Catalan Long-Term Care system reaches the majority of age: What have we learned?

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Abstract

Almost 20% of the Catalan population is aged 65 years or older. By 2050, this percentage is estimated to reach 29%. In addition, this population cohort is associated with the longest life expectancy among OECD countries, yet only half of the total life expectancy at 65 is expected to be healthy life expectancy (OECD, 2024). Far from healthy ageing, in 2021, around 66% of the Spanish elderly do not self-rate their health as good or very good, and 49% report limitations in carrying out activities of daily living.

In this context, the Long-Term Care (LTC) system—representing the fourth pillar of the welfare state—is being consolidated, reaching the majority of age. The first goal of this communication is to present the main features of the system and compare and contrast it with European counterparts. Secondly, we aim to provide the main insights learned from a diverse range of system's analyses.

With respect to the financial sustainability of the Spanish LTCS, underfunding and suboptimal design has increased the burden on families through higher co-payments. Despite this limited capacity, it has been remarked on the significant economic impact through job creation. Regarding the effects of Spanish LTCS on beneficiaries and their families, the introduction of Spanish LTC has reduced hospitalizations, primarily driven by conditions that could be avoided if LTC is adequately provided. In addition, LTC benefits have reduced the level of savings, increased the supply of informal caregivers, caregivers' wellbeing and the probability of early retirement among caregivers. Last but not least, research has also analysed the implementation and design of Spanish LTC. While navigating the system is not associated with socioeconomic horizontal inequity, access to different types of benefits (and their mode of provision) shows evidence of socioeconomic horizontal inequity. Furthermore, the COVID-19 pandemic has highlighted critical weaknesses in nursing home care, including underfunding and inadequate staffing, which have contributed to high fatality rates

1. Introduction

Catalonia is one of the regions with the highest life expectancy within the OECD countries. In the period from 1983 to 2020, life expectancy at 65 years has grown from 14.9 years to 19 for men and from 18.1 to 23.1 for women (IDESCAT, 2024). Yet, only half of the total life expectancy at 65 is expected to be healthy. More concretely, 56% of these years for Spanish women and a 44% for men are with an activity limitation (OECD, 2024). Far from healthy ageing, in 2021, around 66% of the Spanish elderly do not self-rate their health as good or very good, and 49% report limitations in carrying out activities of daily living (ADLs[1]) that may require Long-Term Care (henceforth, LTC) (OECD, 2024). Costa-Font, Jiménez, et al. (2022) estimated that 11% of the Spanish population aged 65 or plus have two or more ADLs limitations, and 25% for those individuals aged 85+, aligning with current indicators on receiving LTC: in 2023, 13.3% of those aged 65 and older received some form of assistance, rising to 22.2% for the old-older (those aged 85 and above).

According to the European Commission (2024), LTC refers to "a range of services and assistance for people who, due to mental and/or physical frailty and/or disability over an extended period, depend on help with daily living activities and/or require permanent nursing care". The need for LTC correlates with the number of limitations in activities of daily living (ADLs). Among individuals aged 65+, approximately 28.4% with either one ADL or none require assistance, while nearly 44% of those with three or more ADLs need support. A similar trend is observed in the older cohort, albeit to a lesser extent (Costa-Font et al., 2023).

Historically, LTC was provided by informal caregivers, often women within families (Barber et al., 2021). This is partly because traditional healthcare systems and social affairs interventions usually excluded LTC from standard service packages (Costa-Font & Raut, 2022). However, the demand for Formal LTC has recently increased due to changes in both, the demand and the supply. On the demand side, ageing has increased both the number of people needing LTC and the duration requiring LTC. In Catalonia, currently, 19.5% of the population is aged 65 or older, and 5.8% are aged 80 or older (IDESCAT, 2024) On the supply side, there are two main drivers: the increase in female labour market participation (Charmes, 2019) and “verticalization” of families (Esping-Andersen, 2016), both reducing the supply of carers at the family level.

