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Quasi-markets Targets and the Evaluation of Nursing-home Funding in the Valencian Region

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Abstract

Spanish long term care is in danger, therefore we propose a change in the nursing home funding system. We use as an example the extremely complex nursing home financing system of Valencian Region. In this region, there are many funding mechanisms: two types of public subsidies, two different accessibility plans, a voucher scheme and a cash benefit approach related to residential service. We evaluate these methods through the quasi-market theory. We find that these approaches have negative impact on equity, efficiency and freedom of choice and we propose a new, homogeneous financing method for all nursing homes through voucher.

Keywords: Long term care, nursing homes, quasi-markets, vouchers.

JEL Classification: H44, H53, I38.

1. Introduction

Care for elderly people in Spain has drastically changed in recent years, moving from a means-tested benefits social care system to a universal care system for both the aged and the dependent. This change resulted in the Dependency Law[1], implemented in 2007, with the aim of providing proper care for all dependents. Dependence can strike at any age, but according to official data[2], 76.1 per cent of beneficiaries are over 65 years old, while those over 80 represent 54.6 per cent of total dependents.

Although the Dependency Law is applied throughout Spain as a whole, the development and implementation of the scheme are the responsibility of the Regional Governments. Funding for these services and benefits is shared between Central and Regional Governments. Each region, apart from funding, has to determine and evaluate citizens' level of dependence, services and benefits available to them, as well as the control of the services supplied. Therefore, the implementation of the Dependency Law will undoubtedly be different across the 17 autonomous regions of Spain[3] and at present is experiencing important financial problems (Barriga *et al.*, 2013 and 2014; FED, 2014). These local and regional variations also arise in many European countries (Fersch and Jensen, 2011).

The Dependency Law provides various services and benefits for dependents. However, in Spain residential care remains one of the most sought after options, especially for elderly people with a high level of dependency. To develop residential services, each region has designed its own system. The Valencian system is quite complex, including different financing methods such as vouchers, cash benefits, and subsidies to centers.

We will analyse the Valencian system on the basis of quasi-market theory. From the *Homo economicus* rationale, some economists believe that the best strategy to success in economic life is to look for efficiency (Cohen, 2014). Following this objective there should be a frequent competence among individuals and centers that would lead prices down and consumers would have more choice. It seems there are no limits of application of this rationale and it can be appropriate to apply to any good or service, in any field and also could be practiced in the public sector.

Quasi-markets have their origin in the 80s when the British Government carried out reforms in its welfare state that accounted for changes in the structure of services such as health, education, housing and social services. These reforms were studied initially by Le Grand and Bartlett (1993) and Le Grand (2003; 2007). The quasi-markets have as their main characteristic the substitution of bureaucratic mechanisms of production, allocation and distribution by competitive elements, freedom of choice and quality fostering. Despite having common features with competitive markets, quasi-markets have their own particularities. On the supply side, service financing and regulation correspond to the public sector, while service production can be performed by public, private or joint action of both providers, but always in a competitive environment. On the demand side, users express their preferences through prices, but demand is exercised in two ways: through agents acting on behalf of consumers; or by consumers themselves who will choose the provider, and the government will be responsible for financing the service. In addition to these objectives, equity, understood as equal opportunity in access to services (and not related to the redistribution of intergenerational transfers, gender burden or household income), has also appeared as a purpose in many studies on quasi-markets (Granell, 2002).

The eldercare was one of those services in which these quasi-markets initiatives were introduced. Furthermore, quasi-markets have been considered by governments as an alternative of public services financing, hoping to reduce public expenditure and prices among nursing-homes, and to achieve better quality and equity (Kähkönen, 2004; Hansen, 2010). Until now, many experts have focused their studies on these topics but without finding clear effects (Forder and Allan, 2011; Forder and Allan, 2014; Rostgaard and Szebehely, 2012; Meagher and Szebehely, 2013). Spain is also introducing some elements of competition in social services for elderly people.

In this paper we analyse the funding of residential care, focusing on the Valencian Region, which has developed a very complex financing system. After this introduction, in the second section, we describe the services and benefits under the Dependency Law with regard to residential care. In the third section we present our main hypothesis: during past twenty years, the Valencian Region has experienced a process of 'marketization', a common process in other

countries (Brennan *et al.*, 2012). To show that, we describe the mechanisms of public funding for nursing-homes facilities that have been introduced in this region. In the fourth section we assess the entire financial system following quasi-market theory as part of main changes in "models of care". In the fifth section, we develop a proposal to improve equity, freedom of choice and efficiency, and finally outline our key findings.

2. Services and benefits of the Dependency Law

Pavolini and Ranci (2008), analyzing the Long Term Care reforms introduced in several European countries (France, Germany, Italy, the Netherlands, Sweden and the UK), stressed several common characteristics: a tendency to combine monetary transfers and in-kind benefits, the introduction of funding measures to encourage care within the family, the introduction of competition in the social care market, and the empowerment of users through a higher purchasing power. As we will see in this section, the former two characteristics (monetary and in-kind benefits, and family care) are the core of Spanish Dependency Law, while the two latter (competition and empowerment of users) are two guidelines specifically aimed in Valencian Region.

The main goal of the Dependency Law is to cater for the individual needs of dependents and establishes in-kind benefits and monetary benefits. The first ones must be used first and foremost. Not being possible to use these in-kind benefits, the monetary benefit could be used[4]. There are five different types of services, depending on the needs of each person: Services for Dependency Prevention, Tele-Alarm, Home-Help, Day Center / Night Center, and Nursing-Homes. It also provides financial benefits for those in need. There are three types of economic benefits:

- Cash benefit linked to residential services. The dependent person pays the provider directly and then receives a financial benefit which covers part of this cost. This benefit is typically used when the dependent person is not satisfied with the range of services offered by the administration, and prefers a different provider. The provision may include any of the aforementioned services: Tele-Alarm, Home-Help, Day Center/Night Center, or Nursing-Homes.
- Cash benefit for a family carer. A family member cares for the dependent person and receives a benefit from the Administration.
- Cash benefit for personal care. Similar to previous case, although the caregiver in this case is a social care professional.

Dependency protection is financed on three different levels. Firstly, the "Minimum Level of Protection", which is in charge of Central Government. According to the National Audit Office (Tribunal de Cuentas, 2013, p. 93), in 2010 Central Government expenses amounted to 81.8 million euros for Valencian Region. Secondly, the "Agreed Level of Protection", which is shared between central and regional authorities, being the percentages different in each region and each year. In 2010, the central government contribution to Valencian Region reached 25.3 million euros, while the Valencian government contribution meant 272 million euros (Tribunal de

Cuentas, 2013, p. 93). Thirdly, each region devoted supplementary funds to the "Additional Level of Protection". At any level, the user must also contribute, according with her level of income. In 2010 the total dependency net expenditure (after several internal adjustments) in the Valencian Region was 405.5 million euros, having paid the central government 126.4 million euros and Valencian authorities 279.2 million euros (Tribunal de Cuentas, 2013, p. 114).

The share between Central and Regional governments varies across regions (being the regional percentage at least 50%). This disparity between regions is due to the financing system derived from the Dependency Law (Consejo Económico y Social, 2013). Central Government financing (mainly through the Minimum Level of Protection) is always the same, no matter if the user receives a benefit or a service. This amount solely varies according to the degree and level of user dependency. However, regional financing is different if the user receives a financial benefit or a service (usually higher in the latter case). The regions that recognize more services (Madrid, 89.50% and Valencia, 63.20% in 2010) are situated among those regions with higher share of regional financing (Madrid, 72.83% and Valencia, 68.84% in 2010[5]), while the regions recognizing more financial benefits have less need of funds. For this reason, the National Audit Office states that Central Government (IMSERSO) should analyze the possibility of changing the financial model (Tribunal de Cuentas, 2013, p. 113). Showing the reduction of percentage of participation of Central Government in the financing of services, Barriga *et al.* (2014, p.22) state that we "are witnessing a gradual withdrawal of central government effort". Table 1 shows current data on dependency in the Valencian Region, compared to the rest of Spain.

