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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.

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