of the population aged over 64 will occur in the under-85 age group, which will have knock-on effects for the system from the point of view of expected entries into it because of the likely degree of loss of autonomy.

*Even if we do not consider forecasts for ageing of the population in the long term which are intrinsically uncertain, the significant rise in the potentially dependent population that can be expected over the coming fifteen years (especially for over-80s and over-90s) points to the need to anticipate increased demand for the SADP.*

*From this perspective, it is important to undertake short and mid-term planning for the investment that the system will require and for the resources needed to fund it.*

From the standpoint of types of home, although in old age households mostly comprise a couple due in large part to greater life expectancy for men, account must be taken of the fact that, according to the Ongoing Survey of Homes (Encuesta Continua de Hogares), in 2019 over two million people aged over 65 lived alone, with women making up 72.3 percent. This gives an idea of the challenge of achieving quality care based on, as far as possible, dependent persons remaining in their home environment. The experience of lockdown and the suppression of home-based care services for dependants, which have still not returned to normal in many territories, has shed light on the seriousness of many situations of unwanted solitude, especially where this is accompanied by a significant worsening in health or functional capacity.

Although most old people live in cities, their weight in the rural population is much higher. The particular conditions of rural environments, such as the dispersion or small size of some municipalities, as well as insufficient services, may make it difficult to ensure access to the full range of SADP in conditions of equity, in particular with regard to certain benefits.

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*The territory matters:  
the importance of  
greater focus on the  
rural world*

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*In the rural world, to which not enough attention has been paid yet, to improve quality of life for persons dependent on care and their relatives who act as carers requires an increased impetus in the development of the network of social and health care services, and in adapting the legislation to the peculiarities of this environment.*

Moving up the pyramid of age, there is a manifest preponderance of women, so that in the groups of over-80s women more than double men, with a ratio of four to one in the still small, but growing, cohort of centenarians. This greater weight of women amongst the oldest groups will continue according to the forecasts, despite the rising life expectancy for men.

*Along with the system for pensions, care for dependent persons will become an essential cornerstone of social protection for the elderly and, given the preponderance of women among both beneficiaries and carers, as mentioned above, should also be considered from the standpoint of gender.*

#### **THE POPULATION DEPENDENT ON CARE IN SPAIN**

Despite the limitations already noted of the information system, one of the most interesting contributions of the SADP has been to make the situation of dependent persons in Spain more visible by means of concrete figures that shed light on certain very significant



aspects of this reality. On the key element, that is, the number of people who require care (1.3 million applicants had their right to care recognised in 2019), the SADP system of information regularly offers updated statistics. However, the figure emerging from application of the scale of assessment for dependency may offer room for interpretation in the evaluations. At the same time, we cannot underestimate the existence of a certain number of persons who, despite meeting the required conditions for benefiting from the system, have not submitted an application, for a range of reasons.

In this context, estimation of the volume of the dependent population should be expanded to take into account all persons who have lost some degree of autonomy. It is important to highlight the fact that almost 1.7 million people aged over 65 (almost 20 per cent) find it difficult to perform one of the activities of daily living, according to the latest data from the National Health Survey. The indicator gives a good idea of the “potentially dependent” population, revealing a volume that is higher than that shown by the system.

With regard to the numbers of people who actually receive care, the data show a profile marked by age: most of the beneficiary population (seven out of ten) are aged over 65, and more than half are 80 or over. However, we should not overlook the existence of a considerable volume of the population aged under 65 who have problems of autonomy. In Spain, in fact, 66,600 under-18s (2,466 infants aged three or under) are recognised by the system as dependants, in other words, 6 per cent of the total for dependent persons. A further 239,000 dependent persons fall within the wide age range of over-18s and under-65s, accounting for 21.5 per cent of the total.

*It would also be of interest in this case to contrast the data from the system with those from other sources, such as the Survey on disability, autonomy and situations of dependency, which, in any event, needs to be updated (the most recent data are from 2008), with the aim of finding out with precision the volume of the population with care needs.*

At the same time, the broad phenomenon of dependency among young people, due to higher survival rates vis-à-vis events which in earlier times would have been fatal, reveals that it is necessary to include this large segment in the design of the policies for care, overcoming the “ageist” focus on dependency.

In any event, the higher rate of health disorders after certain ages, which is manifested in demographic terms in shorter life expectancy in good health for women aged over 65, plus the fact that they live longer, offers an explanation for the fact that most of the population of beneficiaries is made up of women (65 per cent). That is, since women live longer, but with worse health, they account for the greater part of population to be covered by the system.

*Taking into account that the difference in levels of health between women and men is not as severe in countries which, like Spain, report high figures for life expectancy, the possibil-*

*ity for reducing this distance in our country, improving the health of women, should be an objective of health policies. For this reason it seems there is a need to reinforce measures for prevention from a gender perspective.*

#### **INFORMAL CARE**

Historically, the responsibility for caring has been covered within families, mainly by women. Despite the advance that the implementation of SADP has entailed, its limited development and the intensity of the care provided informally in the family environment make it obvious that there is much still to be done to achieve effective development of the right to care for dependent persons.

The impact of the pandemic has profoundly altered family caring strategies. The closure of many day centres, meals centres for the elderly or the suppression or reduction of home services and, subsequently, the fear of contagion, have led dependent persons to withdraw into their homes. This has meant an increase in the care burden for the people acting as carers in the family environment, where they exist, and clear worsening of the living conditions of dependent people, especially if they live alone, or in the increasingly frequent cases of elderly couples who care for each other.

Account must be taken of the fact that in family homes caring for people who need support for the activities of daily living is largely undertaken by women, according to the INE (2016) in 60 percent of all cases, with this situation being increasingly common after the age of 45. Nevertheless, in the profile of carers a number of changes can be observed, with men becoming more and more involved in caring. This is the result of a range of circumstances, such as cultural and educational changes but, above all, it is because men are living to older ages, so it is becoming increasingly common for elderly couples to live together as opposed to homes being occupied by a single person (generally widows), the latter being the most common type of household for this age group until a few years ago.

It is noteworthy that there is very low intensity in terms of social services providing care, far below other options like “other family members or friends” or “employees”. Multiple care strategies have become more common, as well as the outsourcing of care and complementary services, including both formal care, whether exclusive or combined, and informal care provided from outside the home, largely by means of “domestic employees”. The contribution of the latter to informal care for dependent persons in their homes, in spite of their importance for many such persons, is a reality that has not yet been reflected in the statistics.

During the pandemic, the preference of many families for keeping their dependent family members inside the family home in a context of uncertainty regarding trends in contagions, has driven forward a temporary increase in the demand for this type of service. It is difficult to determine to what extent the evolution of this sector, aside from the extraordinary circumstances of the pandemic, is linked to the characteristics of the system of care for dependent persons, or to other social and cultural factors.

*It would be desirable to improve sources of information on this complex reality.*

There is a direct link between the quality of life of the elderly and close contact with their family and social networks, which are the dimensions that are most highly valued by the elderly, as well as their desire to remain in their home environment. For this reason, account should be taken of the important impact on health and on personal autonomy of unwanted solitude, the loss of social contact and the emotional impact that the situation as a whole is having on dependent persons who remain in their homes but have stopped receiving services or have not been able to access them.