In this context, the Spanish Government passed the Dependency Act 39/2006 (DA, henceforth) known as LAPAD (*Ley de Promoción de la Autonomía Personal y Atención a las personas en situación de Dependencia*[2]*).* In January 2007, the Spanish LTC system (Spanish LTCS, henceforth), known as the System for Promotion of Personal Autonomy and Assistance for Persons in a Situation of Dependency (SAAD), was implemented prioritising the benefits towards individuals at the highest level of need[3]. Before the DA and the Spanish LTCS, there was a local-level means-tested financial aid for people with LTC needs in Spain (Costa-Font et al., 2023). Consequently, Spain had one of the lowest-spending rates on LTC within the OECD countries at the beginning of the century (OECD, 2005).

[1] Basic ADLs (BADL) or physical ADLs are those skills required to manage one’s basic physical needs, including personal hygiene or grooming, dressing, toileting, transferring or ambulating, and eating. The Instrumental Activities of Daily Living (IADLs) include more complex activities related to the ability to live independently in the community. This would include activities such as managing finances and medications, food preparation, housekeeping, and laundry (Edemekong et al., 2023).

[2] Approved on 15/12/2006, but in force from 1/1/2007 (BOE, 2006).

[3] Nomenclature in English by (Peña-Longobardo et al., 2016).

The Spanish LTCS follows a universal proportionalism criterion, recognizing the public right to receive benefits and guaranteeing access under equal conditions based on need. The goal was to promote the professionalization of care, expand the number of users covered by public funding, and adapt the system to meet their needs. Additionally, the system was intended to become an effective tool for balancing family and work life. The Spanish LTCS represented a significant advancement in social rights legislation, sparking an ongoing debate about whether it should be considered the fourth pillar of the welfare state (Oliva et al., 2023).

The management of the Spanish LTCS is decentralised, with regional governments, known as Autonomous Communities (CCAA), responsible for implementing and administering the system's services. Each regional government has to adapt the national framework to regional needs, offering more tailored care services to better meet the needs of their population. In Catalonia, the regional government of Catalonia, known as the Generalitat de Catalunya, through the Department of Social Rights and Inclusion, manages the allocation of LTC resources.

This 2025 the Spanish LTCS has reached the majority of age. The aim of this document is to present the main insights learnt from the diverse analysis made of Spanish LTCS. In order to put the Spanish LTCS into context, we first describe its evolution, with a specific focus on the implementation in Catalonia. Then, we compare and contrast the system with the LTCS in other European and OECD countries. After this comprehensive contextualization, we focus on the insights learnt from scientific research.

The financial sustainability of the Spanish LTCS, as well as its effects on the economy have been tackled given its magnitude, continuously growing in the ageing context. Del Pozo-Rubio et al. (2022) identified a limited capacity of the system, which authors attributed to underfunding and suboptimal design. This has increased the burden on families through higher co-payments (Del Pozo-Rubio et al., 2017). The Austerity Reforms in 2012 worsened the system’s capacity to deliver the intended benefits to LTC recipients (Oliva et al., 2023). Yet, research has remarked on the significant economic impact of the Spanish LTCS, particularly through job creation. In particular, In-kind services have been observed to outperform cash benefits in generating employment (Del Pozo-Rubio et al., 2022). Costa-Font & Vilaplana-Prieto (2023) also highlighted a gender effect on female labour participation, identifying that increased LTC expenditure is associated with higher female labour participation and reduced healthcare expenditure. Recent shifts towards deinstitutionalization under the Recovery and Resilience Plan (RRP) (Gobierno de España, 2021) are expected to foster job growth and sustainable economic advantages (Bermejo-Patón et al., 2023).

The effects of LTCS on the well-being of beneficiaries have not been studied. This is due to the lack of a system to gather quality-of-life indicators among users, despite being the primary goal of any LTCS. However, Rodríguez-Míguez & Casal (2024) has taken initial steps by translating, adapting and validating the ASCOT toolkit, which enables the measurement of well-being in populations with LTC needs. Furthermore, Costa-Font et al. (2018), Serrano-Alarcón et al. (2021) and Hernández-Pizarro et al. (2024) have used proxy measures for well-being through health and healthcare use outcomes, as health shocks (and their associated healthcare resource use) deteriorates well-being. This approach allows for consideration of the interaction between LTC and healthcare systems, particularly in a context towards integrated care. All these studies conclude that the introduction of Spanish LTC has reduced hospitalizations, primarily driven by conditions that could be avoided if LTC is adequately provided.

