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The Spanish long-term care system in transition: Ten years since the 2006 Dependency Act[☆]



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ABSTRACT

At the end of 2006, a new System for Promotion of Personal Autonomy and Assistance for Persons in a Situation of Dependency (SAAD) was established in Spain through the approval of the Act 39/2006 of 14th December (the Dependency Act, DA). The DA acknowledged the universal entitlement of Spanish citizens to social services. The recent economic crisis added degrees of uncertainty to several dimensions of the SAAD implementation process. Firstly, the political consensus on which its foundation rested upon has weakened. Secondly, implementation of the SAAD was hampered by several challenges that emerged in the context of the economic crisis. Thirdly, the so-called “dependency limbo” (i.e. the existence of a large number of people eligible for benefits but who do not receive them) has become a structural feature of the system. Finally, contrary to the spirit of the DA, monetary benefits have become the norm rather than a last resort. High heterogeneity across regions regarding the number of beneficiaries covered and services provided reveal the existence of regional inequity in access to long-term care services in the country. Broadly, the current evidence on the state of the SAAD suggests the need to improve the quality of governance, to enhance coordination between health and social systems, to increase the system’s transparency, to foster citizens’ participation in decision-making and to implement a systematic monitoring of the system.

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1. Policy background

The rapid demographic and social changes in Europe and OECD countries have increased the number of dependents in the last decade, challenging not only the

organization of health care systems but also the re-definition of long-term care services. Thus, the Act 39/2006 of 14th December on Promotion of Personal Autonomy and Assistance for Persons in a Situation of Dependency (Dependency Act or DA) was passed to create a new System for Promotion of Personal Autonomy and Assistance for Persons in Situation of Dependency (SAAD) [1]. The DA granted universal entitlement to social services with eligibility set on the basis of degree of dependency. This entailed such a large-scale structural change in organizing long-term care (LTC), that it was coined as the building of Spain’s Welfare State’s fourth pillar [2].

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1.1. Content of the Dependency Act: main features of the SAAD

The main features of the SAAD prescribed by the DA are: public funded provisions; effectively equal, non-discriminatory universal access for all dependents; commitment to organize services to allow beneficiaries to remain in their community/environment of reference whenever possible; and assurance of services' quality, sustainability and accessibility. Despite the SAAD's design to provide universal coverage to dependents, users still share the associated costs through co-payments. The economic memorandum of the DA estimated that, on average, a third of the financing contribution towards the SAAD would correspond to users' co-payments [3]. The magnitude of the co-payment varied according to the economic situation of the beneficiary with sharp differences across regions [4].

Launched in 2007, the SAAD's implementation was conceived as a stepwise process: starting with particularly vulnerable individuals with higher degrees of dependency (i.e. severe dependents) and progressively extending coverage to moderate and mild dependents. The procedure to assess applicants and its ability to identify eligible beneficiaries and to determine their needs are the cornerstones of the system. Three levels of dependency were defined by the DA (mild, moderate, severe) with dependents ranked according to an official scale (originally published in BOE (Boletín Oficial del Estado) 2007 [5] and slightly revised in BOE 2011 [6]). This scale considers 47 tasks grouped into ten activities (eating and drinking, control of physical needs, bathing and hygiene, other physical care, dressing and undressing, maintaining one's health, mobility, moving inside the home, moving outside the home, and housework). The final score is the sum of the weights of the tasks for which the individual has difficulty, multiplied by the degree of supervision required and the weight assigned to that activity. Depending on the final sum of the weight obtained, the degree of dependence is determined as: between 0 and 24 points, not eligible; 25–39 points, mild level 1; 40–49 points, mild level 2; 50–64 points, moderate level 1; 65–74 points, moderate level 2; 75–89 points, severe level 1; and 90–100 points, severe level 2.

The DA did not specify the intensity of services. This point was developed in subsequent legislation. For example, the Royal Decree 727/2007 determined that the intensity of home help service should be between 70 and 90 monthly hours for severe-level 2 dependent people, 55–70 monthly hours for severe-level 1 dependent people, 40–55 for moderate-level 2 dependent people and 30–40 for moderate-level 1 dependent people [7]. Subsequent regulations eliminated existing levels within grades and reduced the intensity of in-kind and cash benefits [8].

