ACCESS TO LONG-TERM CARE SERVICES IN SPAIN REMAINS INEQUITABLE

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Summary: Population ageing poses challenges not only for access to health care systems but also to long-term care (LTC) services. Spain’s Dependency Act (2006) provides universal access to LTC for those with certain levels of dependency. However, evidence suggests horizontal inequity favouring the well-off, especially for those with severe needs. These findings are particularly relevant for countries which, like Spain, have not yet fully developed national LTC services. Investing now in health policy efforts to improve longer life expectancy in good health appears to be the best way forward but requires complex coordination between social and health services.

Keywords: Disability, Dependency, Long-term Care, Unmet Need, Equity, Spain

Introduction

European countries present large differences in the way long-term care (LTC) is organised, as well as in 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 a 3% in that year. These figures probably will increase sharply in the next decades (see Figure 1). Although the baseline is very different between countries and there is a degree of uncertainty in the way the health status of their populations will evolve in the near future, ageing of the population will not only challenge the organisation of health care systems but will also imply a redefinition of LTC systems in the years to come. LTC expenditures will be affected not only by the percentage of the population over 65 years and their relative health, but also by the institutional characteristics of the LTC system, including its organisation, the trade-off between formal and informal care and the availability of support for the latter type of care. In this context, Spain is not an exception, with 3.85 million people living in households reporting a disability or limitation, which implies a rate of 85.5 per 1000 inhabitants.

Moreover, the egalitarian objective defined as “equal access for equal need” for basic services is part of the policy agenda for most European countries. This implies that, for the same level of need, there should not be differences in the access to health care services by socioeconomic conditions, race or sex. The World Health
Organization defines horizontal equity in the access to health care services as an instrumental tool to achieve health improvement, as well as to favour the reduction of inequalities in health by socioeconomic status.

A wide range of studies provide evidence on equity in access to health care services in the adult population within and across European countries, measured in terms of use of health care services and unmet needs of health-related services. However, the level of equity in the use of health and LTC services by older and disabled people still remains a “black box”, even if those individuals are the greatest consumers of care services and possibly, those who face more difficulties in accessing them.

Is access to LTC services equitable?

A crucial issue facing health policymakers in Europe is to understand how access to LTC services is distributed across socioeconomic groups among the impaired population. 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 a lower level of entry barriers to LTC services than those with low levels of education and income. Among other reasons, this could be related to an inequitable geographic distribution of LTC services, to differences in the treatment of patients on the basis of socioeconomic status, or to the existence of differences in the demand for health and social care services among patients with different levels of income and education.

Spain provides an interesting context to investigate potential inequities in access to LTC services. In 2006, a new Dependency Act was approved, recognising the universal right of the dependent population to receive services. The implementation of the new system was designed to be progressive, although at the time of writing, only the population with the highest level of dependency is entitled to receive public LTC. While expenditure on LTC has been estimated to increase over time (see Figure 1), the percentage of GDP spent on LTC in Spain is much smaller than in other European Member States. The most recent data for Spain show that spending on LTC accounted for 0.8% of GDP in 2010 (Figure 1), with strong regional disparities.

The Spanish context

The Spanish National Health Service (NHS) provides universal coverage, with some minor geographical differences in the benefits package. Health competences were totally transferred to the 17 autonomous regions in 2002. Health expenditure in Spain reached US$ 2987 purchasing power parity (PPP) per capita and 9.3% of GDP in 2012. Most health expenditure (71.7%) is derived from public sources (mainly from taxation) and predominantly operates within the public sector.

In contrast, at the start of the new century, Spanish levels of social protection expenditure on LTC were extremely low compared to the rest of Europe. Coverage was not universal; a large share of LTC expenditure was funded directly by households (dependent person and his/her family), with a high level of co-payments and a larger role for informal care. Informal caregivers only received a very low (almost non-existent) formal remuneration, and social protection was weak. The role of the family in this context was highly significant, being the main safety net to cover the needs of people in situations of dependency. Public social services were provided in very specific circumstances, including: when the family did not exist or was no longer available due to the large burden accumulated by caregivers, and when economic capacity was not sufficient to pay for formal professional care. However, demographic projections, coupled with social changes that have occurred in recent decades (e.g. reduction in family size and increasing participation of women in the labour market) seriously threatens the future sustainability of this system.