Table 1
DEPENDENCY STATISTICS IN THE VALENCIAN REGION AND SPAIN, NOVEMBER 2013

	Valencian Region		Spain	
	Number	**%**	**Number**	**%**
Total Population at 1/11/2013	5,129,266	10.85	47,265,321	–
Cash benefits and services recipients	42,078	0.8	754,244	1.5
a) Dependency Prevention	353	0.73	21,082	2.2
b) Tele-alarm	9,795	20.25	121,926	12.8
c) Home-Help	0	0.0	120,926	12.7
d) Day Center/Night Center	3,434	7.1	69,184	7.3
e) Nursing-homes	11,434	23.6	131,616	13.9
f) Cash benefit related to residential services	3,593	7.4	71,234	7.5
g) Cash benefit for a family carer	19,753	40.8	409,598	43.2
h) Cash benefit for personal care	2	0.0	1,287	0.1
Total Cash benefits and services	48,364	100	946,351	100

Source: Own elaboration from Dependency system data. Available online at http://www.dependencia.imserso.es/dependencia_01/estadisticas/inf_gp/2013/index.htm

The most common benefit applied in Spain is Cash Benefit for a Family Carer, which in 2013 accounted for 43.2 per cent of benefits (López and del Pozo, 2010). In an environment of economic crisis, families of dependents may choose to receive a financial allowance and save the cost of a residential facility. Nursing-homes make up the second largest number of beneficiaries; here the relative importance in the Valencian Region (23.6 per cent) is much higher than the national average (13.9 per cent). Residential care is mainly provided for elderly people with a higher dependency degree. In 2011, 23.48% of users with Degree III, Level 2 (DIII-L2) of dependency received residential care; in the case of DIII-L1 the percentage was 15.73%; for DII-L2, a 10.76%; and for DII-L1, just an 8.83% individuals receiving public assistance were eligible for residential care (IMSERSO, 2011, p. 18).

Moreover, residential care accounts for a much higher amount of resources than other benefits. The number or users is quite high, but the cost per user is the greatest among benefits and services. For this reason, according to Barriga *et al.* (2014), residential care goes to 16.2% to elderly people, but uses 51.1% of total resources. On the opposite side, the Cash Benefit for a Family Career reaches 50.8% of people, and consumes 23.8% of resources.

The residential sector has greatly expanded in recent years due to growing demand. In December 2012, there were 5,533 nursing-homes in Spain with a total of 353,642 places available, accounting for 4.2 per cent of the population over 65 years of age. However, this ratio varies considerably among regions. (CSIC, 2013).

3. Public financing of nursing-homes. The case of the Valencian Region

In this section we will focus only on residential services in the Valencian Region, and the way they are financed by the regional authorities. Two main goals could be stressed in public policy related to nursing-homes: the introduction of competition in the social care market, and the empowerment of users through a higher purchasing power (Pavolini and Ranci, 2008). As a result, the distribution of nursing-home centers is represented in Table 2.

Table 2
NUMBER OF NURSING-HOMES CENTERS AND PLACES IN THE VALENCIAN REGION, 2013

	Centers	%	Places	%	Average Size
Public	68	20.36	5,497	20.76	81
Regional Government	40	11.98	4,006	15.13	100
Municipal	28	8.38	1,491	5.63	53
Private	266	79.64	20,984	79.24	79
Non-profit	39	11.68	3,188	12.04	82
For-profit	227	67.96	17,796	67.2	78
Total	334	100	26,481	100	79

Source: Own elaboration from Portal Mayores data. Available online at http://envejecimiento.csic.es/recursos/residencias/index.htm

The number of private nursing-homes in the Valencian Region is larger than public facilities, representing 79 per cent of centers and available places. The average size of centers, both private and public, is around 80 places. Within public nursing-homes two types of centers should be distinguished: those belonging to the Regional Government and those which are owned by municipalities. The former group is greater and centers are usually quite large (100 places), whereas municipal centers have a lower average size (53 places) (CSIC, 2013).

As for private centers, these can be divided into either for-profit or non-profit nursing-homes. The non-profit centers often have distinctive characteristics: most are linked to the Catholic Church; they are usually older centers and have a lower average size. Profit centers, have been the most widely developed in recent years, accounting for nearly 67 per cent of the places available in the Valencian Region.

Originally nursing-homes in Spain could operate thanks to the selfless work of volunteers and religious orders (third sector) as well as from contributions made by residents' families (private financing). However, this pattern has changed dramatically since 1975, with the beginning of the democratic period in Spain. As a result the public sector began to provide, regulate, and fund social care services; firstly through the creation of public nursing-homes, and secondly through the financing of private centers either through public-private contracts or subsidies. The public financing system of residential places has always been complex. However, this complexity has increased noticeably following the adoption of the Dependency Law in 2007.

In order to receive a place funded by the public sector, the elderly person must apply for dependency recognition, expressing their preference for nursing-homes by indicating their three preferred centers. If the assessment is positive, the Regional Administration will recognize a degree of dependence, will propose an "Individual Care Program", trying to respect the preferences of the beneficiary, and will specify the nursing-home assigned by the administration. Requested and assigned centers can pertain to any of the four types discussed below, each funded differently: public nursing-homes (regional or local) and private nursing-homes (profit or non-profit).

In the four types of centers, the public sector apparently bears the full cost of service. However, the dependent person has to pay a public price to the Regional Government for the service delivery. This public price, regulated by the Valencian Authorities since 1993[6], ranges between 80 per cent and 95 per cent of the user's family monthly per capita income. This is a public price that increases with income, as shown in Table 3.

Table 3
PUBLIC PRICES FOR NURSING-HOME PLACES IN VALENCIAN REGION, DEPENDING ON THE PCMI

Per capita monthly income (PCMI)	Monthly price	Monthly price interval
Less or equal to 240.40€	80% PCMI	0 – 192.32€
Between 240.41 and 390.66€	83% PCMI – 6.01€	193.53 - 324.25€
Between 390.67 and 540.91 €	85% PCMI – 6.01 €	326.06 – 453.76 €
Between 540.92 and 691.16 €	87% PCMI – 12.02 €	458.58 – 589.29 €
Between 691.17 and 814.42 €	90% PCMI – 18.03 €	604.02 – 714.95 €
Between 814.43 and 991.67 €	93% PCMI – 30.05 €	727.36 – 892.20 €
Between 991.68 and 1,141.92 €	95% PCMI – 36.06 €	906.04 – 1,048.76 €
More than 1,141.92 €	PCMI – 90.15 €	1,051.78 €

Source: Decreto 23/1993, de 8 de febrero, del Govern Valencià, por el que regula los precios públicos correspondientes a centros y servicios del Institut Valencià de Serveis Socials. (DOCV nº 1.995 de 31 de marzo de 1993).

If the dependent person prefers to be served in another residential facility, not included in the public offer, then she has another choice. She can apply for the Cash Benefit linked to Residential Services (CBRS). In these cases, the elderly person chooses where she would like to live and pays the center directly. Subsequently, she will receive this financial benefit from the Regional Administration.

Now we review the most important features of the five existing funding mechanisms, including the CBRS. Its evolution over time is summarized in Figure 1.