As a social protection program, the Spanish LTCS has significant effects on other family-level decisions, such as savings and informal caregiving (Costa-Font & Vilaplana-Prieto, 2017), Costa-Font, et al., 2022). LTC benefits have increased the supply of informal caregivers, increased downstream transfers from parents to children, reduce the likelihood of early retirements among partner and spousal caregivers and lowered the probability of depression among caregivers ((Costa-Font & Vilaplana-Prieto, 2022a) Costa-Font & Vilaplana-Prieto, 2022b).

Las but not least, research has also analysed the implementation and design of Spanish LTC in three key areas. First, it has studied the horizontal (in)equity (Vidiella-Martin et al., 2024): While navigating the system is not associated with socioeconomic horizontal inequity, access to different types of benefits (and their mode of provision) shows evidence of socioeconomic horizontal inequity. Second, unintended strategic behaviour in assessing LTC claimants' needs has been documented, linked to the use of discrete intervals to determine eligibility for LTC benefits (Hernández-Pizarro et al., 2020). Third, the COVID-19 pandemic has highlighted critical weaknesses in nursing home care, including underfunding and inadequate staffing, which have contributed to high fatality rates (Costa-Font et al., 2021, Via i Redons & Prades-Colomé, 2023).

2. The Spanish LTC system: Reaching majority of age

2.1. Gradual implementation

The Spanish LTCS has been designed under proportional universalism, defining three levels of assistance based on the extent of autonomy loss and the requirements for LTC: Grade I (or moderate needs), Grade II (or severe needs) and Grade III (or major needs)[4]. Under common guidelines set by DA, each autonomous community managed the allocation of the benefits for individuals with LTC needs. The implementation of the Spanish LTCS began in 2007 gradually prioritising the allocation of benefits by the level of LTC needs. Grade III was implemented as planned in 2007, followed by Grade II that was implemented from 2008 to 2011[5]. However, deployment of the LTC Grade 1 was delayed for both levels due to the Great Recession, finishing in July 2015[6].

This delayed rollout was not the only mechanism through which the Great Recession affected the Spanish LTCS. In 2010, the implementation of Royal Decree Law 8/2010, aimed at curbing public spending, restricted retroactive payment rights. By that time, the Spanish LTCS had 821,147 individuals entitled to LTC benefits, and 242,194 were waiting for an evaluation (30%). Further austerity measures were implemented in July 2012 under Royal Decree Law 20/2012. This new package of measures promoted a reduction of the benefits' generosity, eliminated levels within grades and delayed the provision of LTC benefits for Grade I until 2015 -which had originally been planned for 2011-. By July 2015, the number of individuals entitled to LTC benefits had risen to 1,186,653, with a corresponding increase in waiting lists, reaching 433,852 (37%). Despite the expansion of eligibility that year to include applicants with moderate LTC

[4] When the Spanish LTCS was implemented, Grades were divided in two levels: level 1) for lower levels of need, and level 2) for people with higher levels of LTC needs within each grade. This levels were eliminated in 2010 (BOE, 2010), aiming to contain the level of public LTC spending.

[5] Grade II - level 2 was implemented in 2008, whereas individuals in grade II - level 1 received the benefit from 2009 to 2011 progressively.

[6] The implementation of Grade I (level 2), initially planned to progress between 2011 and 2012, was postponed to the period between 2013 and 2014. Meanwhile, Grade I (level 1), which was scheduled for deployment from 2013 to 2015, was not fully implemented until July 2015 without a transition period.

needs, the growth in beneficiaries remained constrained due to ongoing budget limitations (Oliva et al., 2023). In April 2019, a significant policy shift occurred with the re-introduction of state-sponsored social security contributions for informal caregivers in Royal Decree Law 8/2019, removed earlier. Initially, the Dependency Act (DA) promoted these contributions to support informal caregiving, but austerity measures, particularly the *Resolution of July 13, 2012*, led to their suspension.