The 17 autonomous regions (Autonomous Communities, ACs) are responsible for the provision of benefits and services established by the DA. The Ministry of Health, Social Policies and Equality (MSPSI) sets a threshold of minimum services and benefits for allocation to eligible people dependent upon degree of dependence. Additional resources are provided by each region to complement contributions made by the national government.

The DA designs a system for autonomy and dependency care consisting of a minimum level of protection established by the state, and an additional level of protection funded exclusively by the ACs. The economic memorandum of the Law indicated that in 2015, when the SAAD was fully operational, the financial contributions would be 42.6% by the ACs, 23.7% by the central government and 33.7% by the beneficiaries through co-payments. The percentage corresponding to ACs (42.6%) included 1,777 million euros that regional governments had previously used to cover dependency care before the DA enactment [3].

2. Impact of the financial crisis on implementation of the SAAD

The 2008 financial crisis and its recessive economic aftermath have taken a toll on the SAAD. The initial forecasts were altered by several royal decree laws (RDLs) enacted over the following years (see details below). The implementation of austerity policies hampered the planned progressive implementation of the SAAD in its very early stages as follows:

1. *Public expenditure contraction*: the SAAD is mainly funded by general taxes. Since the economic crisis greatly affected the general state tax revenues (decrease of 30% from 2007–2010) [9], most public services, such as dependency, education and health, were likewise affected [10]. Consequently, data reported by the Spanish Dependency Care Observatory shows decreased annual public spending per SAAD user from 8,648 euros in 2009 to 7401 in 2011 and 6879 in 2013 (latest data available) [11]. In fact, estimates from the State Association of Social Services Directors and Managers [12] found an accumulated budget cut of 2,865 million euros for the SAAD from 2012–2015. Simultaneously, the estimated annual co-payment per user grew from 961 euros in 2009 to 1,614 in 2013 [11]. Critics suggest that the DA's equity principle is not met with the current, regressive model of cost-sharing. The lower-middle incomes are supporting proportionately more payments than the upper middle-incomes [13].
2. *Decrease in services intensity*: The RDL 20/2012 was particularly relevant in reducing the intensity (hours) of home help support which raised concerns about the sufficiency of those services, particularly for major dependents [14]. Furthermore, conditions for entitlement to monetary benefits for family care hardened parallel to a 15% reduction in allocated funding [11].
3. *"Stagnation" of actual access to benefits*: The initial forecast regarding access to benefits for dependents was altered by several enacted RDLs over the years. First, the RDL 20/2011 blocked all requests for evaluating level 2 moderate dependents that were not evaluated before the end of 2011. This caused a two-year delay in the DA application, and a one year delay for mild level 1 dependents (unable to request benefits until 2014). Afterwards, the RDL 2/2012 on State Budget [15] rendered mild dependents (level 1 and 2) unable to request any benefits until 2014. Finally, the RDL 20/2012 on "urgent measures to ensure NHS's sustainability and to