In this context, at the end of 2006, a new National System for Autonomy and Assistance for Situations of Dependency (SAAD) was established through the approval of the Promotion of Personal Autonomy and Assistance for Persons in a Situation of Dependency Act (Act 39/2006 of 14th December). Social benefits are recognised by the Act under equal conditions for all disabled people, including older people who fall within this group, and who need help carrying out basic daily living activities. The autonomous regions are responsible for the provision of benefits and services established by the Dependency Act. 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

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

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The implementation of SAAD was designed to be gradual. According to the schedule in the Act, from 1st January 2007 only those with the highest dependency degree (major) were to be provided with the corresponding services. Only individuals in their lowest degree of dependency (minor) were declared as ‘dependency limbo’ and were required to receive some sort of aid. This gap is known as “dependency limbo” and has persisted since the application of the Dependency Act.

What does the evidence tell us?

A first attempt to evaluate the level of income-related inequity in the access to LTC services (rather than health care) in Spain has been recently published, 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 LTC. In particular, formal care appears to be disproportionately concentrated among the rich, while unmet needs and intensive use of informal care services (at least four hours per day of informal care) seems to be concentrated among the relatively less well-off. Moreover, beneficiaries of LTC services (those with major dependency) seemed to experience relatively higher pro-rich inequity in the use of formal services in 2008. This implies that, despite universal LTC services, those who are well-off and have major dependency are more likely to access LTC formal services than their peers who are worse-off.

Analysis of the distribution of utilisation and unmet needs across socioeconomic groups for LTC services shows that there is evidence of horizontal inequity in access to LTC services. In particular, high levels of pro-rich inequity are found for the use of community care services and for home care services, including privately provided services. This may be related to the existence of access barriers for poorer individuals in terms of both availability (e.g., waiting lists) and the costs associated with these services.

Evidence also suggests that the intensive use of informal care services appears to be disproportionately concentrated on the worse-off, with families acting as safety nets.

Some conclusions and challenges ahead

While the current evidence is useful as a first step to understand the association between income and the use of several LTC services and unmet needs, caution is needed when generalising the results to other LTC systems. Differences in public and private spending for LTC are related to the use of formal and informal services provided in different European countries. These differences depend on the income per capita of the countries as well as on organisational, social and cultural elements surrounding the concept of care and on whether the family or the state is responsible for LTC and how it should be financed. However, current results may be relevant for European countries which have not yet established comprehensive national programmes in LTC. Italy in Southern Europe and Poland and Hungary in Central Europe may also have important access barriers to LTC that are similar to those found in Spain, which might be particularly driven by the role of private funding in LTC for these countries.

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

Currently, there is no conclusive evidence on whether people will age in good or bad health in the future. The large baby boom cohorts will push up social services spending, but the extent and amount of such spending growth will depend on whether or not there will be a compression
of morbidity and disability in older people. This implies that for future generations, it is worth investing now in health policy efforts focused on children, youth and adults to enjoy a longer life expectancy in good health, involving the development of health policies beyond the health care arena and focusing on other sectors (education, employment, housing, environment, etc.) But it also means that research on LTC must fill information gaps, and that coordination of formal (health and social care) and informal care should be improved to enhance efficiency and equity in the joint provision of these services.

References


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Health spending continues to outstrip the economic growth of most member countries of the Organisation for Economic Co-operation and Development (OECD). Pay for performance (P4P) has been identified as an innovative tool to improve the efficiency of health systems but evidence that it increases value for money, boosts quality or improves health outcomes is limited.

Using a set of case studies from 12 OECD countries (including Estonia, France, Germany, Turkey and the United Kingdom), this book explores whether the potential power of P4P has been over-sold, or whether the disappointing results to date are more likely to be rooted in problems of design and implementation or inadequate monitoring and evaluation.

Each case study analyses the design and implementation of decisions, including the role of stakeholders; critically assesses objectives versus results; and examines the “net” impacts, including positive spillover effects and unintended consequences.

With experiences from both high and middle-income countries, in primary and acute care settings, and both national and pilot programmes, these studies provide health finance policy-makers in diverse settings with a nuanced assessment of P4P programmes and their potential impact on the performance of health systems.