Furthermore, Spanish LTCS was hit in 2020 by the COVID-19 pandemic. This shock had a profound impact on the Spanish LTCS unravelling systemic vulnerabilities (Bermejo-Patón et al., 2023). High mortality rates, especially within residential care homes, exposed the fragility of care provider organisations. The main causes of the system's frailty were linked to the lack of coordination between the healthcare and LTC systems and workforce deficiencies (widespread understaffing across many facilities and precarious working conditions for workers and a critical). The pre-pandemic growth of the sector, without addressing its underlying limitations, left the system unprepared and fragile.

To overcome the system's deficiencies, which were magnified by the Covid19 pandemic, the government published the Recovery and Resilience Plan (Gobierno de España, 2021). RPP was an expansive plan that affected many economic sectors, including LTC. The objective of the plan was to create a multiplier effect, stimulating the economy as identified by Bermejo-Patón et al. (2023). Main objectives regarding LTC were to 'deinstitutionalize' the Spanish LTCS, reduce waiting lists, enhance the quality of professional services and working conditions, and increase the coverage of benefits, all with a 'person-centred' focus. Another effect was to stimulate employment by generating new jobs, as noted in other studies.

2.2. Allocation of LTC benefits

During the 18 years since the implementation of the Spanish LTCS, the process for being granted a benefit consists of two main steps. First, individuals' LTC needs are assessed, and eligible individuals are classified into one of the three grades that entitle them to LTC benefits. Second, individuals choose their preferred benefits based on their needs and the local supply.

The first step begins with an individual's application. This application can also be made by other family members, general practitioners, social workers, or social services (Law 39/2006). Claimants are assessed against an official scale (Decree 504/2007, Royal Decree 174/2011). If eligible (with a score higher than 25 points), they are classified into three grades, as mentioned earlier: moderate needs or Grade I (25-50 points), severe needs or Grade II (50-75 points), and major needs or Grade III (75-100 points). In Catalonia, the needs assessment is performed by local team of examiners —formed healthcare professionals and called SEVADs[7]. These teams of examiners work independently from the social services units, in charge of managing the benefits, and using a national scale to ensure the most objective examination[8]. This contrasts to other Spanish regions, where the social service office assesses the level of need and allocates benefits (Vidiella-Martin et al., 2024). By March 2024, there have been 983,919 first-time applications in Catalonia (91% of which have had its associated grade resolution) and 635,946 applications for reassessment of LTC needs[9], primarily due to deterioration in functional capacities. From this accumulated inflow, the last data available (December 2023) reports that

[7] Servei de Valoració de la Dependència, or Dependency assessment service.

[8] The LTC Needs Assessment Scale is available on (Royal Decree 174/2011)

[9] From which 13% were either ongoing or de-estimated by that date.

there were 250,190 persons currently entitled to LTC (i.e. assessed with a score above 25 points), while 25,368 were still pending LTC needs' evaluation (Departament de Drets Socials i Inclusió, 2024a)[10]. This first step is supposed to last at most 180 days. The average waiting time of the first period, measured as the period between the application and grade resolution (understood as the time when the individual LTC needs are classified in one Grade) is 177 days in 2024, just below the limit. This waiting time has been similar to the period since 2015, when the law had already been fully deployed, and the effects of 2012 cuts stabilised. At the beginning of 2020, when the state started to publish official data through IMSERSO, it was 174 days. From 2020 to 2023, the COVID-19 pandemic increased waiting times to a maximum of 230 days (January 2021), and a minimum of 155 in April 2022 (Departament de Drets Socials i Inclusió, 2024a).

Once LTC needs have been assessed, benefits for eligible individuals are allocated in the second step. Each different grade of LTC needs gives access to a menu of services and subsidies, which includes institutional care (day care centre and residential care), formal care at home, telecare and a cash-transfer in case of informal caregiver (Hernández-Pizarro et al., 2024). The provision of care services at home or in an institution could be delivered in kind or acquired with a voucher[11] (Vidiella-Martin et al., 2024). All these options are available, regardless of the grade, except for residential care in Grade I. Yet, the subsidy's amount and intensity (care hours, vouchers' amount, or cash transfers) vary depending on the grade received.