*The new circumstances require new approaches from the SADP in order to adapt its response to the new care requirements of dependent persons in their own environment, both in the scenario of the pandemic and after it.*

*It should be stated once again that there is a need to implement effective coordination between the health system and that for care for dependent people, because a holistic response is required to meet the social and public health needs brought on by the loss of autonomy.*

*The experience of the pandemic has highlighted even further the importance of initiatives to make cities and municipalities friendly places for the different age groups, especially in regard to the elderly and/or people with functional limitations in terms of accessibility and local amenities.*

Up to now, the main measure adopted by the SADP in support of family members who care for dependent persons has been their inclusion in the Spanish Social Security system (Régimen General de la Seguridad Social) in a situation assimilated to that of active status, by means of the possibility of signing up to a special agreement. Following the initial four years of functioning of this facility, Royal Decree-Act 20/2012, amongst other important measures that affected the development of the SADP, established that it would be the non-professional carers of dependants who would pay their own contributions. As a result of this measure, the majority of carers stopped making contributions. With approval of Royal Decree-Act 6/2019 on urgent measures to guarantee equal treatment and opportunities for women and men in employment and occupation, the special agreement was re-established but this time the central government (Administración General del Estado) was designated to pay Social Security contributions.

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*The special agreement  
for non-professional  
female carers*

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Since its re-instatement, the average monthly affiliation rate for non-professional carers has been well below the maximum level reached in December 2011, when more than 170,000 persons were registered in the system, with about 60,000 active, non-professional carers signed up at the end of the month. In the first six months of 2020, the evolution of the agreement was stable, at levels similar to those that preceded the health crisis, with a very slight upward trend.

*It is necessary to continue observing trends in this facility and to study their causes and its suitability for the needs of carers and dependants.*

In any event, the responsibility for the provision of care in many instances reduces the quality of life and physical and emotional health, as well as the routine and career pathway of carers, especially in the case of women, who already face greater difficulties in accessing the labour market. In addition, ageing increasingly affects carers themselves, and it has become increasingly common for elderly couples living together to care for one another. There is a patent risk of situations of precariousness in care provision due to a lack or loss of the skills needed and the onset of care requirements for the carers themselves.

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*The need for more support for carers within the family environment*

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*The measures for advice, support and respite for carers within families remain insufficient, and this is a weakness in the system that should be addressed as soon as possible.*

*Likewise, with regard to policies, it is important to continue promoting measures to achieve work-life balance, so as not to disincentivize the participation in the labour market of persons who provide informal care.*

This does not detract from the fact that the main aim remains that of reinforcing the system itself, given that it is impossible to sustain it mainly on the basis of informal care provided by family members. Carers from outside the family network will become increasingly necessary and their professionalisation is imperative in order to achieve quality for the SADP.

In the coming period, it will be vital to pay attention to any changes in the system for informal care provision for dependent persons, in the context of increased unemployment due to the COVID-19 epidemic together with a reduction in families' incomes, uncertainty about the evolution of the pandemic per se, and the reputational crisis of the care home model and of centres for the elderly.

*In order to avoid a possible resurgence of informal care within families, which women would be highly likely to perform, the image and the offering of the SADP will require a huge effort in rehabilitation.*

#### **DEVELOPMENT OF REGULATIONS FOR THE CARE FOR DEPENDENT PERSONS IN SPAIN**

Like most European countries since the start of the century, Spain has become increasingly involved in addressing the issue of care provision for dependent persons through its system of social protection. A range of initiatives led the debate on how to guarantee care for dependent persons in Spain, and this eventually led to approval of the 39/2006

Act, on 14 December 2006, on the Promotion of personal autonomy and care for dependent persons (known by its Spanish acronym, LAPAD). Up to the entry into force of the LAPAD, the Spanish system of social protection had lacked a holistic and universal model for care provision for dependent persons, although a range of public bodies (state-level, regional and local) did offer partial responses to this situation, although they had not been designed for this specific purpose. These fragmented public support mechanisms, some of which continue to this day, were not enough to meet the demand for care services for dependent persons, and their scope was unequal and insufficient.

The approval of the LAPAD therefore represented a milestone in the evolution of the Spanish system for social protection. The configuration of a new universal subjective right to care services for dependants, with the collaboration and participation of all of the Public Administrations and the guarantee from the central government (Administración General del Estado) of minimum common rights for all citizens throughout Spain, and the creation of an institutionalized system to realize this, the SADP, added up to a significant qualitative leap forward in care for the disabled and the elderly. An especially outstanding feature of the creation of the SADP was the intense participation of the social partners via the social dialogue.

Unlike other European systems, the SADP lacks a direct link to the Social Security system or to the health system, because its design was included in the pre-existing structures for social services, which fall within the competency of the Spanish regions, the Autonomous Communities. In fact, the LAPAD is the sole basic law in force in regional social services systems which all have their own legal framework.

The SADP came into being with the stated aim of guaranteeing to citizens, and to the Autonomous Communities themselves, a stable framework for resources and services for the provision of care services for dependent persons.

However, this aim has not been fully achieved because of a number of circumstances, especially budgetary restrictions and the scope of a number of measures adopted during the years of economic crisis, by means of

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*A launch marred  
by the crisis and its  
budgetary consequences*

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a series of royal decrees-acts which served to update the LAPAD. These include Royal Decree-Act 20/2012, dated 13 July 2012, which fundamentally affected the timeline for application of the LAPAD and the contents and principles of the subjective right to care for dependants, thus generally weakening the intensity of its protective action.

The LAPAD required significant regulatory development by the Spanish government in order to establish the threshold common criteria in essential aspects for territorial equity, such as the dependency scale of assessment. It may be stated that as of now, the LAPAD has been formally rolled out in all the aspects planned. However, generally speaking, the common criteria in the different spheres were set in quite an open manner, meaning that there has been disparity in the case studies used in the regional regulations. In practice, the rollout of the LAPAD was conditioned right at the outset by the competence-related

legal definition chosen by the legislator, which has led to a complex cooperative system for sharing out the relevant competences. This has led to difficulties in the interpretation and combination of the act with the recognised regional exclusivity for social services competences as proclaimed in the statutes of the Autonomous Communities. These have approved an abundance of legal regulations with the purpose of adopting and applying the LAPAD. Among others, these aim to regulate the scales and procedures for the rights of people who are dependent on care to be effectively recognised in their territories, as well and to determine economic benefits or the establishment of the degree of protection and the compatibilities of the services of the SADP. To all of this should be added the services that local government bodies (municipalities) provide in this field delegated to them by the Autonomous Communities for the management of basic social services or the provision of care to dependent persons.

As a result of this complexity, more than fourteen years after approval of the LAPAD, significant territorial differences prevail in its application, orientation or implementation, on the basis of the different regional models for development of care for dependent persons. This disparity of models may be causing problems of inter-territorial equity, resulting in greater difficulties for accessing SADP in some regions than in others, in the application of different criteria for assessing applicants for care, or in the different types of care available in each region. In fact, the considerably uneven development of the different regional systems translates into specific rates of coverage which vary greatly, or significant differences in the levels of quality of the structure for provision of care services in the different Autonomous Communities.

Taken as a whole, the majority of relevant studies note, over these years a range of problems or dysfunctions of the system have become evident. These include the excessively profuse, complicated and unequal nature of regulations, although there has been some progress in the structuring of the legal mechanisms for implementation of the SADP. Studies also highlight the complexity of the system and the slow management system which is hampered by red tape; ambiguity in the different areas of competence; difficulties for applying inter-administrative cooperation; lack of recognition of the role played by local corporations; a lack of measures to prevent dependency and promote autonomy; dysfunctions when the LAPAD and the social services regulations of the regions are married; difficulties in social and public health coordination and/or integration; and the inter-mixing of care services and grants with others in the field of disabilities. Altogether, this has brought about inherent and significant inequality in the application of the LAPAD.