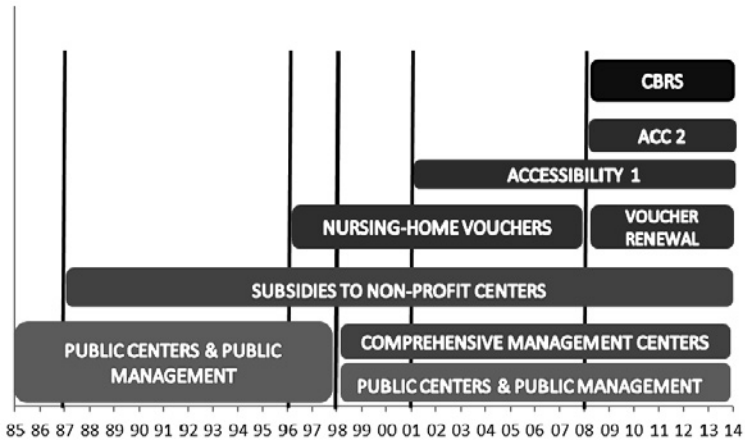

Figure 1. Evolution of public financing for nursing-homes in the Valencian Region

As we will see, in the past decades, a process of marketization has been developed in the Valencian nursing-home sector. The process of marketization has two dimensions (Anttonen and Meagher, 2013). Firstly, competition could be used to organize service provision, including for-profit and non-profit providers. In the Valencian Region it was introduced through subsidies to non-profit centers and through the nursing-home voucher. Secondly, the private sector rationalities and practices are imported into the public sector, introducing competition between public centers. This second dimension was introduced through Comprehensive Management in public centers, besides Public Management.

3.1. Public nursing-homes owned by the Valencian Government

Public financing of residential places in the Valencian Region began in the early democratic period, using the most common method at that time: the creation of public centers. Those public nursing-homes, which were owned by the Regional Administration, were intended to be an alternative to the private non-profit centers existing to date. The public care network became increasingly important over time, and today there are 40 centers offering a total of 4,006 places. During the first years of operation, these residences could be regarded as completely public centers, as the provision, production of the service (staff, facilities, activities), financing and regulation were entirely the responsibility of the Regional Administration. However, in 1998 a process of marketization began and some nursing-homes were then managed by private entities (Brennan *et al.*, 2012). So, while the provision, financing and regulation of the service remained the responsibility of Regional Government, the running of the service passed into private hands. These centers became known as "Comprehensive Management Centers". The main argument to justify this marketization was to improve the efficiency of centers due to lower costs in providing the service. The number of these centers has steadily increased over time; but there still remain fully public institutions. Currently, only 12 public nursing-homes are managed by the Regional Authorities, while the remaining 27 are Comprehensive Management Centers (CSIC, 2013).

Regardless of the management model, all public centers are funded by the Regional Administration. Public managed nursing-homes are directly funded through the budget, while the Comprehensive Management Centers receive a transfer from the Regional Administration, which varies depending on the "Fee per Place and Day" agreed with each company in each individual contract. In 2012, these fees ranged between € 54.94 and € 76.75, with an average cost of € 60.95.

3.2. Subsidies to nursing-homes

Grants aimed at residential centers have existed since 1987 and still remain one of the main means of financing for nursing-homes. This grant scheme, aimed both at centers owned by municipalities and at private non-profit centers, allowed the Regional Authorities to supplement the public network with additional places for users who could not cope with the

private cost of residential care. This method was chosen because there was no need to build new residences, as there was already a strong network of non-profit centers, mostly linked to the Catholic Church. To qualify for such aid, centers must be licensed by Regional Authorities and must belong to a non-profit association. Private for-profit centers cannot apply for these grants, among which we can find Social Accessibility Centers, which are discussed below. The amount paid to nursing-homes in 2012 is €50 per subsidized place and day[7].

The main advantage of the grant scheme is that the Regional Authority can ensure a relatively low cost (€ 50 per day) per user. These nursing-homes meet all legal requirements related to facilities and staff. In addition, for many of these centers, the altruistic work of religious and secular volunteers contributes to greater attention to the residents. However, the subsidy scheme has two clear disadvantages. First, the "Fee per Place and Day" criterion does not discriminate on the basis of user characteristics, as it doesn't take into account the level of dependence of residents, nor their purchasing power. Second, these grants are awarded annually and renewal is not guaranteed, creating great uncertainty for both nursing-homes and users alike. Finally, the financial criterion does not allow an equitable treatment to for-profit and non-profit centers.

3.3. Nursing-Home Voucher

The voucher is a characteristic mechanism in quasi-markets. It was originally proposed by Friedman (1962), and has been used in the marketization of public services, like education (Levin, 1992), health (Chalkley and Malcomson, 1996), housing and social services (Cave, 2001). There are not many experiences of vouchers in residential care. Pavolini and Ranci (2008) mentioned some cases in the Centre-North Italy, and a Swedish quasi-voucher mechanism. FORTÍN (2002) examines some advantages and disadvantages of vouchers in the area of residential care.

The mechanism of vouchers was first used in Valencian nursing-homes in 1996[8]. Beneficiaries receive a monthly voucher from Regional Authorities which users pass on to their chosen nursing-home. Subsequently, the center sends these vouchers to the Regional Government and exchanges them for money. If a center wishes to participate in this program it must apply formally. Once approved the center is recognized as a "Member Center of Nursing-Home Voucher Program" and offers the Administration a certain number of places to be occupied by beneficiaries within this program. The Member Centers may be municipal public centers, private for-profit centers (including Social Accessibility Centers) and non-profit private nursing-homes. The only centers that cannot participate in this program are the public homes owned by Regional Authorities.

Since the implementation of the Nursing-Home Voucher System in 1996 until 2007, any elderly person could apply for the voucher, whether they had benefited from the program in previous years or not. However, from 2008 onwards, due to the implementation of Dependency Law, the voucher becomes an extinguishing mechanism to be gradually replaced by Cash

Benefit Linked to Residential Services. Since 2008, the voucher can only be requested by those who were already beneficiaries in previous years. That is, vouchers are no longer awarded to new users and only those beneficiaries who already held one of these places can still avail themselves of it. In any case, vouchers are renewed annually, but users have no guarantee of renewal in the future. Since 2008 Nursing-Home Voucher amount is calculated as follows:

Monthly Voucher Amount = Place Cost - Beneficiary Contribution.

Where:

- The place cost is not a homogeneous quantity, as it increases with the degree of dependency of the elderly person. In 2012 the amount was between € 39.47 per day and € 57.70 per day[9].
- Beneficiary Contribution: the user must deal with a public price for the service. The public price is the same as in public housing and in subsidized centers (see Table 3).

To understand the advantages of the voucher scheme one must think back to 1996, when the initiative began. At that time the public sector could not cope with the sharp increase in demand for residential places. One possible solution was to build new public centers or subsidized new private centers, but this possibility would only have long-term effects and the waiting list in public centers was such a problem that an immediate solution was required. At the same time, many private nursing-homes could not fill all available places because their prices were too high for many potential users. The nursing-home voucher was therefore a useful mechanism to mitigate both problems simultaneously. On the one hand, it served to reduce waiting lists in public and subsidized centers; on the other hand, it allowed many private nursing-homes to increase their occupancy, hire new workers and improve their financial viability (Tortosa and Granell, 2002).

Since its introduction, the voucher scheme also had features that favored equity both between centers attached to the program, and between users. Firstly, it is a public financing method open to all accredited centers, which receive the same support for place and month regardless of their characteristics (religious / secular, for-profit / non-profit, public / private, etc.). As for users, the criteria of both horizontal equity and vertical equity are met: the granting of the voucher depends on the level of need and the amount awarded increases with the level of dependency of the user. Finally, the voucher system has also served to achieve one of the main objectives of quasi-markets: increasing the power of center choice by users. And this in turn may enable elderly people to select those centers nearest to their homes or their families.