This second step is managed by local social workers, who meet with the beneficiary to explain available care options (and the waiting times associated with different care options, if they exist). Local social workers also assess the individual's financial situation using the information from the Personal Income Tax Declaration. This assessment determines the amount of the co-payments for in-kind services and the amount of the subsidy in case of vouchers and informal caregiving cash transfer, which are reduced up to 20% as financial capabilities increases (Hernández-Pizarro et al., 2024). Beneficiaries and their families (or legal representatives) can choose the type of benefit and form of provision for care services, with the possibility to combine benefits or switch options later. This flexibility is particularly important due to waiting lists for certain LTC services caused by limited supply. During the waiting period, individuals may opt for his second-best preferred benefit as an interim solution. This occurs only when the preferred benefit entails an extended waiting period (mainly in residential care and, sometimes for formal care at home). The individual is advised to accept alternative benefits temporarily.

The duration of the second step is longer and comprises two distinct waiting periods. The first is the period between grade resolution and the selection of benefits, determined through the *Individual's Care Programme*, known as PIA agreement (Acord del Programa Individual d'Atenció). The second is the time between the choice of benefit(s) (PIA agreement) and it's (their) reception. The PIA is a personalised care plan designed by the claimant and her family together with the public local social services unit to determine the most suitable interventions for individuals with LTC needs. As of December 2023, the average waiting time for PIA was 112 days, with 48,463 individuals awaiting benefit allocation[12]. This waiting time has shown consistent improvement since January 2020, when it stood at 340 days. After reaching a peak of

[10] In addition, there were 77,381 individuals who have applied with a level of LTC needs, below the minimum threshold (25 points in the score).

[11] Individuals opting for a voucher can only choose LTC providers that have been previously authorised by the Social Service Authorities. These authorities maintain a list of all providers that meet a specified set of quality criteria.

[12] 18,767 individuals were awaiting access to residential home care, and 6,381 to day care centres

408 days in May 2021, the duration has steadily declined to the current 112 days (Departament de Drets Socials i Inclusió, 2024a)[13].

By December 2023, there were 244,089 active benefits in Catalonia, awarded to 200,302 individuals with LTC needs (80% of individuals entitled to LTC benefits). Table 1 reports the number of beneficiaries by care option. Around 50% of claimants opted for informal care cash subsidies, accounting for 44% of all the benefits. Among formal care services, residential care has the largest number of users, followed by home care at home and teleassistance services. When examining the profile of users, 63% of them are women, and 72.7% of them are older than 65 (Departament de Drets Socials i Inclusió, 2024c)

Table 1: Benefits by type in Catalonia, December 2023.

Type of benefit	**Number of receivers**	**Share (in %)**
Informal caregiver subsidy	107,666	44.1%
Residential care	47,450	19.4%
Residential care in-kind	*36,557*	*15.0%*
Residential care voucher	*10,893*	*4.5%*
Formal care at home	44,591	18.3%
Formal care at home in-kind	*34,207*	*14.0%*
Formal care at home voucher	*10,384*	*4.3%*
Teleassistance	27,622	11.3%
Day care centre	15,751	6.5%
Day care centre in-kind	*13,861*	*5.7%*
Day care centre voucher	*1,890*	*0.8%*
Others	1,009	0.4%

Notes: Residential care in kind includes residential care for the elderly (27,767), for people with disability (7,346) and people with mental health disorders (1,444). Formal care at home in-kind includes: home care for the elderly (33,851), for people with mental health disorders (257) and personal assistant service (99). Day care centre in-kind includes day centre care for the elderly (6,243) and for people with disability (7,618). Others include: Personal autonomy promotion service (842) and Sociosanitary service (167)
Source: (Departament de Drets Socials i Inclusió, 2024c)

In Catalonia, service-based benefits[14] account for 55.9% (March 2024), compared to the Spanish national average of 70% (December 2023). Informal caregiver benefits in Catalonia represent 44.1% (March 2024), while the national average stands at 29.5% (December 2023). 83% of the service-based benefits are provided in-kind (vs. 17% of voucher provision). If we exclude telecare –as it is a basic service-, in-kind benefits represent a 78.7% of the total service benefits', while vouchers represent 21.3% (Departament de Drets Socials i Inclusió, 2024b).