*The different regulations implementing the LAPAD together form a complex framework, making interpretation hard. For this reason, it would be advisable to codify and simplify them.*

*It is vital to undertake an exercise to ensure improved transparency in the dissemination of the criteria for approving care services for applicants in relation to the de-*

*pendency and financial situation of potential beneficiaries, so that all applicants gain greater certainty regarding their prospects and the possible scope of the services they may be entitled to.*

All of this complexity in the governance of the system of care for dependent persons reached its peak during the management of the pandemic, when the usual difficulties for reaching consensus on common management criteria obstructed the urgent decision-making that was needed in such a situation. Matters were complicated even further because in this field it is necessary to act in a coordinated manner and under the leadership of the health authorities, which also faced similar problems for the adoption of joint decisions among the different health services. It proved impossible to make up for the lack of pre-existing structures for public health coordination that have been awaited ever since the system was first introduced.

In this context, during the first few months of 2020, urgent measures were adopted to deal with the impact of the pandemic on elderly people. Key amongst these was the closure of meals rooms for old people, day centres, occupational centres and other similar services, given how badly certain of them had been affected right from the outset of the propagation of the virus. Measures were also approved to reinforce care services, in particular in view of the serious lack of staff caused by contagions, amongst the many measures that were adopted one after the other during the state of emergency.

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*Measures adopted in the context of the COVID-19 pandemic*

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Subsequently, in the months of June and July 2020, against a backdrop of lower propagation of the virus, although just prior to the second wave of the pandemic, a series of urgent measures for prevention, containment and coordination were implemented so as to continue combating and controlling contagions during the health crisis.

At the same time, with the aim of establishing the foundations for reconstruction of the country, a parliamentary commission under this name was created, and at the end of July it approved a series of actions, many of which focused on the changes needed in the health system and in public health. In regard to the latter, a series of objectives and measures were introduced to improve certain services covered by the SADP, for which details on implementation and funding should not be delayed.

*However the efficacy of these special measures is evaluated, once the emergency is over there will be an inevitable need for urgent and in-depth review of the care system for dependent persons in our country.*

*Such a review should be based on the highest possible degree of consensus among all the agents involved, and in these terms it is important to note the very significant constitution, at the end of July 2020, of the Social Dialogue panel to address current and future challenges for the System for Autonomy and Care for Dependent Persons (SADP) and to agree on strate-*

*gies to correct weaknesses of the system, as witnessed down the years and, in particular, as a consequence of the COVID-19 crisis.*

## 2. Situation of the SADP

Now that over fourteen years have gone by since the creation of the SADP and all the levels and degrees of dependency have been reached, it seems appropriate to adapt its regulations, as well as the existing instruments and resources of the system to respond to the needs of those dependent on care, in accordance with the objectives established the 39/2006 Act, passed on 16 December 2006 (LAPAD). Following the enormous disruption to the system caused by the expansion of the coronavirus as of the initial months of 2020, it is now even more essential that this effort be made.

The impact of the pandemic shed light on the limitations to the scope, intensity and quality of the services provided by the system for care for dependent persons. The COVID-19 pandemic represents a turning-point which in future assessment periods will make it necessary for there to be analysis of the situation before and after this tragedy. It is therefore appropriate to recall the situation prior to the first wave of contagions and evolution up to that point.

### **THE SCOPE OF THE SYSTEM FOR CARE FOR DEPENDENT PERSONS**

The system's registry data provide valuable information on its evolution and its current status, but also point to considerable deficiencies in relation to key parameters, as already stated.

Information relating to most of its dimensions indicates a situation that is very unequal throughout Spain, beginning with the basic aspects. With regard to applications, differences are noted between the Autonomous Communities, which, up to a point, seem to respond to the age make-up of the populations in each territory. But such a purely demographic explanation does not tie in with some cases, for example Andalusia, Castilla-La Mancha or Catalonia, where in 2018 the proportion of applications was above average, whilst the average age of their respective inhabitants was not, which seemed to point to a need to consider other causes such as the generation of expectations from the public administrations. In addition, it is possible that other elements such as the expectation of a healthy life, which is closely linked to the wealth of each territory, intervened to some degree in the variability of a parameter that, as already noted, does not depend exclusively on the degree of ageing of a given population.

In addition, the system does not offer information on the flow of applications since it only provides the accumulated volume for them. This is a factor which, linked to the lack of information on registration and de-registration in the SADP, means that analysis of its functioning from a dynamic perspective is very difficult. For this reason it would be desirable for the SADPIS to start including this information in a systematic manner.



We must conflate all the above with the commotion caused by the COVID-19 pandemic to a system that had neither finished rolling out all of the instruments for care nor covered all the demand, whether in terms of population or intensity of protection. Most of the analytical parameters were affected by the health crisis, with falls in applications, beneficiary numbers, service provision and also, in a dramatic way, waiting lists. However, the abrupt appearance of the new scenario and the fact that the health crisis has still not been overcome bring extra uncertainty regarding the possible future of SADP and in any event mean that reference should still be made to the situation prior to March 2020.

At the closure of 2019, in relation to the population dependent on care, the SADPIS showed that 3 percent of the population in Spain had applied for help from the system and had been assessed and recognised as dependent. However, in practice, coverage by the system reached 1.1 million people, that is, 81 percent of all persons assessed as being dependent on care by the SADP.

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*Almost 20 percent of persons on the waiting list for care*

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It is therefore the case that almost 20 percent of persons recognised as dependent on care were not receiving it and were therefore on the waiting list for care (the group of persons who have been evaluated and for whom a ruling on their precise degree of dependency has been issued, but who have nevertheless not obtained a resolution in regard to the exact services they are entitled to). In 2019, after several years in a row of reductions, the size the waiting list rose by 8 percent (that is, almost twenty thousand extra people) when compared to 2018.

This indicator also shows considerable differences throughout Spain, with some Autonomous Communities having above-average levels of coverage.

To this must be added the number of persons awaiting assessment, which up to 2019 was 159,193, of whom some 127,000 might be dependent persons who are not in receipt of any care (and who are not even classed as being dependent), and who also form part of the group who have until now been unable to exercise their right to care. The sum of the two gives an overall total of 397,000 persons waiting either to be assessed or to receive the care which they are due.

However, this data item is not specifically reported by the SADP information system which, in spite of progress over the last few years, still has a lot of room for improvement in terms of the supply of precise data on the functioning of the public care system.

Among the shortcomings of official information on waiting lists is that regarding average processing times, on which no statistics are given by the system. Given that this is a question on which it is vital to have information to evaluate the functioning of the SADP, it would be desirable for the information system to gather and publish data on the time that passes from the date of application until the provision of care to the dependent person. A number of estimates produced by the sector (Asociación Estatal de Directoras y Gerentes de Servicios Sociales – AEDGS, the state association of directors and managers of social

services) set the average wait at 426 days, well above the legally-established maximum period of 180 days, in particular in certain Autonomous Communities, where the figure is double or triple this, according to recent estimates.

Since the start, the assignment of benefits has been predominated by those of a financial nature, despite the fact that the LAPAD stated that these should only be granted exceptionally. In 2019, the most recent year for which full statistics exist, financial benefits continued to grow, although more moderately than in previous years, in their two versions, family-based care and those linked to services. In any event, since 2016 there has been a rise in in-kind benefits, which is visible above all in telecare and domiciliary care, the foremost options in less severe cases.

It can also be seen that certain of the Autonomous Communities show an inclination towards the award of financial benefits for care in the family environment of the dependent person, diverging from the original aim of the LAPAD, which prioritised professional services over the payment of financial benefits.

#### **THE STATUS OF THE DIFFERENT SADP BENEFITS**

The scope and type of the benefits recognised under the SADP depend to a large extent on the way that the system is implemented in each Autonomous Community. This depends on socio-demographic, economic and cultural aspects and the characteristics of the different systems for social services, a field over which the Community holds exclusive competence. The preponderance of one type of benefit or another has changed over the years, as the system has gained in maturity and as beneficiaries with all the possible degrees of dependency have been included. From the most recent figures it is possible to observe significant differences in territorial patterns, especially regarding the weight of the different types of benefit recognised. The main disparities seem to be in financial benefits (both those for family care and those linked to services), and in the proportion of benefits without accommodation.