As for criticisms, it is doubtful if users can truly exercise real freedom of choice or if it is in fact the center that chooses the user. The success of that power of choice will depend on the definition of both voucher components: place cost and beneficiary contribution. Further, it must be stressed that voucher quantity depends on the amount budgeted, so not all who meet the requirements will finally receive the financial aid, but only those who obtain higher scores on the scale. Its annual renewal is also criticized, as it does not guarantee the perception of

support to the border user. Finally, administrative costs of voucher management have also been criticized. Although the user is responsible for most of the steps, the Administration also has to negotiate with many different nursing-homes that have diverse characteristics as well as having to assess the personal and economic circumstances of users every year.

3.4. Social Accessibility Places

The development of these residential places has its origin in the Access to Residential Places Program in 2001[10], which envisaged the creation of 9,000 new residential places by private companies, whereby the Regional Government committed to financing up to a third of them. The program was put out to tender and subsequently was awarded to 13 companies, who agreed to build new residential facilities and then make up to a third of the new places available to the Regional Government. These commitments were reflected in administrative contracts signed by the Administration with each of the successful tenderers. The contracts have a 15 year term from the beginning of the service, and may be extended to a maximum of 25 years. The contracts also include the price the successful tenderers will charge for each of the Social Accessibility Places and will be reviewed annually for changes in the RPI. In relation to fees per place and day received by these nursing-homes, there is no uniform amount, but depends on each individual contract, ranging from € 50.86 to € 57.36 in 2012. In late 2007 there was a legislative change, tripling the number of Social Accessibility Places awarded in the 2001 auction (2nd Access to Residential Places Program, or ACC2). This increase was effected through new management contracts signed with the same companies. Each contract also sets a price for the new places, higher than those paid for the previous places. This new fee, identical for all nursing-homes, was € 58.30 in 2012.

As for the advantages of this system, the creation of Centers of Social Accessibility came about due to the high demand for places in recent years. Thanks to Accessibility Centers, the supply of places in different areas of the region has been extended significantly, although this increase could have been achieved too through the building of new public and also non-profit nursing-homes. In addition, these Accessibility nursing-homes have inputs and human resources beyond the legal requirements demanded by the Regional Government. The main advantage of Accessibility Centers for regional authorities is its lower cost. First, the construction and equipment of centers is provided by the successful tenderers, saving this investment to the Government. Second, the fee per place and day the Regional Government must pay (between €50.86 and € 58.30) is significantly less than the cost of public places in Comprehensive Management Centers (€ 60.95, on average).

However, Accessibility Centers have also been strongly criticized. The most common criticism has to do with the exclusive advantages of these centers. The fact that some companies won a public competition in 2001, has given them an advantage when competing with other organizations and companies, as they have guaranteed public funding for an important part of their places (between 33 per cent and 100 per cent) during a period of up to 25 years. The process of marketization was similar to one developed in Sweden at the beginning of the

1990s. It was a process of competitive tendering for large nursing-homes and geographical areas. According to Brennan *et al.* (2012, p. 381), this procedure "is important in explaining the oligopolistic structure of private sector provision". Other criticisms have been expressed relating to the characteristics of the successful tenderers and the nursing-homes built. The level of concentration is very high, as 43 of the 50 Centers of Social Accessibility are owned by four major companies that have greater power when negotiating the economic conditions with Valencian Regional Authorities. Furthermore, Accessibility Centers are characterized by their large size, with an average of 129 places. This may result in lower costs per place, but, maybe, in less personalized attention for residents or in displacement as the centers were mainly built in the suburbs.

3.5. Cash Benefit Linked to Residential Services

The Cash Benefit Linked to Residential Services (CBRS) is one of the financial aids in the Dependency Law. Its requirements and conditions are regulated in the Valencian Region since 2007[11]. The main feature of this provision is its residual character, as it is recognized only when there is no residential care available through the public and private network of Valencian nursing-homes. This may occur when there are no available places in public or subsidized centers, when the elderly person does not like the centers offered, or when the user has already lived in another non-contracted private center and wants to continue being treated there.

Nursing-homes that want to participate in this program must be accredited by the Regional Government, which opens the range of centers to those already seen in the Nursing-Home Voucher: centers owned by municipalities, private for-profit centers (including Social Accessibility Centers) and non-profit private nursing-homes. The only non-eligible residences are Public Centers owned by the Regional Government. The CBRS has been designed as a replacement to the voucher scheme. Voucher recipients in previous years had two options: to renew the voucher annually or get the CBRS, which has the advantage of being indefinite in time. In addition to the unlimited period, this benefit differs from the voucher scheme in two ways:

- The economic benefit is paid by the Government directly to the user. Residents must address the total cost of residential place (with their own resources and the amount of the benefit).
- The cost of residential places is not set by the public sector, as is the case with vouchers. This characteristic allows centers to charge the user whatever price they want.

The maximum benefit is the same in the whole Spain and depends on the degree and level of dependency recognized. However, this maximum quantity is reduced in the Valencian Region based on the economic capacity of the elderly people, as measured by per capita income of the family unit. Table 4 summarizes all funding mechanisms that currently exist. It includes information about which nursing-homes can profit from each of these mecha-

nisms, the number of places supported with each of them and also the amount received by the center in each case. The last row shows the daily public price per user.

Table 4
PUBLIC FINANCING MECHANISMS FOR NURSING-HOMES IN VALENCIAN REGION, 2012

	PUBLIC FINANCING MECHANISMS				
TYPE OF CENTER	**Public Budget**	**Subsidies to centers**	**Nursing-home voucher**	**Places of Social Accessibility**	**Cash related to residential service**
Regional centers	X				
Municipal centers	X	X	X		X
Social Accessibility			X	X	X
(only for-profit centers)					
Private non-profit		X	X		X
Remaining private centers			X	X	X
Places Financed	3,892	2,971	7,106	3,974	3,039
Place Cost	54.94-76.75	50	39.47-57.70	50.86-58.30	Variable

Source: Own elaboration.

4. Financing system evaluation from the theory of quasi-markets

Quasi-markets elements have been introduced progressively in eldercare of developed countries (UK, Nordic countries, Canada, etc.). European Commission (2012) has noted that elderly care marketization is increasing in many European Countries (Meagher and Szebehely, 2013).

The introduction of different mechanisms of public financing enhances private providers to enter in eldercare. Such participation pretends to create competition with public suppliers and to gain in efficiency and greater choice for users. However, there is a lack of economic evaluations of these initiatives to find if targets are met. Although the composition of supply sometimes has turned into an oligopoly (Brennan *et al.,* 2012), it remains to prove the most important aspects of efficiency such as the reduction of nursing-homes prices and the improvement of quality of these services. This is one of the most important challenges in this process since information of elder services is scarce, especially on results and quality (Knapp *et al.*, 2001). Despite of this, Caravaglia *et al*. (2011) advocate that competition seems to produce positive effects on efficiency in Italian nursing-homes, mainly due to better control on labour costs.

Other kinds of problems make it difficult to achieve efficiency in nursing-homes, as barriers to real competition among providers (excessive costs of managing competition, and

limitations to entry). Market based solutions could create the opposite results as those expected and the worsening on equity, as happened in Canada (Randal and Williams, 2006; Abelson *et al.*, 2004; Cloutier-Fisher and Skinner, 2006). This quasi-market approach pays less attention to issues as equal access and equal opportunities, and the level of social trust on public services evaluation (Fotaki and Boyd, 2005).

In the Valencian Region, the introduction of quasi-markets has been a process of trial and error. Authorities have tried several measures apparently not connected, where it couldn't find a political plan. Multiple financing mechanisms, together with a large regulatory dispersion have led the Valencian Region to a system which lacks a defined structure and clearly stated objectives. What does seem clear by looking at Figure 1 (see above) is that the financing system's evolution has been towards marketization, first materialized with subsidies and vouchers, but later reached its climax with the Comprehensive Management of public nursing-homes and the Social Accessibility Plans.