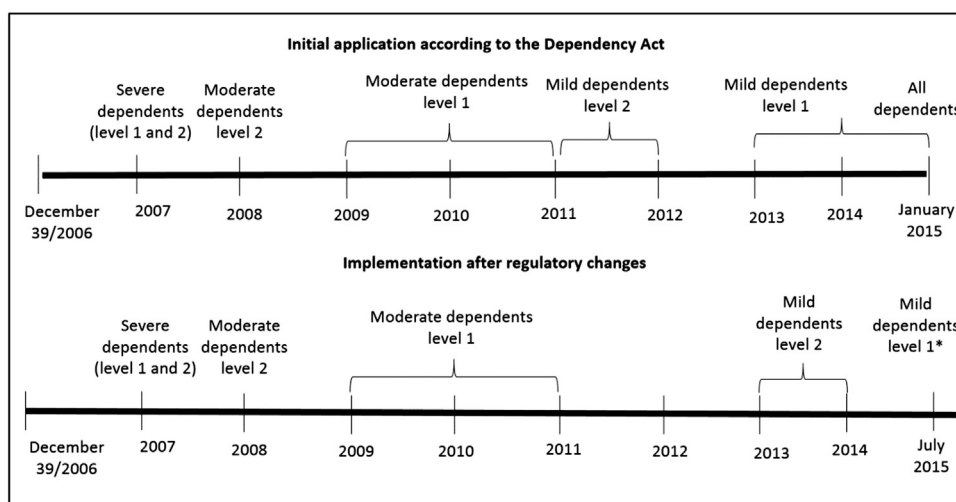


Fig. 1. Implementation of the Dependency Act. * Mild dependents level 1 have entered the system in July 2015. However, no transition period (i.e. the period of time during which all mild dependents level 1 should be covered by the SAAD) has been established, as for other categories of dependents in the previous years.

improve the quality and safety of its services” [8] implied another delay in access for moderate dependents classified within level 1 until July 2015 (see Fig. 1). Another notorious consequence is the “dependency limbo”: individuals officially assessed as entitled to benefits who have not actually received any (in-kind or monetary) provisions. The number of positive entitlement assessments more than doubled from 2008 to 2010 to over one million official beneficiaries (see Fig. 2). Meanwhile, those waiting in the “dependency limbo” grew to over 300,000 people in 2011. However, since 2012, this figure has more than halved because of the attrition rate. Entitled beneficiaries who died (often before receiving any benefits) largely outnumber the new waiting plaintiffs [11]. This situation grew cumbersome in July 2015 when the SAAD’s implementation reached the second planned step: the inclusion of people assessed as moderate dependents. As a result, the size of the “dependency limbo” increased by nearly 434,000 dependents [16].

The extended coverage has repopulated the “limbo” and forced the SAAD to unsustainably provide services for new users (mild dependents) with decreasing resources.

4. *Shifting the benefits basket’s composition:* contrary to the spirit of the DA, the monetary benefits have become a usual practice. In October 2015, 63% of social services consisted of in-kind services and 37% were financial benefits [16]. The cause is closely related to the economic crisis. From the funder’s perspective with severe budgetary constraints, cash benefits are more affordable than investing or contracting out for service provisions. From the families’ perspective, cash benefits are preferred because: (i) they represent income entry for the household (high unemployment rate and 770,000 households with no income entry) and (ii) families do not have to bear the co-payment for in-kind services. However, an unintended consequence of cash benefits for family care is lower than planned job creation in the social services sector [4,17].

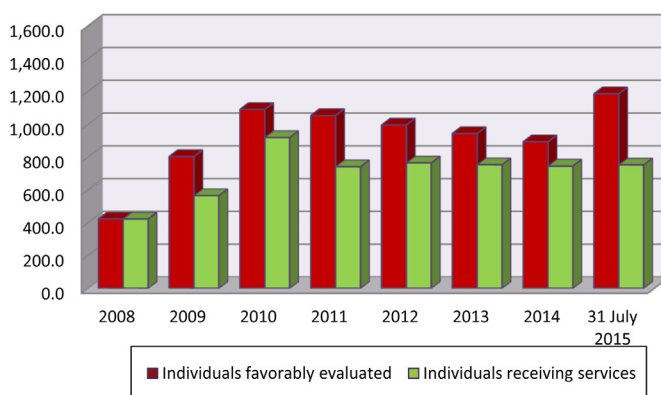


Fig. 2. Evolution of the number of individuals favourably evaluated and number of individuals receiving social services, in thousands (2008–2015). Source: Data from IMSERSO [16].

