



Is access to long-term care services unequitable? The Spanish case

by *Pilar García-Gómez, Cristina Hernández-Quevedo, Dolores Jiménez-Rubio and Juan Oliva-Moreno*



There are large differences in the way European countries organise their long-term care (LTC) system, as well as in their spending: while half of the EU-27 countries spent less than 1% of their Gross Domestic Product (GDP) on LTC in 2010, Nordic countries and the Netherlands spent more than 3% of their GDP in the same year. Notwithstanding these differences, spending on LTC is expected to increase sharply between now and 2040 in all European countries (see Figure below from the [European Commission](#)).

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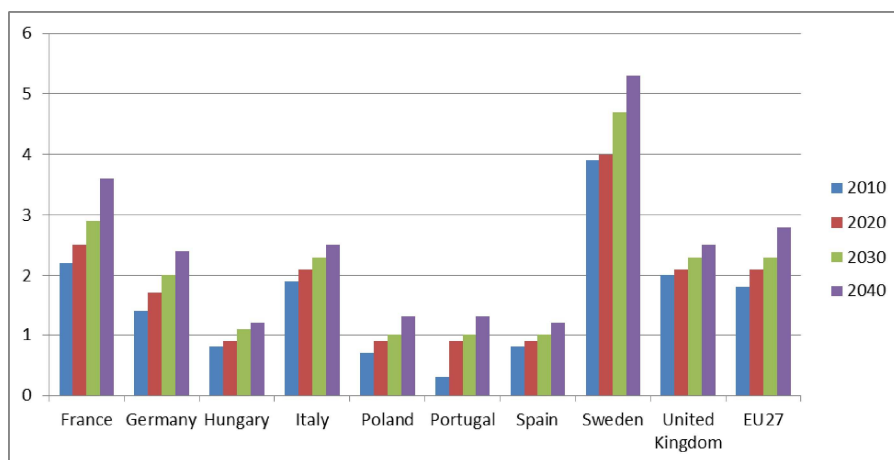


Figure 1. Total public spending on LTC as a % GDP (2010 – 2040 projections in Spain, EU 27 average and selected countries) (Source: European Commission)

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Furthermore, over the next few decades the population of Europe will contain a much greater share of older people. In particular, the proportion of population over age 65 will double in the next 40 years as a consequence of the baby boomer generation reaching retirement age. In particular, the proportion of very old (over 80 years) in the total population, who constitute the main users of long-term care, **will rise from 4.1% in 2005 to 6.3% in 2025, and to 11.4% in 2050.**

Is the access to LTC services equitable?

While the egalitarian objective defined as “equal access for equal need” is part of the policy agenda for most European countries, the ageing of the population is posing challenges not only to gaining access to health care systems but also to LTC services. Moreover, it is likely that barriers are not distributed equally among socioeconomic groups, so people with high levels of education and financial safety may experience lower entry barriers to LTC services than those with low levels of education and income. An inequitable geographic distribution of LTC services, and differences in either the care of patients or in the needs and demand of health and LTC services by levels of income and education may be behind this potential gap.

In Spain, the Dependency Act was approved in 2006 providing universal access to LTC for those with certain a degree and level of dependency. The implementation of the new system was designed to be progressive by degree and level of dependency, although at the time of writing, only the population with the highest degree of dependency is entitled to receive public LTC. While expenditure in LTC has been estimated to increase over time in Spain (see Figure above), the percentage of GDP spent in LTC is much smaller than in other European Member States (0.8% of GDP in 2010, with strong regional disparities).

The Spanish SAAD

The Spanish National Health Service provides universal coverage, with some minor geographical differences in the benefits package. At the end of 2006, a new National System for Autonomy and Assistance for Situations of Dependency (SAAD) was established in Spain through the approval of the Promotion of Personal Autonomy and Assistance for Persons in a Situation of Dependency Act (Act 39/2006 of 14th

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December). Until then, Spanish levels of social protection expenditure on LTC were extremely low compared to the rest of Europe, with no universal coverage. The provision of benefits and services established by the 2006 Dependency Act is the responsibility of Spanish regions. The Ministry of Health, Social Policies and Equality sets a threshold of minimum services and benefits that should be allocated to eligible people, depending on their degree of dependence. Additional resources can be provided by each region to complement the contributions made by the national government.