Unlike other comparable information systems in the field of social protection, like those for health, which provide series of statistics on allocation of resources, staffing, activity and cost, the information system of the SADP does not include data on most of these essential aspects related to its tasks so, as things stand at the moment, any attempt to focus more closely on the different benefits requires the use of other sources.

*As already mentioned, this shortcoming should be corrected as soon as possible.*

The situation of the different benefits is also affected by the still insufficient development of the network of services, based to a large degree on the offering from the private sector under the regime of public-private agreements, and asymmetry in territorial implementation of services, which may influence the different propensity of Autonomous Communities vis-à-vis the award of one type of benefit or another. To this must be added

very low development of the network of services in rural environments and the serious difficulties in them for meeting general requirements regarding centres and services, which take no account of their peculiarities.

*It is essential to give a greater boost to the development of infrastructures and services to guarantee the right to care for dependants, taking account of demographic perspectives. The care sector still has to fulfil its role as a galvanising element for the economy and for jobs, and this is especially necessary in the rural world.*

A further circumstance that affects the quality and the holistic nature (or otherwise) of care provision is the adequate combination of benefits as required in each case. In this regard, limited compatibility between benefits and low intensity of some of them, may be hindering full effectiveness of the right to care for dependency in many cases.

*In the opinion of the ESC, the effects caused by the incompatibilities in force should be considered from the point of view of a holistic and person-centred approach to care. This should impregnate the provision of care in all cases.*

In addition, it should be recalled that the SADP's role was envisaged as completing and coordinating the systems for protection which already existed in the field of social services. However, the latter, whether via Autonomous Communities or local corporations, continue to cover activities that are very similar to those of the SADP and are designed for old people in need of help but not necessarily in a situation of dependency as defined by the LAPAD. The idea was that these would be more interventions of a preventive nature and in the field of benefits to support people remaining in the family environment and in the community (such as the home help services provided under the joint Social Services plan, telecare or town councils' centres for the elderly), without there having been in all cases integration or a rollout of both levels of action.

*It would be advisable to evaluate the set of actions carried out by the SADP, by social services systems and locally, with a view to aligning priorities for action and to reinforcing the efficiency of all the actions together.*

There are not many other spaces of social reality where health and social needs conflate so frequently as in the provision of care to dependent persons. Person-centred care is the type of long-term quality care that is wanted, according to European recommendations, and this will inevitably require reinforcing holistic and ongoing health and social care, regardless of whether the care takes place in the home or in specialist centres.

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*Necessary boost  
for coordination and  
social and health care*

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Even though there is a legal structure and this need is unanimously recognised, attempts over several decades to build a holistic model of social and health care in our country have had little success, in spite of various initiatives in this direction. Experiences at Autonomous Community level to coordinate the health and social sectors are very disparate in terms of implementation, focus, intensity and results.

The obstacles to creating a shared health and social services space link up with the complex governance of the SADP mentioned above. The tragic consequences of the pandemic have only made more visible the lack of attention paid to the complementarity of health and social elements that has marked the development of both dimensions of social protection in our country. The lack of coordination between the sectors is one of the explanations for the magnitude of the crisis, as indicated in early analyses of management of the pandemic.

*It is essential to boost social and health care coordination and to create a common political framework in this field. The reactivation of the social dialogue on care for dependent persons will provide the opportunity to reach a consensus on strategies for health care and social service coordination in the framework of the SADP, as was proposed by the social partners in their document of July 2020.*

#### **RESIDENTIAL CARE**

Institutionalization is the option with the lowest acceptance amongst the potentially dependent population, despite the fact that the LAPAD prioritises the objective of patients remaining in their environment. However, residential care is often an unavoidable solution in view of the personal circumstances and of the environment of dependent persons, especially the eldest, given that it is a type of care which is particularly important due to higher-level intensity of care, the time required, and the resources it commonly requires, as well as the vulnerability in terms of the health of the people who live in such care homes, and this requires very close coordination of public health and social services.

*The dramatic impact of COVID-19 in care homes brought to light significant weaknesses which, far from being remedied, point to a need for reflection on the changes required in order to ensure people's right to holistic, quality care focussed on dependent persons.*

Residential care still bears considerable weight amongst benefits, accounting for 12 percent of total recognised benefits at the end of 2019. If financial benefits are excluded, residential care accounted for 21 percent of the benefits in force as at the end of 2019, behind telecare and home help.

As in rest of the system, the official information available on the network of care home services and their characteristics is limited, especially with regard to indicators on the qualitative aspects of care provision. For Spain as a whole, according to the IMSERSO, in

2018 the offering of care home services consisted of 6,240 centres, with a total of 391,475 places, and a rate of coverage of the population aged over 65 of 4.32 percent, which was highly variable in territorial terms. In terms of the typology, there were 5,457 care homes and 783 homes for the elderly, a formula which would appear to fall under alternative models to traditional institutionalised care homes and for which this is the only information available as of now. A total of 81.8 percent of care home residents were aged over 80, a percentage which fell to 59.7 percent in the case of homes for the elderly.

According to the IMSERSO, there are 5,457 care homes for old people which provide a total of 381,158 places. Although the report does not detail all of the features of care homes and their types, the reality of the sector is very heterogenous when it comes to size, ownership, urban or rural setting, availability or otherwise of their own health care services, their relationship with or closeness to primary healthcare and the local hospital, their users' social and economic and age profile, family support and health and levels of satisfaction.

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*Residential care homes, uneven coverage and a lack of qualitative information*

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In any event, the allocation of places varies greatly across Spain, as does ownership of care homes (public or private). In general, private ownership of places is the most common, accounting for 73 percent. 63 percent of places were financed with public funding, while 40 percent were privately paid, with significant differences between the different Autonomous Communities.

Most of the places available are in homes with less than 100 places, although in recent year there has been a rise in the number of large homes, which already account for over twenty percent of the total number of care homes. However, in this respect, significant territorial differences are observed.

The minimum requirements for the accreditation, authorization and functioning of residential homes (staff ratio, required professions, timing intensities, etc.) are regulated in the legislation approved by the Autonomous Communities, as are the conditions for public-private agreements. This generates a very different panorama of agreed prices, generally lower than those of the market, that may place pressure on certain aspects related to the quality of services and their suitability for people's needs, such as the characteristics of jobs in the sector.

*In line with the contents of the section on sectoral dynamics, it would be desirable for the SADP itself and its participating bodies to assess the possibilities for aligning criteria on aspects of the functioning of the system of public contracting that could lead to an improvement in the quality of the benefits and increased inter-territorial equity.*

Another peculiarity of the residential sector is the VAT charged for this type of service, which is different depending on whether the place has a public subsidy or not.

Generally speaking, it is still striking that this type of service carries such weight in the system, considering the strong preferences of elderly persons to remain in their homes and receive care there for as long as possible. Recently, the IMSERSO has started offering quantitative information on the number of “homes for the elderly” which would seemingly correspond to formulas that differ from the traditional model for institutional care, being more people-centred and seeking to achieve a higher degree of integration of the elderly in a community environment more akin to their usual living space. These are presently very concentrated in certain Autonomous Communities. In any event, the low level of coverage alongside the cost to users means that this is, for now, very much a minority solution.