At present the Valencian nursing-home financing system fulfils many characteristics of a quasi-market. Users entitled to receive benefits can choose in the request their favorite center (public, accessible, subsidized or voucher center) and public nursing-home funding will be targeted to the center selected. Nursing-homes must compete to attract the largest number of users and thus to obtain enough financing.

Although initially the funding system meets the basic precepts necessary for the operation of a quasi-market, it will be necessary to examine in detail the Valencian financing system to know if typical quasi-market targets really are achieved: promoting the freedom of choice by users; improving efficiency through greater competition among providers; and more access to nursing-homes places (Le Grand and Bartlett, 1993).

4.1. Freedom of center choice

Freedom of center choice is implemented today through the Dependency Law when dependent people submit an application. In this application if elderly people opt for nursing-home care, they have to indicate three centers chosen in order of preference that can be public, of Social Accessibility or subsidized (non-profit or municipal), disregarding those private for-profit centers that do not benefit from the Accessibility Plan. If the applicant prefers one of these private nursing-homes, she has the option of requesting the CBRS. If she chooses this option then she must pay the difference between the price charged by the center and the amount of the cash benefit. In brief, elderly people considered dependent can choose the type of cash benefit or service they want, as well as their preferred nursing-home. However there are significant constraints that will limit the real possibilities of choice.

First, public information about centers and the financing system is clearly deficient[12]. In addition to the regulatory dispersion which makes the nursing-home financial system almost unintelligible, the Regional Government does not provide any kind of information on cen-

ters. Indeed, there is not even a list of those that have public places. The only help available to elderly people when choosing a nursing-home is the information supplied by the social worker who is assigned to them. But the whole process of allocation of places is not transparent.

The second limitation to freedom of choice may occur when the decision of the Regional Government does not take into account the preferences of elderly people. At times their chosen center may not be assigned and instead they are allocated to a center with a different set of characteristics. Additionally, this problem is compounded by a real lack of information. No list is published outlining the places available in each center, nor is there a waiting list for those who have not been able to access the requested center. Those who are dissatisfied with the award by the Regional Government may ask for the CBRS, although this possibility has a different cost for the user.

The third limitation is related to the costs of selecting one kind of institution or another. If they opt for a public, Social Accessibility or subsidized center, they must pay the price mentioned above, which is related to per capita income of their household. However, if they prefer any other private nursing-home, then they must apply for CBRS. In this case, the price that the user will eventually have to pay depends on three factors: per capita household income, level of dependency, and price charged by the private center selected. In other words, freedom of choice will be influenced by the price finally paid by the user, a price that will be different if they choose CBRS.

4.2. Efficiency

Quasi-markets attempt to emulate the competitive behavior of traditional markets in order to achieve a higher level of efficiency. In this section we analyze whether the characteristics of the centers are appropriate for them to compete freely. Centers must meet a minimum of requirements to ensure a quality level of services provided, but if they have to compete freely, the requirements should be identical for all. In the case of the Valencian Region both conditions are met by regional regulations introduced in 2005[13]. These requirements refer to spaces, activities and staff and are identical for all authorized nursing-homes. Restrictions on free competition are mainly due to the characteristics of the financing system and, in particular, the discriminatory treatment given to the different providers. This discrimination occurs at different levels:

- Centers cannot have access to the same funding mechanisms, as shown in Table 4, thus preventing them from competing under the same conditions. Some nursing-homes are only eligible for one mechanism, such as public centers, while others have up to three different mechanisms at their disposal. Discrimination in public and subsidized centers can be justified by the absence of non-profit or public ownership. However, positive discrimination towards centers from Social Accessibility Plans compared to the rest of private centers is hardly justifiable.

- Financing mechanisms set different amounts, so nursing-homes will receive a different daily fee per place by the Regional Government depending on the funding mechanism that they may choose. In the year 2012, nursing-homes that receive more resources per resident, on average, were Comprehensive Management public centers (€ 60.95), followed by the Social Accessibility Centers (€ 54.58). By contrast, the non-profit centers (both private and municipal) generally receive a lower amount (€ 50). But sometimes the subsidy is not the same for centers that receive the same financing mechanism. Comprehensive Management contracts and Social Accessibility contracts are signed individually with the companies awarded, negotiating different prices[14].
- Public financing is not the same for all the places at the same center. If the nursing-home is host to various public funding mechanisms, it will receive different amounts per place. For example, a center with subsidized places and places with vouchers receive € 50 for the first and a variable amount based on dependence level (between € 39.47 and € 57.70) for the latter. They do not even receive the same amount in the same residence with the same funding system. Social Accessibility Centers will receive an amount for the initial third of their places (between € 50.86 and € 57.36) and a higher amount for the rest of places (€ 58.30).

To summarize, we believe that the discriminatory financial treatment given to centers does not allow them to compete on equal terms and to maintain a certain level of quality (Hardy and Wistow, 1998; Forder and Allan, 2011). According to the current model, an inefficient center can continue to operate if it gets an individual contract with the Regional Government, ensuring a higher level of funding than the rest. The efficiency of these centers should be adequately demonstrated by relevant economic evaluations. However, these have never been carried out in the Valencian region due to the lack of information.

Regardless of the discriminatory treatment mentioned, the financing system should take into account other problems related to supply. The greater the level of dependency of the elderly people the higher the service cost becomes, which should lead Regional Government to pay a higher price to nursing-homes that treat the most dependent users. This possibility was considered in the centers with vouchers and also in those with CBRS, however it does not exist in public, Social Accessibility or subsidized centers. Some discrimination in prices depending on users' level of dependency should be applied to these centers, as centers that primarily serve more independent, or moderately dependent residents, receive the same funding per place as those who attend high-dependence users.

4.3. Equity

In this section we examine whether the financing system allows the same access opportunities for citizens[15]. From the point of view of horizontal equity, it would mean to ensure the same services and benefits to those who are in the same situation (Frediksson *et al.,* 2013; Comas, 2012). If we analyze in detail all these funding mechanisms, we can conclude that

in all cases the user will receive the service at an authorized center and in return must pay the same price regardless of the selected center. Furthermore, this public price will be higher as household income increases, which gives the public price some degree of vertical equity (Table 3). The only exception to this uniform treatment is the CBRS. In this case, the nursing-home can charge the price they want to the user who will receive the public service according to their degree of dependence and economic status. In some cases, it might be more profitable for the user to pay for a private place and receive the CBRS, and in others, it will be preferable to pay the public price for a place in a public or subsidized nursing-home. This decision depends on three variables: the price charged by the private nursing-home, the user monthly income per capita, and the degree and level of dependency accredited. Substituting these three variables by values we can find out when it will be preferable for the user to pay the public price or the perceived cash benefit.

In Figure 2 we see the price the user would eventually have to pay through the two available options: public price and CBRS. Although this figure will change depending on the level of dependency recognized, we have chosen the case of higher dependence, which is the most common. It is appreciated that the public price only depends on income, while the final price paid in the case of cash benefit also depends on the price set by the nursing-home. For illustrative purposes we have considered three possible private prices, according to common prices in the Valencian Region: a low (€ 1,500 / month), an average (€ 1,800 / month) and a high (€ 2,100 / month) price.