The level of dependency establishes the level of coverage and the timing of the service delivery. Three degrees of dependency (moderate, severe and major) and two levels of dependency were defined by the Dependency Act, with citizens who apply for coverage being ranked according to an official scale. The implementation of SAAD was designed to be gradual. According to the [schedule in the Act](#), from 1 January 2007, only those with the highest dependency degree (major dependents) would receive the corresponding services, and the last group (least severe moderate dependent) would be covered from 1 January 2013. There have been a large number of delays in assessing and implementing effective service delivery or financial assistance, so since 2007 only those with the highest degree of dependence have been covered by the Act in practice. This does not mean that other people with less severe levels of dependency were not receiving LTC, either because they were receiving them from the social services before the enactment of the Act, or because these services were privately financed. According to data for March 2015, there are 742,813 dependents receiving some type of support (either monetary or in kind) in Spain, with moderate dependents still excluded from universal coverage.

What does the evidence tell us?

We made the [first attempt to evaluate the level of income-related inequity in the access to LTC services](#) (rather than health care) in Spain, based on 2008 data. Findings are not very encouraging, suggesting the existence of horizontal inequity in access to LTC services, both in terms of use and unmet needs across socioeconomic groups for long-term care. In particular, formal care appears to be disproportionately concentrated among the rich, while unmet needs and intensive unpaid care seems to be concentrated among the relatively less well-off.



Beneficiaries of LTC services (major dependents) seem to experience relatively higher pro-rich inequity in the use of formal services in 2008. This implies that, despite enjoying universal LTC services, the well-off major dependents are more likely to access LTC formal services than the worse-off peers.

Some challenges ahead

While there are 742,813 individuals receiving some type of support, according to March 2015 data, **880,186 impaired individuals** are entitled to receive any aid. This gap is known as “dependency limbo” and persists since the onset of the SAAD. Over time, the dependency limbo has been reduced. In 2011 (March), for example, there were **1,058,072 dependents** with the right to receive support and 696,366 people receiving some form of support effectively. The number of individuals with the right to support has also been substantially reduced. Sadly, the explanation of this trend is not due to improvements in the coverage but to the fact that major dependents are very old, with bad health and with a high rate of mortality. While they die, there are low numbers of people entering the system (new severe dependents, given that entry by dependents with moderated needs has been paralysed).

From July 2015 onwards, it is expected that the inclusion of dependents with moderate needs in the system will be allowed. However, there is no additional budget allocated to cover their inclusion. With approximately 150,000 dependents defined as major/severe, who do not have access to LTC services, the 4th pillar of the welfare state crumbles.

While the current evidence is useful as a first step in understanding the association between income and the use of several LTC services and unmet needs, caution is needed when generalizing the results to other countries due to differences not only in the amount spent on public and private LTC but also on how it is organized, as well as social and cultural elements that play a key role in how societies arrange LTC. However, the Spanish example may be relevant for European countries that have not yet established comprehensive national programs in LTC such as Italy in Southern Europe and Poland and Hungary in Central Europe.



Further policy efforts focused on children, youth and adults to enjoy a longer life expectancy in good health as well as relying on an intersectoral approach (involving other sectors such as education, employment, housing, environment, etc.), may be pertinent in this context. Improvements to facilitate the integration between the health and LTC systems, with special attention to unpaid care, may be relevant to enhance the efficiency and equity in the joint provision of both types of care in Europe.

Further information

García-Gómez P, Hernández-Quevedo C, Jiménez-Rubio D, Oliva-Moreno J (2015) [Inequity in long-term care use and unmet need: Two sides of the same coin](#), *Journal of Health Economics*, 39, 147–158.

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