*The ESC feels there is a lack of information on the range of new, emerging residential realities, such as sheltered apartments and new types of community living. Although in many instances models cannot be exported to all types of habitat or territory, the SADP should monitor this type of experience that differs from the classic residential care home model, weighing up their advantages and disadvantages and, where appropriate, assessing how they might fit into the system.*

*Likewise, in line with our comments above, to guarantee the right to care for dependent persons, it would be desirable for there to be permanent, standard, independent mechanisms to evaluate the quality of care provided in residential care homes.*

The COVID-19 pandemic has had tragic effects on care homes, especially during the initial months following its outbreak in Spain: between March and July the IMSERSO estimates that 18,911 people died, that is to say, 7.6 percent of dependent persons cared for in residential homes providing a service recognised by the SADP. The seriousness of the fatality rate at care homes for the elderly was not homogeneous, in line with the enormous heterogeneity of the sector itself, as the first reports on this issue indicate. Levels of contagion varied not only between regions, but also inside individual Autonomous Communities, with some care homes being very seriously affected, while in others no fatalities were recorded.

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*The impact of COVID  
in residential care  
homes*

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In any event, the lack of information on COVID-19 morbidity amongst residents and staff throughout Spain currently means that it is difficult to draw robust conclusions on the prevalence of the disease in the different types of establishment, the routes of contagion and the relationship of these with other factors such as the regional rate in itself, the profile of the people receiving care, aspects related to management, or the efficiency and speed of the measures adopted by the administrations responsible in each instance.

*All of this contrasts with the stigmatization or even criminalization to which the residential care system as a whole has been subject and with the need for it to exist, irrespective of the necessary evaluation of its weaknesses and strengths with a view adopting changes and improvements in the future.*

The seriousness of events as a whole will require in-depth evaluation, although it is true that initial diagnoses coincide in pointing to the confluence of a range of factors, such as the initial lack of knowledge regarding the virus and its capacity for infection, the ease of contagion in collective establishments, the high vulnerability of residents in care homes as well as, in particular, the lack of coordination at all levels (inter and intra administrations, and between sectors), especially in terms of social and health care coordination, which contributed to the delay in the adoption of measures and the degree of exposure of users, who in many cases were unable to receive adequate health treatment or even die with dignity.

The backdrop to this accumulation of circumstances includes the role that ageism may have played in today's society, which meant that the pandemic was not initially perceived as so important, given that it "only" seriously affected the elderly. This ties in with the low and late priority given to care for dependent persons throughout the management of the crisis.

In spite of the fact that all dimensions of the system were also affected by the pandemic, although to a lesser degree, the impact of the coronavirus on care homes focused the attention and placed them in the spotlight for initial analyses of the pandemic, such as the recent Report by the Ombudsman (Defensor del Pueblo). This report makes a series of recommendations on aspects strictly linked to management of the pandemic while also emphasising other more structural weaknesses in this area, such as the insufficient number of places on offer, insufficient staffing or the need to reassess the viability of a model for care homes which offers full social and health coverage, with sufficient medical and nursing treatment available.

*With a view to the future, it will be important to establish the position to be occupied by residential care and the changes needed based on a broader reflection on the system as a whole and its care provision. In this context, a key role should be played by the current Social Dialogue panel on care for dependent persons, because only on the basis of a consensus among all the agents concerned will it be possible to undertake reforms that will effectively guarantee the rights of dependent persons.*

#### **SERVICES WITHOUT ACCOMMODATION: SUPPORT FOR REMAINING IN THE HOME ENVIRONMENT**

Services that do not provide accommodation (home help, telecare, day/night centres and prevention) contribute to persons remaining in their usual living environment. In general, they have the potential to offer holistic, person-centred care, although it remains true

that in some instances the current scheme of incompatibilities hampers complementarity between the different types of care. This circumstance is made worse by the very low number of hours that are normally dedicated to home help.

One common trait of these services is that they are often offered by local councils and corporations, both within the framework of the SADP through partnership agreements between the competent council department and local entities and other public law entities, and in the implementation of the competences for management of basic social services within the territory (financed at least partially by payments under the agreed Social Services Plan).

*As mentioned at the start, it would be desirable to give greater visibility to all actions carried out by the different administrations for prevention, for developing personal autonomy and for assisting people to remain in their homes, with the aim of boosting achievement of these objectives.*

The impact of COVID-19 on persons receiving support in their homes led to 9,715 excess deaths in the period March-July, that is, 1.1 percent of the total of 872,358 receiving such care in March.

#### **THE DOMICILIARY CARE SERVICE**

The LAPAD established that the domiciliary care service (DCS) should be integrated within the network of social services as a specific service for those dependent on care. However, it appears that there remain administrative/procedural difficulties and conceptual problems for fitting this SADP service into the social service structures of the Autonomous Communities. This will potentially lead to problems of coverage and efficiency in both economic and organisational terms.

Over the last decade the DCS has developed positively in terms of its relative weight among SADP provisions. After a small decrease observed at the end of 2013, its quantitative importance in total recognised provisions has risen constantly, with a higher rate of growth as from 2015, the year in which the right to benefits was made effective for many people assessed as degree I dependants.

As of 1 December 2019, the weight of the DCS amongst the set of SADP services stood at 17.7 percent, just slightly down on that for 2018 (17.9 percent). These aggregated data on the relative weight of the DCS are the result of very mixed implementation among the Autonomous Communities, which show very widely varying trends and percentages.

Domiciliary care provided specifically by the system for care for dependent persons is configured in accordance with a series of elements that determine its quality and sufficiency as well as its viability and scope, such as the actual contents of the service, its timing, the regime of incompatibilities, participation of the beneficiary in funding (co-payment) or the professionalisation of the people who deliver help to the home.



The information offered by the SADPIS in this respect is very scant, although recently a number of interesting statistics started to appear, for instance on service intensity, which serve to confirm that on average it is insufficient. Thus, according to IMSERSO statistics, the monthly average throughout Spain is 19.6 hours, which include both personal care tasks, and domestic tasks. The average hours strictly spent on personal care are given as 12.7. Once again, inter-territorial differences are very striking.

*The necessary improvement in domiciliary care services depends on the setting of sufficient time to allow for dignified, quality care; the need for greater professionalisation and accreditation of staff qualifications; the promotion of public health coordination and collaboration with primary care teams, in addition, as already mentioned, to more attractive employment in the sector, which is already facing hiring problems, especially in rural areas.*

These latter difficulties worsened in a particularly serious manner during the most acute phase of the pandemic, when in many cases the service was cancelled. This gave rise to urgent measures to support municipalities, to make requirements for professionals more flexible and to promote hiring, amongst other measures.

*The consequences of interrupting the service, which in many cases was not provided at all, for the health and wellbeing of dependent persons must be taken into account. It is now necessary not only to restore normal services as they existed prior to the pandemic, but also to work on improving their intensity, quality and professionalisation.*

#### **TELECARE**

The aim of the telecare service is to care for beneficiaries by means of information and communication technologies (ICTs), providing an immediate response in emergencies, or for reasons of safety, loneliness and isolation, with a view to enabling users to remain in their own homes. The telecare service provides security and tranquillity for users and their families and is therefore eminently preventive in nature and complementary to domiciliary care. Local organizations (councils) have been providing this service as a fairly normal part of their work. It is a service which has great potential for detecting social problems in the early stages, preventing them from becoming serious.

*As with domiciliary care and certain other services, telecare has been traditionally provided by different administrative levels (councils and Autonomous Communities), sometimes within the SADP and sometimes as part of basic social services. This can generate differences in types of services as well as a certain degree of discoordination in the coverage of people's needs.*

In the wake of the crisis years and after 2015, the volume of telecare grew to become the third most widely-recognised benefit after financial grants for care in the family environment and domiciliary care. As of 31 December 2019, 246,617 SADP telecare services were recorded. During the first quarter of 2020, the number of telecare benefits continued to rise, but in April and May, in the midst of the first wave of the pandemic and after declaration of the state of emergency, they fell significantly, precisely during the lockdown period when many dependent persons were in their homes and were unable to attend their day centres or even, in many cases, receive domiciliary care or help or from their own family members.