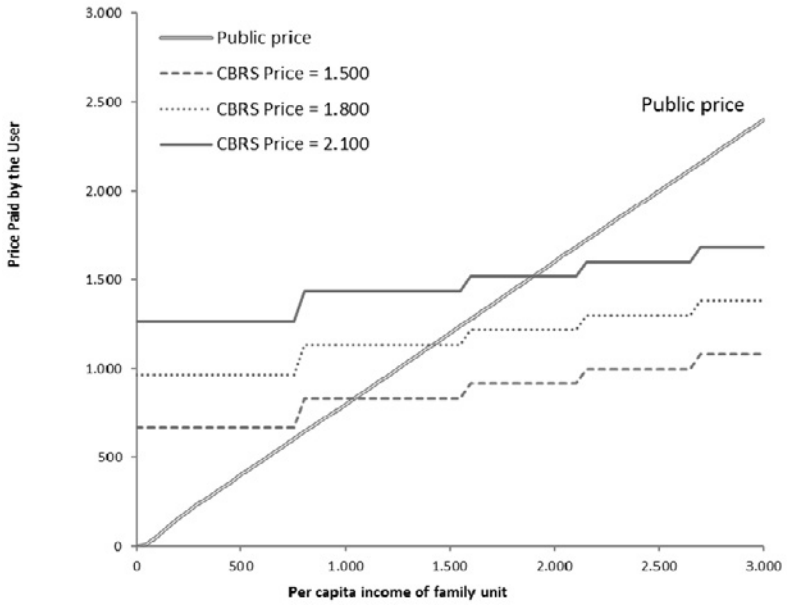

Figure 2. Final Price for user (degree III level 2)

The most interesting result of this graphic is where exactly the cut-off point is located, because from a certain level of income the CBRS becomes a better option. This cut-off is set at € 929, € 1,224 and € 1,524 depending on the price of the center (€ 1,500, € 1,800 and € 2,100). These cut-off points confirm that the cash benefit provision only favors those elderly people who have a relatively high income level.

5. An alternative proposal

The Government report for the evaluation of the Dependency Law (Ministerio de Sanidad, Política Social e Igualdad, 2011) states that in Spain public contracts are sometimes allocated to the lower-cost proposals without analyzing the quality of services offered. Furthermore, it is recommended that Central Government set a general framework of actions to prevent excessive heterogeneity in the allocation of public contracts and center accreditation. Bearing this in mind, along with the thoughts of other authors (Barriga *et al.,* 2013; López, 2011; León, 2011) we will make a homogeneous proposal for financing nursing-homes. Inevitably we must adopt a three-pronged approach to address and deal with the serious issues within the nursing-home funding system in the Valencian Region: excessive complexity, lack of information and discrimination.

Obviously, the first step towards improvement would be the simplification of the funding system. At present five mechanisms of financing coexist: vouchers, public places, Social Accessibility, subsidized places, and finally CBRS. In order to rationalize the system and improve the finance of Dependency Law, we propose the unification of all financing mechanisms into a single method that would work the same way for all nursing-homes, with the exception of the cash benefit provision, which should maintain its alternative character for those elderly people that cannot be cared for in public or subsidized centers. The new system should include both public institutions (Regional and Local Government) and the private (non-profit, Social Accessibility and other private nursing-homes). The only condition for participation of public funds would be to meet a set of quality requirements with regard to space, equipment, activities and staff requirements, similar to those regulated since 2005. As for the specific funding mechanism, there are several alternatives that have already been implemented in the Valencian Region: subsidies, public agreements or vouchers. Although any of these alternatives could be valid, the nursing-home voucher has certain advantages. First, it is a mechanism that has been used for 18 years and the Regional Government has extensive experience in its management. Second, it is a system already used by both local and most private nursing-homes (including social accessibility and non-profit), allowing an easy adaptation. Third, vouchers take into account the personal characteristics of each elderly person, in particular their level of dependency. Finally, with the voucher system nursing-homes can be monitored to ensure they meet certain basic requirements. It is the preferred system from the perspective of competition and freedom of choice.

Another key issue that should be determined is the price paid to centers attached to the new system. This is surely the biggest change from the current situation. For all nursing-

homes to compete under the same conditions, an identical price should be set for all, regardless of ownership in order to avoid the discrimination that exists today. However, it should distinguish different prices depending on each resident's level of dependency, increasing the funding received by the center as the user's dependency increases. As we discussed in the previous section, the voucher system is the ideal mechanism to achieve this positive discrimination, as here public funding clearly follows the user. To determine these prices, the most sensible approach would be to make a detailed study of nursing-home costs, in order to differentiate costs by level of dependency (KPMG, 2010; PriceWaterhouseCoopers, 2010; Fernández *et al.,* 2011; Tortosa, Fuenmayor and Granell, 2011).

A financing system such as the one proposed would also improve the quantity and quality of publicly available information. Furthermore, a list of participating centers should be published outlining the characteristics (ownership, facilities, services, staff, etc) of each provider as well as the number of places available with public funding. With this information, users could choose the center that best suits their needs; while at the same time to improve equity (Fredriksson *et al.,* 2013). However, elderly people and their family should be coached by some kind of care manager to coordinate all the kinds of information they need to be an informed user (Meinow, Parker and Thorslund, 2011)

Of course, some centers will be more sought after than others. When demand exceeds the number of places in a nursing-home, some mechanism should be set up to allocate these places taking into account the level of need of the applicant, as in fact is the case at present with the nursing-home voucher. The most important thing is that this information is made public, so that users can choose another option or wait until there are places available in the center that represents their first choice.

The price paid by the user would also have to be determined. We recommend keeping the current system, which sets the price according to the economic status of the user rather than their level of dependency. Based on equity, fixing a lower price for the less dependent would clearly put at a disadvantage those who are in more urgent need of care. On the other hand, we think the public prices established in 1993 should be updated to take into account the current economic climate and contain a clause for automatic update according to future developments in prices.

Finally, a timeframe needs to be put in place to implement the new system. All of these suggested changes cannot be acted upon immediately, due to the commitments acquired by the Regional Government. These commitments are embodied in Comprehensive Management contracts, which are usually fixed for a four-year period, while the contracts with Social Accessibility Centers were established for a 15-year period. The latter term should be the maximum time horizon to consider. The system should be operational as soon as possible, encompassing from the beginning those nursing-homes that currently use the voucher system as well as those that are subsidized. Subsequently, those public nursing-homes with Comprehensive Management may join, once they have completed their present contracts, and finally Social Accessibility Centers should join once they finish their 15-year contracts agreed with the Regional Government. Finally, real political consensus is needed

to implement these proposals, as such a system cannot be easily altered with every change in government.

6. Conclusions

In this paper we have reviewed the financing of Valencian nursing-homes. The system used in the Valencian Region is characterized by great complexity, as it has established five possible means of funding: public centers (with public or private management), subsidies to non-profit centers, nursing-home vouchers, Social Accessibility Plans and Cash Benefit related to Residential Service (CBRS). To evaluate the performance of this funding system we have relied on the literature on quasi-markets, analyzing if the objectives of freedom of choice, efficiency and equity are adequately met. The results of the evaluation are clearly negative. Freedom of choice is conditioned by the complexity of the system, the limited information available to citizens and also because their preferences are not always met. Both efficiency and quality are compromised because nursing-homes do not compete under the same conditions. The amount received by each center depends on the financing mechanism to which they have access and not the level of dependency of residents. Finally, equity among users would be better guaranteed by establishing a uniform price, which depends solely on the income level of residents. The only source of inequality would be the CBRS, which is favorable for higher income users.

In order to solve these problems, we propose a much simpler financing alternative to that in currently used, namely a consistent method for all centers: the nursing-home voucher. This new system would provide similar funding to all nursing-homes, irrespective of their characteristics. However, the price should differ depending on the level of users' dependency. As part of the new system, improved public information procedures are essential as well as the updating of the public prices. These proposed changes would undoubtedly ensure greater efficiency, equity and freedom of choice for all.