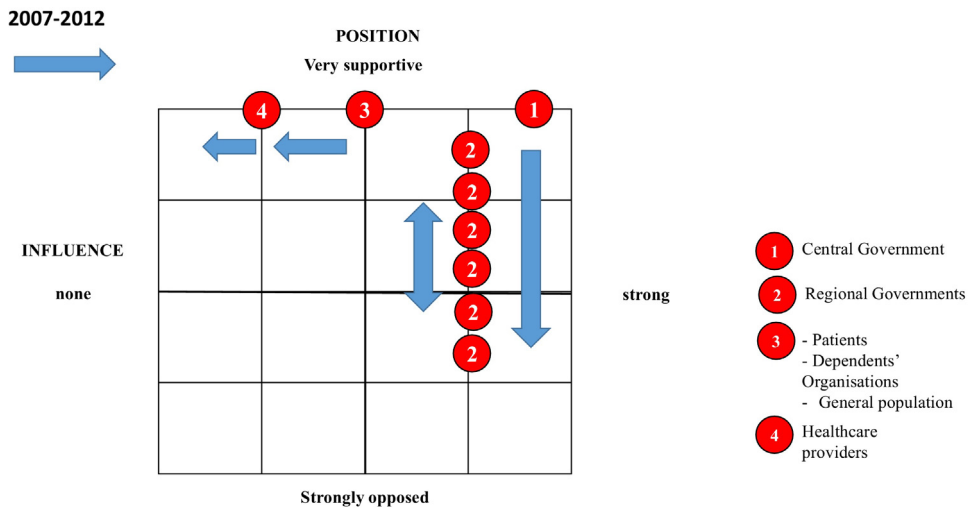


Fig. 3. Position of stakeholders and their influence at the origin of the SAAD. Note: Regional governments are captured by several positions within the graph, reflecting the geographical heterogeneity in their support to the SAAD, which varies from region to region.

3. Stakeholders position

Stemming from the PSOE’s (Social Democratic Party) 2004 election program, the DA was passed in their second year of government (PSOE, 2004) through a pact with the opposition (PP-Conservative Party). The Act received wide support within Parliament [18]. Organizations representing dependents (e.g. UNAF, FEAPS, CEOMA, CERMI) were strongly supportive of the DA (see [19]) despite some groups’ reluctance to face co-payments [20]. In 2006, the DA had the general citizens’ endorsement with 9/10 citizens (87.8%) approving that informal carers be recognized as employed with a salary and Social Security coverage [21]. Some ACs thought the DA violates regional competencies (e.g. Basque Country) [18]. Providers’ influence over the SAAD was scarce, but their support remains high over time.

However, the political change and associated cuts following the economic crisis broke the initial political consensus. Major political parties prioritized other social policies (e.g. pension benefits) over the SAAD [22]. The initially strong patients’ influence on the creation of the SAAD has decreased.

Hence, changing stakeholders’ positions have delayed DA enforcement through the lack of expected funding from the central government and the heterogeneity in the implementation of the SAAD across regions (e.g. some ACs have fully applied the law while others do not prioritize it in their agendas) (Fig. 3).

4. Preliminary outcomes

Nine years since its implementation, the system exhibits both several strengths and many weaknesses (see Box 1). First, the baseline projections misestimated the number and relative proportion of beneficiaries [14]. In October 2015, the actual people entitled as ‘severe dependent’ reached around 348,000, while initial projections estimated 252,000. Projections for people in ‘mild status’ were

Box 1: Strengths and weaknesses associated to the SAAD	
Pros – strengths	Cons – weaknesses
Recognition of universal access to dependence care	Financial shortfall
The gist of the Act: promoting personal autonomy	Lack of coordination between the Central Administration and ACs
Entry of an important number of individuals into the system	Large heterogeneity on its implementation across ACs
	Excessively focused on economic aids
	Existence of a “dependency limbo”
	Doubts on the coordination among health care and social services
	Absence of rigorous evaluation of the system

overestimated (around 648,000 vs. an actual 382,000) (see Fig. 4) [8,14]. Of assessed individuals, 29% are classified as ‘severe dependent’ and 38% as ‘moderate dependents’ [16]. These proportions are well beyond those found in other European countries [8,14,23].

Second, the proportion of above 65 year olds receiving social services (i.e. domiciliary care, day care, nursing home care) peaked in 2012 and declined afterwards. Only the proportion of people receiving telecare has continuously increased, doubling from 2008–2014 [16].

Additionally, the private insurance market for dependents in Spain continues to be irrelevant. In 2014, only 35,074 people (0.08% of the Spanish population aged 18 and over) subscribed into private insurance [24].

Moreover, the SAAD is characterized by high heterogeneity across regions in terms of the number of beneficiaries covered and services provided [16]. Firstly, waiting lists for social services vary by region from 10% of the total individuals entitled to benefits to over 40% [25].