From June onwards, after the end of the state of emergency, these services rose again but levelled off in September, in the middle of the second wave. This was paradoxical considering that the pandemic had stepped up the use of new technologies to facilitate the remote provision of services in all fields.

In addition, in spite of the development of telecare contents in legal terms and of a number of advances, projects or promising experiences in the practices of certain of the Autonomous Communities, advanced telecare is still not a tangible reality in the SADP as a whole.

*It is necessary to truly extend this service and optimise the solutions provided by new technologies, artificial intelligence and digitalisation to facilitate care services and the daily routine of dependent persons, not only as an emergency instrument but also to help maintain personal autonomy in daily life.*

*At the same time, it is important to clarify its compatibility with other benefits, because it is difficult to meet all the needs of dependent persons who remain in their normal environment with a single type of care service.*

The possibilities of digitalisation and the introduction of the new technologies in people's homes, along with the need to reinforce social and health care services, mean that it is necessary to develop a greater variety of services, including, for instance, telemedicine or home automation, for the improvement of people's autonomy and wellbeing, and thus make it easier for dependent persons to remain in their own homes. In this regard, it is important to stress that the opportunities in this direction provided by the European Union's recovery plan are also applicable to the improvement of the SADP by furthering digitalisation in this field.

*During the COVID-19 pandemic it became clear that there was potential for technological expansion in the field of the SADP and, for this reason, there has been emphasis on the need to continue optimizing and increasing its applications, beyond the scenario of the pandemic. Attention should be paid to the opportunities afforded by the new European funds for recovery in this field.*

**DAY AND NIGHT CENTRE SERVICES**

With the aim of assisting users to remain in their normal environments, this type of centre provides holistic care services during daytime or night-time to persons dependent on care, so as to improve or maintain the optimum level of personal autonomy and to provide support for their families or carers. From a *biopsychosocial* approach, they cover the needs for advice, prevention, rehabilitation, guidance for the promotion of autonomy, assistance or health and personal care. It is estimated that the average age of persons who use this service is over 80.

From 2008 to 2019, the number of benefits provided via day or night centres increased. However, in 2020, the number of these benefits fell to a total of 90,102 on 31 October. This downward trend was most pronounced at the outset of the COVID-19 pandemic, due to lockdown and to the measures adopted by the different public administrations in this field.

After prevention services, this is the service with the lowest number of beneficiaries, accounting for just 6.36 percent of the total benefits recognised, with marked large territorial differences.

It is striking to note the large weight of this benefit among total benefits recognised in the Canary Islands (where, however, home help services have not been developed) as of 31 October 2020 and the low weight in the Autonomous Community of Navarre.

*It is necessary to improve information on the SADP network of day/night centres, the extent to which it meets the demands of users and the reasons as to why its rollout has been so unequal among the different territories.*

The impact of the pandemic was very significant for day centres, which were the first collective establishments to close in the middle of March, and which have still not restored either their normal activity, in most cases, or the rate of new awards of this type of benefit. Whereas in December 2019 around 96,748 persons were users of benefits of this type, the figure had fallen to 90,102 by 31 October 2020. We should not overlook the negative consequences for dependent persons of the loss of this service, which is crucial for maintaining their social life and for preventing dependency for many old people, as well as for the peace of mind of their families.

**PREVENTION OF DEPENDENCY STATUS**

This service has the aim of preventing the appearance or worsening of diseases or incapacities and their impacts, by means of coordination between the social services and the health service in actions to promote healthy living conditions and in specific prevention and rehabilitation programmes for elderly and disabled people and those affected by complex processes of hospitalization.

From 2008 until 2019, the number of benefits for the prevention of dependency status increased. However, after declaration of the state of emergency in mid-March 2020 as a

consequence of the COVID-19 pandemic, the number such benefits gradually fell, reaching 61,298 on 31 October 2020, just 4.33 percent of the total benefits recognised in the whole of Spain. This is the service without accommodation that has the lowest weight in the state-level total. In addition, it is the second recognised benefit with the lowest weight in Spain (the first is financial aid for personal assistance).

There is great territorial disparity. The Autonomous Community of Cantabria has the highest percentage for this benefit out of total benefits recognised; and Catalonia is at the other extreme.

All this indicates that the current configuration of the SADP mostly tends to address situations of dependency that have already been declared, as opposed to the prevention of such dependency.

*In line with these comments, this benefit should receive greater emphasis over coming years as the entry into the system of people with a lower degree of dependency becomes consolidated.*

*Altogether, it is necessary to attach greater relevance to the preventive aspects within the SADP, meaning not only this benefit in itself, but also the set of services and benefits geared towards assisting dependent persons to remain in their normal environments and avoiding or delaying their institutionalization: domiciliary care, telecare, day centres and preventive benefits.*

*It is important to stress the need for effective coordination and interaction with the health care system, especially with primary care teams, as well as person-centred, holistic care services.*

*It is also important to reinforce complementarity with other services provided in the field of the social services provided by Autonomous Communities and by local corporations, such as centres for the elderly, which also contribute to the maintenance of autonomy and the prevention of dependency.*

#### **FINANCIAL BENEFITS**

From its creation, the system for autonomy and care for dependent persons opted for care provision for the target population by means of services, with the aim of guaranteeing quality standards for care, with professionalized resources throughout Spain. Only when it proved impossible to provide care via one of these services, were financial benefits to be used. The reality shows that from the outset these priorities were inverted.

There are three types of financial benefit: for care in the family environment, service-linked, and linked to the recruitment of a personal carer.

In spite of their exceptionality, until recently these benefits were the most widely-used. Only over the last few has it been possible to confirm a change of trend that points to a bigger weighting of services in the panorama of care for dependent persons, although not to the clear prevalence of awards of services.

However, from the point of view of the state contribution to the coverage of the requirements of the dependent population, the current situation is still marked by financial grants. But the lack of specific information on where these go makes it hard to find out the type of services received by beneficiaries.

From the point of view of the care received, it seems clear that financial contributions always result in the provision of care, either through contracted services, or by persons from the family environment. The latter case relegates professionalized support.

The crisis generated by the pandemic seems to have led to a surge in financial benefits for care in the family environment. The risk of “substitution” of residential benefits (professionalized services, with a high unit cost) for family care (financial benefits, at a much lower cost for the administrations), in a context in which the preference for “care in the home” as opposed to “institutionalisation” appears to be on the rise, indicating that a watch should be kept on the evolution of these two options. It should not be forgotten that the goal of quality care requires elements including professionalisation of carers, and in any event, it needs services to be prioritised as opposed to financial benefits.

In relation to the financial benefit linked to a service, in practice and in line with the estimates of the sector, given that unfortunately no official data has been published, the amounts paid out are very insufficient, meaning that users have no option but to assume a very significant part of the total cost of the services contracted. In fact, considering that these benefits are subject to co-payment according to income and capital, the fact that beneficiaries must pay for a substantial part of the service attributed in the ICP (individualized care plan) means that in practice this constitutes a second co-payment.

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*Limited data on benefits  
linked to the service*

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Although the system does not provide quantitative information about the services which are paid for by the benefits or on average amounts, there are a number of estimates pointing to a prevalence of residential care. This means that the production and publication of statistics from the system is still needed to progress to full evaluation of the functioning of the SADP as a whole.

In addition, the promotion of pacts with the sector on maximum prices, ensuring access for all citizens and limiting the effect caused to equal access by significant price differences among the Autonomous Communities, would bring about a definite improvement from the point of view of fair and equal access.