With all the above, our interest is to draw attention to an unbearable situation of nursing home funding in the Valencian Region, that could be extensible to other Spanish regions, and should be amended in order to a proper functioning and peaceful coexistence among providers of these services in future.

We may also stress the limitations of this study. The main problem is related to the lack of available information. In the case of Spain and particularly in the Valencian Region, information about nursing-homes, places and their financing is scarce and inconsistent. The Spanish National Audit Office stresses in its latest report the problems of information between central and regional authorities (Tribunal de Cuentas, 2013, III.2). There is no official register of centers, and information about availability of places is scattered. No information exists about quality of centers, or satisfaction of users. It is to be hoped that the information provided by the Spanish and Valencian Governments will improve in future according to OECD (2013) recommendations in order to continue future quantitative research in this area.

Notes

1. Ley 39/2006, de 14 de diciembre, de Promoción de la Autonomía Personal y Atención a las Personas en Situación de Dependencia *(BOE* n.º 299, de 15 de diciembre de 2006).
2. Statistics Service of Attached General Department of Value, Quality and Evaluation of the System to Autonomy and Dependence Care, offered by Institute of Elderly and Social Services of Spain (IMSERSO, 2014)
3. Resolución de 13 de julio de 2012, de la Secretaría de Estado de Servicios Sociales e Igualdad, por la que se publica el Acuerdo del Consejo Territorial del Sistema para la Autonomía y Atención a la Dependencia para la mejora del sistema para la autonomía y atención a la dependencia *(BOE* n.º 185, de 3 de agosto de 2012). See also the Report from Tribunal de Cuentas (2014).
4. Art. 14, Ley 39/2006, de 14 de diciembre, de Promoción de la Autonomía Personal y Atención a las Personas en Situación de Dependencia *(BOE* n.º 299, de 15 diciembre de 2006).
5. Data obtained from Tribunal de Cuentas (2013), Cuadros n.º 31 and n.º 32.
6. Decreto 23/1993, de 8 de febrero, del Govern Valencià, por el que regula los precios públicos correspondientes a centros y servicios del Institut Valencià de Serveis Socials *(DOCV* n.º 1.995 de 31 de marzo de 1993).
7. Orden 14/2011, de 21 de diciembre, de la Conselleria de Justicia y Bienestar Social, por la que se regulan y convocan ayudas en materia de servicios sociales para el ejercicio 2012 *(DOCV* n.º 6.682 de 30 de diciembre de 2011).
8. Orden de 5 de febrero de 1996, de la Conselleria de Trabajo y Asuntos Sociales, por la que se regulan y convocan ayudas para financiar estancias en residencias de tercera edad mediante el sistema de bono-residencia *(DOCV* n.º 2.686 de 12 de febrero de 1996). This order is updated annually.
9. Orden 11/2011, de 16 de diciembre, de la Conselleria de Justicia y Bienestar Social, por la que se regula y convoca el programa para financiar estancias en residencias de tercera edad en el año 2012 *(DOCV* n.º 6.681 de 29 de diciembre de 2011).
10. Acuerdo del Consell de 30 de enero de 2001. This agreement was not published, as it was a private agreement.
11. Orden de 5 de diciembre de 2007, de la Conselleria de Bienestar Social por la que se regula los requisitos y condiciones de acceso a las ayudas económicas del programa de atención a las personas y a sus familias en el marco del sistema para la autonomía y atención a la dependencia en la Comunitat Valenciana *(DOCV* n.º 5.656 de 10 de diciembre de 2007).
12. Tribunal de Cuentas (2013-2104) has stressed the problems related with the information generated by the Dependency System, including some problems between central and regional authorities.
13. Orden de 4 de febrero de 2005, de la Conselleria de Bienestar Social, por la que se regula el régimen de autorización y funcionamiento de los centros de servicios sociales especializados para la atención de personas mayores *(DOCV* n.º 4945, de 14 de febrero de 2005).
14. In 2013 and 2014 it should be stressed that regional authorities moved towards a moderate equalization in some of these prices.
15. There is a recent paper examining inequity in long-term care in Spain (García-Gómez *et al*., 2014). Unfortunately, the data used does not include residential care.

References

Abelson, J.; Gold, S. T.; Woodward, C.; O'Connor, D. and Hutchison, B. (2004), "Managing under managed community care: the experiences of clients, providers and managers in Ontario's competitive home care sector", *Health Policy,* 68: 359-372.

Anttonen, A. and Meagher, G. (2013), "Mapping marketization: concepts and goals", in Meagher, G. and Szebehely, M. (eds.), *Marketisation in Nordic eldercare: a research report on legislation, oversight, extent and consequences*, Stockholm: Department of Social Work, Stockholm University.

Barriga, L. A.; Brezmes, M. J.; García, G. and Ramírez J. M. (2013), *Desarrollo e implantación territorial de la Ley de Promoción de la Autonomía Personal y de la Atención a las Personas en situación de Dependencia. Informe de evolución de la Ley cuatro años después*, Madrid: Asociación Estatal de Directoras y Gerentes de Servicios Sociales. http://www.directoressociales.com/images/x%20dictamen%20.pdf (Accessed 10/02/2013).

Barriga, L. A.; Brezmes, M. J.; García, G. and Ramírez J. M. (2014), *Informe sobre el desarrollo y evaluación territorial de la ley de promoción de la autonomía personal y atención a las personas en situación de dependencia*, Madrid: Asociación Estatal de Directoras y Gerentes de Servicios Sociales, http://www.feafes.org/publicaciones/XDictamenANEXO.pdf (Accessed 27/11/2014).

Brennan, D.; Cass, B.; Himmelweit, S. and Szebehely, M. (2012), "The marketization of care: Rationales and consequences in Nordic and liberal care regimes", *Journal of European Social Policy,* 22, 4: 377-391.

Caravaglia, G.; Lettieri, E.; Agasisti, T. and Lopez, S. (2011), "Efficiency and quality of care in nursing-homes: an Italian case study", *Health Care Management Science*, 14: 22-35.

Cave, M. (2001), "Voucher Programmes and their Role in Distributing Public Services", *OECD Journal on Budgeting*, 1: 59-88.

Chalkley, M. and Malcomson, J. M. (1996), "Competition in NHS quasi-markets", *Oxford Review of Economic Policy,* 12, 4: 89-99.

Cloutier-Fisher, D. and Skinner, M. W. (2006), "Levelling the playing field? Exploring the implications of managed competition for voluntary sector providers of long-term care in small town Ontario", *Health & Place*, 12: 97-106.

Cohen, D. (2014), *Homo economicus. The (lost) prophet of modern times*, Cambridge: Polity Press.

Comas, A. (2012), "Long-Term care systems and horizontal and vertical equity: Germany, the Netherlands, Poland and Spain", Paper presented at 2nd International Conference on Evidence-based Long-Term Care Policy, London: London School of Economics, 7-8 September, http://www.ilpnetwork.net/documents/ilpn2012/Presentations/greenroom/g_07_1000_Comas-Herrera.pdf (Accessed 10/20/2012).

Consejo Económico y Social España. (2013), *La aplicación de la Ley de Dependencia en España*, Madrid: Consejo Económico y Social.

CSIC (2013), *Recursos sociales,* Madrid: CSIC, http://envejecimiento.csic.es/recursos/residencias/index.htm (Accessed 12/09/2013).

European Commision (2012), *Long-Term Care for the elderly. Provisions and providers in 33 European countries*, Brussels: Publications Office of the European Union.

Federación Empresarial de la Dependencia (FED) (2014), *Observatorio del sector de atención a la dependencia en España*, Madrid: FED, http://federacionfed.org/documentacion/observatorio-del-sector-de-atencion-a-la-dependencia-en-espana-informe-junio-2014/ (Accessed 25/03/2015).