2.3. LTC expenditure and funding

Before DA's introduction, LTC expenditure in Spain was 0.5% of GDP in 2003 (Costa-Font et al., 2022). The implementation of Spanish LTCS steadily increased this expenditure, reaching 0.7% in 2012. However, spending cuts enacted that year under Royal Decree Law 20/2012 slightly reduced expenditure. It was in 2017 when this level of expenditure (0.7%) was reached again (Departament de Drets Socials i Inclusió, 2024b). These cuts resulted in an accumulated revenue shortfall of 433.7 million Euros for Catalonia and 6.3 billion Euros for Spain. From 2017 onwards, LTC spending relative to GDP began a slight upward trend. In 2023, the total expenditure of publicly funded LTC in Spain during 2023 was 10.45 billion Euros, which rises to a final 11.07

[13] No data is available on the waiting time between the PIA agreement and the receipt of benefits, as each service and centre providing the benefit has its own specific waiting period.

[14] Benefits excluding informal care subsidies.

billion of Euros if user contributions through co-payments are included. This represented a 0.8% of Spanish GDP at the end of the same year (Ramírez-Navarro JM et al., 2024, INE, 2024)[15]. This share remains low compared to the OECD average of 1.8% (OECD, 2024) and the 1% of GDP recommended by the DA Law 39/2006. According to AIReF (2023), LTC spending will need to reach 1.7% of GDP by 2050 and 2% by 2070 to meet the estimated demand, from current demographic projections.

The Spanish LTCS is funded and managed through a combination of central, regional, and local contributions. Primarily tax-funded, the system also incorporates user co-payments (European Commission, 2019). The Spanish LTCS funding is structured into three levels: a minimum level funded by the central government, an agreed level co-funded by both central and regional governments, and an additional level that regions can supplement based on local needs. Regional budgets are calculated based on several factors (including but not limited to the estimated number of people with LTC, regional investments and employment in LTC, care service costs).

It has been widely acknowledged that there is general underfunding in the Spanish LTCS, as current expenditure does not allow meeting the demand of LTC needs. In addition, the central government has continuously contributed less than initially anticipated. This results in a shift of the burden towards the regional government and the users. The LTC in Catalonia, like in other regions of Spain, has been significantly underfunded by the Central Government, which currently contributes only 18.7% of the funding. This figure is notably lower than the level initially defined in the Dependency Act (DA), which stipulated that the central government contribution should be at least as large as the regional government one. The underfunding in Catalonia leads to higher financial effort of the Catalan government (who is responsible of 65.7% of the expenditure) and beneficiaries (funding through co-payments the 15.6%)[16].

Since 2021, the total budget for Catalonia's LTCS has increased significantly due to the Recovery and Resilience Plan (RPP). RPP provided an additional funding for LTCS of 1.55 billion Euros to all Spanish territories. Catalonia's share of the RPP funds remained disproportionately low, receiving only 16.2% of the total in 2021, 12.5% in 2022, and 13.0% in 2023. This allocation falls short, considering that Catalonia accounts for 17.2% of the population requiring LTC in Spain (Departament de Drets Socials i Inclusió, 2024a). Consequently, while the RPP intended to recover the central government funding to the agreed level it was insufficient to address the historical shortfall in central government support.