Given the existence of a current total of over 150,000 benefits, financial benefits linked to the service amount to 11 percent of all benefits granted by the system and have increased constantly since the start of the SADP.

Conceived as an instrument for care which would be brought to bear only exceptionally, the financial benefit for care in the family environment has been, from the start of the SADP, one of the principal elements used to satisfy the demand for care for the dependent

population. One of the most interesting elements in the regulation of this benefit was the recognition of the family carer, a figure with a great tradition in Spain.

These have accounted for as much as half of all the benefits and services awarded. However, over the last few years their weight has dropped to 30 percent of the total.

To date, the IMSERSO has failed to publish information on the intensity of the benefits in terms of the amounts of money paid out or in terms of hours for services provided. However, it is possible to cite some statistics (from the information disseminated on the design of a new SADP information system) according to which the average value of benefits is 247 euros per month.

When account is taken of the fact that the financial benefit awarded for care in the family environment is intended to be compensation for the reduction in labour market activity of the carer, it must be concluded that these amounts are far from achieving their aim. In any event, the compilation and publication of official information on the amounts of these benefits are essential for assessing the capacity of the system to ensure care for beneficiaries.

In spite of the expectations generated, this benefit has not in fact been rolled out in the framework of the SADP Territorial Council. This means that the financial benefit for personal aid has only become a minor-

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*Personal aid, a minority resource, with no rollout*

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ity resource that it is practically non-existent in most of the Autonomous Communities and bears very little weight in those where the contents of the benefit were rolled out.

The information gathered by the SADP highlights the very low adoption of this benefit, which accounts for just 0.5 percent of the total, with a total of 7,837 actual services. In addition, only ten of the Autonomous Communities actually offer the possibility of receiving personal aid, and even then, in most of them the weight of this type of service among total benefits awarded is practically non-existent.

It is probably the case that most of the care that could be provided by this type of benefit is being channelled through “domestic service” contracts in the private sector, on the edges of the professionalised care which the law had set out to achieve.

*Therefore, it would appear to be especially necessary to approve as soon as possible specific legislation to embed the figure of the personal helper. This should set out the ordinary status of his/her labour relationship, and regulate the professional profiles as well as the training required for this type of care provision. By so doing quality care would be prioritised.*

#### **A PANORAMIC VIEW OF THE CARE SECTOR FOR DEPENDENT PERSONS IN SPAIN**

Amongst the returns produced by implementation of the system for care for dependency since the approval of the LAPAD is its noteworthy contribution to economic growth and business dynamism. Both now, and in terms of its potential in the future, the system impacts directly on the creation of jobs.

The benefits accruing from the public and universal right to promotion and care for dependent persons are provided by means of a mixed system for management, provision and collaboration in which different types of entities take part. There is a part of the network of services for care for dependent persons that is public by nature and in terms of provision, whilst another important part of the benefits recognised by the SADP, within both the residential and the non-residential sector, are delivered to users on the basis of agreements established with the private sector by different types of companies and entities from the social economy and from the third sector for social action.

The group of social services activities, including those most closely related with care for dependent persons, intensified the growth in its contribution to the economy during the period 1995-2017, especially from 2007 onwards, coinciding with the start-up of the system for care for dependent persons. However, its evolution points to clear stagnation during the crisis years, with renewed growth more recently. Thus, the gross added value (GAV) of these activities in 2017 (15.18 billion euros) tripled that of the year 2000, having increased its percentage share in the total GAV of the economy from 0.8 percent to 1.4 percent.

The volume of companies in the sector for care for dependent persons went from 6,204 to 7,889 in the years between 2008 and 2018 (INE, DIRCE). The majority of these are different types of company from the care home (residential) subsector. However, significant growth occurred in companies from the non-residential sector, which doubled in number between 2008 and 2018.

Considering the volume of wage-earning employees, companies providing care for dependent persons are characterised by their employment intensity. Companies with more than 50 workers hold the greatest weight among all such companies or in other comparable sectors, like health care. In residential activities, the most common size for a company is from 10 to 49 workers, although throughout the period of comparison a trend was noted towards the increased presence of large companies with more than 200 workers. In the activities without provision of accommodation, the most common size for companies is lower (ranging from 1 to 9 workers).

It is also important to note the higher survival rate for companies providing care services for dependent persons with respect to the figures for the economy as a whole, especially for residential services.

From this trend, it may be assumed that the creation of the SADP, which took place in parallel with ageing of the population and the growing need for care, contributed to galvanization of the sector and to increased demand for this type of service among the population. In addition, it is important to stress that this is a job-intensive sector, which seems to have gone through a significant internal reconfiguration, and now displays incipient growth in the footprint of large companies in certain of its sub-sectors.

In terms of the legal status of such companies, it should be noted that in the four social services activities there is a higher weighting for “other” legal conditions apart from that

of public limited company (in Spanish, SA, sociedad anónima), limited liability companies (in Spanish, sociedad limitada) and 'natural persons', but these figures are not broken down by the DIRCE (INE).

*As in other spheres of care for dependent persons, it is necessary to improve statistical sources in order to ensure greater knowledge of the dynamics of the sector and the different types of companies that operate in it.*

The system for care for dependent persons is one of the structures for social protection in which public-private partnership is most prevalent and a large part of the activity of the companies in the sector is carried out in accordance with a system of agreements for the provision of services.

*It would be useful to evaluate the aspects of the functioning of the system for public procurement that could help achieve an improvement in the quality of service delivery and improved inter-territorial equality.*

#### **JOBS IN THE SECTOR**

The implementation of the SADP was accompanied by a number of significant expectations in regard to its potential as a source of jobs, but these proved to be far-removed from what it has actually achieved in this sense. For instance, the 2004 White Paper on dependency (IMSERSO) estimated a forecast for net generation of a total of more than 330,000 new jobs (some 262,000 full-time equivalent jobs) directly linked to provision of care for dependent persons, against the 2010 horizon. With inclusion of the indirect effects and the growth of shadow economy jobs, the potential effect on jobs was expected to reach figures in that year of over 450,000 full-time equivalent jobs. These forecasts were produced during a period of expansion in which it was not possible to predict the economic crisis that was just around the corner and which commenced just as the system itself was rolled out, largely stymying its progress.

In 2018, just under four hundred thousand people were working in the provision of social services linked to the care of dependent persons, according to the EPA. This information indicates that the boost given by the creation of the SADP to the activities involved in care for dependent people led to the net creation of just over eighty thousand jobs from 2009 to 2018. Almost three quarters of the workers were employed in the care home subsector, whilst around one quarter of them worked in the subsector for social services not including accommodation. Although both subsectors do share a number of traits, they also display different behaviour in most of the variables related to trends in employment and job characteristics.

Although activities linked to care for dependent persons resisted the crisis somewhat better than other sectors of the economy, in the initial phase of analysis (2009-2013), care



homes appear to have lost more jobs. Nevertheless, they seemingly did not only recover their initial position, but visibly improved (27 percent) in 2018. On the other hand, the creation of jobs in the non-residential care sector, which took off between 2009 and 2013, has not recovered since then.

The high level of salaried employees in this type of activity is worthy of note, as is the important weight of salaried employees in the private sector, which has increased since 2009 to reach over 80 percent in the care home sector and 90 percent in non-residential care. It is here that new jobs were concentrated in the period under consideration, because in the public sector jobs were lost, especially in services not offering accommodation, where they decreased by almost half.