Fersch, B. and Jensen, P. H. (2011), "Experiences with the privatization of home care: evidence from Denmark", *Nordic Journal of Social Research*, 1, 2: 1–14.

Fernández, M.; Dizy, D. and Ruiz O. (2011), *Análisis de los costes sanitarios en centros residenciales privados para personas mayores*, Madrid: Fundación Edad & Vida.

Forder, J. and Allan, S. (2011), *Competition in the Care Homes Market*, *A report for the OHE Commission on Competition in the NHS*, London: Office of Health Economics.

Forder, J. and Allan, S. (2014), "The impact of competition on quality and prices in the English care homes market", *Journal of Health Economics*, 34: 73-83.

FORTÍN (2002), *Servicios sociales y "cheque servicio",* Madrid: Asociación Estatal de Directoras y Gerentes de Servicios Sociales, http://www.directoressociales.com/images/SERVICIOS%20SOCIALES%20Y%20CHEQUE%20SERVICIO%20ZARAGOZA%202002.pdf (Accessed 26/10/2014).

Fotaki, M. and Boyd, A. (2005), "From Plan to Market: a comparison of health and old age care policies in the UK and Sweden", *Public Money and Management*, 25, 4: 237-244.

Friedman, M. (1962), *Capitalism and Freedom*, Chicago: University of Chicago Press.

Fredriksson, M.; Blomqvist, P. and Winblad, U. (2013), "The trade-off between choice and equity: Swedish policymakers' arguments when introducing patient choice", *Journal of European Social Policy,* 23, 2: 192-209.

García-Gómez, P.; Hernández-Quevedo, C.; Jiménez-Rubio, D. and Oliva, J. (2014), "Inequity in long-term care use and unmet need: Two sides of the same coin", *Journal of Health Economics (forthcoming).* doi: 10.1016/j.jhealeco.2014.11.004.

Granell, R. (2002), Education Vouchers in Spain: The Valencian Experience. *Education Economics*, 10, 2: 119-132.

Hansen, M. B. (2010), "Marketization and economic performance: competitive tendering in the social sector", *Public Management Review*, 12, 2: 255–74.

Hardy, B. and Wistow, G. (1998), "Securing Quality Through Contracts? The Development of Quasi-markets for Social Care in Britain", *Australian Journal of Public Administration*, 57, 2: 25–35.

IMSERSO (2011), Información estadística del SAAD a 1 de enero de 2011. Resumen global. http://www.dependencia.imserso.es/InterPresent2/groups/imserso/documents/binario/presentacionest2010.pdf (Accessed 27/11/2014).

Kähkönen, A. L. (2004), "Quasi-markets, competition and market failures in local government services", *Kommunal ekonomi och politik*, 8, 3: 31-47.

Knapp, M.; Hardy, B. and Forder, J. (2001), "Commissioning for Quality: Ten Years of Social Care Markets in England", *Journal of Social Policy*, 30: 283-306.

KPMG (2010), *Estudio de costes y viabilidad de la prestación de servicios residenciales a personas mayores en régimen de concierto público en Andalucía*, Sevilla: LARES Andalucía.

Le Grand, J. and Bartlett, W. (eds.) (1993), *Quasi-Markets and Social Policy*, London: MacMillan.

Le Grand, J. (2003), *Motivation, Agency, and Public Policy*. *Of Knights & Knaves, Pawns & Queens,* Oxford: Oxford University Press.

Le Grand, J. (2007), *Delivering Public Services through Choice and Competition: The Other Invisible Hand*, Princeton: Princeton University Press.

León, M. (2011), "Ideas, políticas y realidad: análisis crítico de la Ley de Dependencia", *Papeles de Economía Española*, 129: 170-181.

Levin, H. M. (1992), "Market Approaches to Education: Vouchers and School Choice", *Economics of Education Review*, 11: 279-285.

López, G. (2011), "La ley de Autonomía y dependencia. Reflexiones y recomendaciones para su mejor desarrollo", *Gaceta sanitaria*, 25, (Supl. 2): 125-130.

López G. and del Pozo R. (2010), "La protección social de los problemas de dependencia en España". *Documentos de trabajo CRES-Fundación CASER*, N.º 1.

Meagher, G. and Szebehely, M. (eds.) (2013), *Marketisation in Nordic eldercare: a research report on legislation, oversight, extent and consequences*, Stockholm: Department of Social Work, Stockholm University.

Meinow, B.; Parker, M. G. and Thorslund, M. (2011), "Consumers of eldercare in Sweden: The semblance of choice", *Social Science & Medicine,* 73: 1285-1289.

Ministerio de Sanidad, Política Social e Igualdad. (2011), *Informe del gobierno para la evaluación de la Ley de promoción a la autonomía personal y atención a las personas en situación de dependencia*, Madrid: Ministerio de Sanidad, Política Social e Igualdad.

OECD/European Commission (2013), *A Good Life in Old Age? Monitoring and Improving Quality in Long-term Care.* Brussels: OECD Health Policy Studies, OECD Publishing, http://dx.doi.org/10.1787/9789264194564-en (Accessed 06/03/2014).

Pavolini, E. and Ranci, C. (2008), "Restructuring the welfare state: reforms in long-term care in Western European countries", *Journal of European Social Policy,* 18, 3: 246-259.

PriceWaterHouseCoopers. (2010), *Situación del Servicio de Atención Residencial en España*, Madrid: PriceWaterHouseCoopers.

Randal, G. E. and Williams, A. P. (2006), "Exploring limits to market-based reform: Managed competition and rehabilitation home care services in Ontario", *Social Science & Medicine,* 62: 1594-1604.

Rostgaard, T. and Szebehely, M. (2012), "Changing policies, changing patterns of care: Danish and Swedish home care at the crossroads", *European Journal of Ageing*, 9, 2: 101–109.

Tortosa, M. A. and Granell, R. (2002), "Nursing home vouchers in Spain: the Valencian experience", *Ageing & Society*, 22: 669-687.

Tortosa, M. A.; Fuenmayor, A. and Granell, R. (2011), "Evaluación de costes y financiación de las residencias de mayores. El sector no lucrativo en la comunidad valenciana. LARES C. V." *Informe Portal Mayores IMSERSO*, diciembre, 136.

Tribunal de Cuentas (2013), *Informe de fiscalización de la gestión económico-financiera y de la aplicación de la Ley 39/2006, de 14 de diciembre, de promoción de la autonomía personal y atención a las personas en situación de dependencia*, n.º 977, Pleno de 21/03/2013. http://www.tcu.es (Accessed 20/01/2013).

Tribunal de Cuentas (2014), *Informe de fiscalización sobre las medidas de gestión y control adoptadas en las comunidades autónomas para la adecuada aplicación de la Ley 39/2006 de 14 de diciembre, de promoción de la autonomía personal y atención a las personas en situación de dependencia*, n.º 1035, aprobado el 29 de Mayo de 2014.

Resumen

El sistema español de cuidados de larga duración está en peligro, por ello planteamos cambiar la financiación de residencias de mayores. Utilizamos como ejemplo el extremadamente complejo sistema de financiación de residencias de personas mayores de la Comunidad Valenciana. En esta región, hay muchos mecanismos de financiación: dos tipos de subvenciones, dos planes de accesibilidad, un sistema de bonos y la prestación vinculada al servicio. Evaluamos estos métodos a través de la teoría de los cuasi-mercados. Encontramos que estos mecanismos producen un impacto negativo en la equidad, la eficiencia y la libertad de elección, y proponemos un método homogéneo de financiación para todas las residencias de personas mayores a través de bonos.

Palabras clave: cuidados de larga duración, residencias de ancianos, cuasimercados, bonos.

Clasificación JEL: H44, H53, I38.