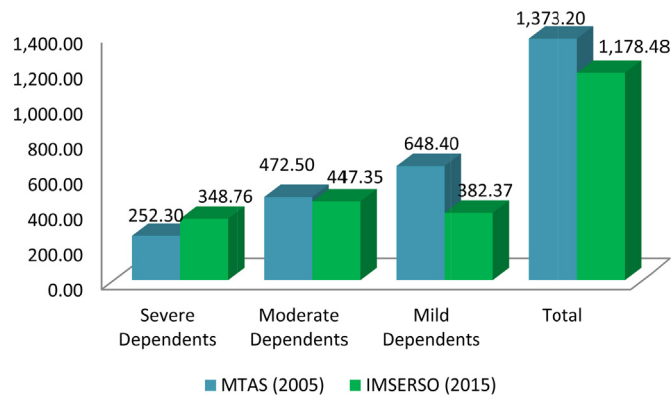


Fig. 4. Comparative figures of the initial expectations of the number of beneficiaries for 2015 and the current number of beneficiaries by level of dependency (in 1,000 people).
Source: Data from MTAS [4] and IMSERSO [16].

Secondly, the provision of public residential services oscillates from 2.44 places to 0.57 per 100 individuals. Likewise, the intensity of home aids ranges from 35.86 to 6.39 weekly hours. In fact, several regions have not provided any home aid services since the DA's implementation [16].

In 2013, the National Association of Directors and Managers of Social Services developed a performance index to measure the degree of deployment of social services in each region [26]. According to this index, the social services deployment is classified as inadequate or irrelevant in 8 out of 17 regions. Only 3 regions reached a medium-high level of performance, resulting in large differences relate to extreme disparities in social services expenditure across regions. For instance, the public expenditure in social services per inhabitant in the Basque Country is four times higher than in the Balearic Islands [25].

Additionally, inequity in access to long-term care services was already documented during the early stages of the DA's implementation (2007–2008). Comparisons of utilization in long-term care benefits across the socio-economic spectrum found the use of professional services concentrated among economically better-off groups while utilization of intensive informal care was concentrated among those worst-off [27]. Unfortunately, no up-to-date evaluation is available to assess changes in citizens' inequitable access to the SAAD benefits.

A minimum set of core management data (number of applicants, resolutions made, number of benefits and type) is published monthly by the MSPSI. This data is insufficient to determine strengths and weaknesses of the system. As a result, a proper evaluation of the SAAD's performance is still pending. Thus, the evaluation of the SAAD and the identification of successes (and failures) are particularly relevant given that the aim of social services is to promote personal autonomy (not only the attention of dependency). Simultaneously, the NHS is responsible for protecting population health (not only the attention of the disease). Both systems share common goals that would benefit from coordinated action [28–30]. At the time of writing, evidence suggests that several ACs are working towards these goals, but evaluation and dissemination of these experiences are almost unknown in Spain [31].

5. Conclusion

The creation of the SAAD has led to improvements in dependent peoples' rights in Spain. Despite great expectations during its creation nine years ago [19,21], the SAAD failed to meet them.

In 2013, dependency funding reached 0.65% of GDP (71% from public resources and 29% from household resources) [32]. These figures are lower than other European countries [33]. The financial inadequacy, intensified by the economic crisis that has accompanied the system since its inception [11,14,25] has brought many unforeseen problems to the SAAD's implementation. The dependency limbo, the predominant use of cash benefits, and the regressive co-payment system reflect that. Additional shortcomings include the lack of systematic evaluation of the quality of services provided, and the lack of benchmarking between different programs and between provision models across regions.

A weak private insurance market for dependency, the uneven development of the SAAD between regions, and the lack of coordination between central and regional governments show the varying levels of priority political actors give towards promoting the personal autonomy and attention to people with long-term care needs. Also, the lack of transparency in both systems and a lacking culture of accountability towards citizens makes the evaluation and dissemination of experiences clearly insufficient [34].

Altogether, the current state of the SAAD indicates the need to improve financial resources, the governance system quality, the coordination between health and social systems, system transparency, participation of citizens in decision-making and continuous overall system evaluations.

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