The working conditions are also different in some respects. Almost one third of the staff in care homes and a quarter of the people working in services not offering accommodation had temporary contracts. In addition, the weighting of part-time work in the sector is especially noteworthy: the rate for part-time work is higher than average, both in care homes and in services without accommodation, but it is much higher in the latter, where it occurs in over one third of all cases. Both of these subsectors stand out in the degree to which this type of work contract is involuntary, because the people employed would prefer to be in a full-time post and are seeking other employment, due to insufficient working hours or the low rate of pay per hour, more frequently than the whole set of working people, or than the health care sector. When we turn to other working conditions apart from the usual ones, there is a high occurrence of night work or work on Sundays in the care home sector.

There is a staggering preponderance of women working in the sector for care for dependent persons. In 2018, women accounted for almost 90 percent of workers, both in care homes and in services without accommodation. This is practically double their weighting in the total for people employed as a whole and is also above the figure for the health care sector, despite this being one of the sectors with most female workers.

The presence of people with foreign origins amongst the total workforce employed in the sector is large, particularly in services without accommodation, where they accounted for 20 percent of the total.

Taken as a whole, this is a working population which has already reached maturity, with their average age being around 45, which is in line with the health care sector and similar to that for total people in employment (43).

With regard to levels of education and training, the profile of the people employed appears to have altered over time, tending towards greater balance as of 2009, with greater weighting for people with mid-level qualifications and a reduction in the proportion of persons who at the most have only completed the period of mandatory education. The latter group is slightly more prevalent in services without accommodation, representing almost 30 percent. In terms of the sectors for education and training, amongst those whose training was of a level other than basic, weighting for training related to health care

stood at around 40 percent of people employed in care homes and 20 percent of workers in services without accommodation.

The participation of people working in training activities stands at below 5 percent in the case of official studies, and at about 10 percent in unofficial studies. In the case of the latter, in most instances the training was related to the job, with the company participating in it in about half of all cases.

Improving the qualifications and accreditation of the professionals providing services in this field is of capital importance in the development of the SADP, in view of the fact the professionalisation of jobs in the sector is a necessary condition for its quality. According to the IMSERSO, some 132,320 workers had obtained the relevant professional certificate by means of the calls offering recognition of their on-the-job experience.

It is important to boost the monitoring and evaluation of the process of accreditation of centres and services, as posited in the agreement of the Territorial Council dated 17 October.

Likewise, there is a need to make progress in the definition of the most suitable professional profiles for the different types of care provision, some of which, as is the case of personal assistants, have still not been developed.

The quality of the services provided by the system is inseparable from the quality of the jobs in it. However, the high level of temporary work, high turnover in jobs and the short duration of contracts, the high level of involuntary part-time work and the noteworthy percentage of those working in the sector who are looking for another job for salary reasons, are all factors indicating that there is a long way to go to provide the required stability to the workforce and ensure their working conditions are decent. The significant differences with the health care sector, towards which many professionals from the social services gravitate in search of better working conditions, do not seem to be reasonable, especially in cases of professionals with equivalent profiles and reporting at the same level within the administration.

*Precisely in a context in which it is urgent to ensure more robust social and health care coordination and the construction of common spaces for action between the two systems, it is necessary to deal with these issues in the framework of social dialogue with the social partners.*

*The improvement of qualifications and making these professions more attractive by undertaking actions vis-à-vis working conditions should be a priority objective so as to avoid the difficulties in recruiting staff to the sector which were particularly acute during the pandemic, and to guard against a reduction in the quality of the services provided.*

*The extremely high level of women employed in these activities, over 85 percent, means that it is necessary to reflect on the effects of the rollout of the system of care for dependent persons from a gender perspective, in connection with the characteristics of the jobs which are created in the sector.*

*In these terms, the more unfavourable working situation of people working in the sector for services without accommodation, particularly the situation of people working in home help, should be given special consideration.*

#### **FUNDING AND COST**

Unlike the other functions of social protection in Spain, it is not possible to find out the real spending on care for dependent persons at the current time. In the first instance, the Autonomous Communities, which have exclusive competence in this area, do not provide the essential information for separating from the “social affairs” function the expenditure and revenues that are strictly linked to dependency in enforcement of the LAPAD. This means there are no official statistics on spending on services and benefits, or on the relative contribution to the funding of these made by their users and the different public administrations.

It is necessary to make up for this shortcoming by creating a common system for the accounting information of the SADP, based on a specific accounting system and standard criteria for allocation and classification of spending and revenues. This would increase transparency and facilitate financial reporting by the administrations responsible for cost allocation, allowing for rigorous evaluation of the functioning of the system and its various elements and of the requirements for funding of the various Autonomous Communities.

Even so, in spite of the caution required due to the lack of official information, the estimates for public spending on dependency show very modest figures when compared with the need for care of dependent persons, which are mostly still being met by recourse to the work of informal female carers in return for low pay or no pay at all.

*For this reason there is a need for all the public administrations to increase their efforts to substantially increase the funding of the system.*

While the increase to state funding of the system included in the draft budget for 2021 (Proyecto de Presupuestos Generales del Estado para 2021) is significant in relative terms and overturns part of the cuts suffered in 2012, it remains totally insufficient for providing an effective response to the problems and shortcomings of the system, so it would be desirable for further increases to be agreed on by parliament.

Likewise, if there is to be a reform of the System for Funding of the Autonomous Communities with a common regime, an agreement should be reached on an increase of additional funds for care for dependent persons that the state could incorporate, as non-conditioned funding, to the fund for guaranteeing essential public services (Fondo de Garantía de Servicios Públicos Fundamentales).

In any event, an improvement should be made to the criteria for territorial distribution of state funds, both targeted and non-targeted, so that the share-out system, which should be agreed in the framework of the bodies for management and participation of the SADP,

generates incentives for the improvement of the system on the part of the Autonomous Communities. In specific terms, in addition to the number of persons who receive care in each Autonomous Community, the cost of the benefits and services effectively recognised and delivered in each of them should be considered. This would generate incentives for the development and strengthening of the regional public services, which are more expensive but much more effective than the payment of financial benefits. Likewise, there should be recognition in financial terms of the efforts made to reduce waiting lists, to comply with quality standards for services (workforce ratios, professionalisation of care, compliance with the collective bargaining agreements, etc.), to improve agreed prices linked to achievement of the quality standards for jobs as mentioned above, and in the balanced provision of the network of public services in accordance with the real costs of the services and the investments in innovation required for the maintenance and development of said quality standards.

But in addition to increasing the state injection of resources, it is also necessary for the territorial administrations, especially the Autonomous Communities which are competent in the field, to make a greater budgetary effort to increase the funding of the SADP, and to prioritise this policy over other areas where they have competences, but which have lower social returns, making use of their fiscal autonomy to increase their own revenues.

Lastly, an effort should be made within the Social Services Territorial Council and the System for Autonomy and Care for Dependent Persons to improve co-payment systems. Common and transparent criteria should be agreed for the computation and consideration of the economic capacity of users, ensuring that they have greater certainty regarding their rightful expectations. Progress should also be made in establishing measures to simplify administrative management, to introduce progressivity and, in general terms, to substantially limit their weight in the funding of services so that they do not act as a disincentive to dependent persons applying for or accepting the relevant benefits.

To summarise, as our final conclusion, it should be stated that the SADP was already facing significant challenges prior to the onset of the pandemic. These meant that it was urgent to rethink the future of the model for long-term care, with a view to optimising the system for care of dependent persons as part of the scheme for social protection in our country, as well as driving forward in an effective way the maintenance of personal autonomy using preventive policies and policies to promote active and healthy ageing. The dramatic consequences of COVID-19 amongst dependent persons should represent a turning-point for addressing, by means of a consensus with the social partners and the agents involved, the changes and reforms required to effectively guarantee the universal right to care for dependency based on the paradigm of quality in which decisions place priority on persons.



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