The underfunding has led to a growing number of people experiencing what Peña-Longobardo et al. (2016) defines as “dependency limbo”: the number of individuals who are officially eligible for benefits but have not received them yet. This gap in the provision is key to understanding the systemic shortfall in meeting care demands. The "limbo" was particularly aggravated by funding cuts and the delay in rolling out Grade I benefits for moderate LTC needs, which was postponed from 2013 to 2015, causing a peak of 385,000 individuals waiting for services that year (Costa-Font et al., 2023). By the end of 2023, Spain had 1,567,107 individuals with recognized LTC needs. Of these, 179,244 (11.4%) were still awaiting benefits, including 82,817 people with Grade II or III LTC needs. In Catalonia, 19.4% of eligible individuals were in this

[15] These figures exclude private expenditure, which is beyond the scope of the Spanish LTCS.

[16] In 2022, *Generalitat* paid 61% of the cost. Central Government for 21.2%, and co-payment from users represented a 17.7%.

"limbo" as of December 2023, marking a significant improvement from 27.1% at the start of 2022 (Ramírez-Navarro JM et al., 2024).

2.4. Comparison with other systems

The establishment of national LTCS is prevalent among the OECD countries in response to the challenges posed by a global ageing population with growing LTC needs and a reduction in the supply of traditional informal caregivers. Improving the well-being and health of people with LTC needs (and their caregivers) remains the central goal of these systems. In addition to this primary objective, other factors have been identified as major drivers for the implementation of LTCS. According to Costa-Font & Raut (2022), in Southern European countries, including Spain, the main driver for establishing a LTCS was ensuring the affordability of care services and guaranteeing access to necessary care because families alone are unable to bear the burden of LTC. Conversely, in Northern European countries, the systems of LTC are aimed to address gender inequalities by facilitating greater female participation in the labour market. In this vein, the LTCS serves to mitigate productivity losses in the labour market associated with caregiving responsibilities, and prevent the overutilization of healthcare systems.

Thus the decline of informal caregiving, due to the abovementioned causes, has led to a growing demand for formal LTC services. Aside from the change in caregivers' employment patterns, this shift towards formal care has been triggered by other socio-economic factors like the increased geographical distance between traditional caregivers and care recipients. All these characteristics have limited the availability of informal LTC has pushed the establishment of LTCS based on formal care (Costa-Font & Raut, 2022).

Each country's LTCS is shaped by its unique institutional, demographic, and health-related context. However, certain shared characteristics allow for comparative analysis and the classification of the system from different perspectives. Table 2 summarises key features, which allows LTCS classification, including the type of system, funding, eligibility criterion, and type of benefits. Additionally, it also incorporates some key indicators which enables to assess at glance the dimension and the expansion of LTCS, such as the percentage of adults aged 65+ receiving care, LTC spending as a share of GDP, and the institutional care cost for individuals aged 65+ with severe needs relative to median income. Table 2 reports the international experiences from Belgium, France, Germany, the Netherlands, and the United Kingdom[17]. These countries have been chosen for their similarity to Spain in terms of LTC needs while illustrating a range of implementation approaches, facilitating the comparison and contrast of Spain's LTCS on an international scale.

[17] If data refers to a characteristic not consistent across all regions of the UK, the term "United Kingdom (UK)" specifically refers to data from England in those cases.

Table 2: Main characteristics of LTCS for a set of OECD countries.

	Spain	Belgium	France	Germany	The Netherlands	The UK
LTC Financing	Ex-post	Ex-post	Ex-post	Ex-ante	Ex-ante	Ex-post
Funding source	Taxation: Federal and Municipal & Co-Payments.	Health Insurance Scheme (Social Insurance), General Revenue, Co-Payments & Income Tax credit.	Social Contributions, Taxation (Local) & Personal Funding	Long-Term Care Insurance (Public or Private)	Central Government Budget Funding & Individual tax contributions.	General Taxation, Local Business and Property Tax, Individual payments
Coverage	Universal	Universal	Universal	Universal	Universal	Means-tested
Types of benefits included	Cash subsidies, home care supports, and residential care supports	Cash subsidies, home care supports, and residential care supports (co-payments except in Flanders)	Cash subsidies	Cash subsidies, home care supports, and residential care supports (only for people with severe needs)	Cash subsidies, home care supports, and residential care supports	Personal budgets for in-kind services, with limited home care support and residential care restricted to NHS nursing services
% of 65+ adults receiving LTC	12.4%	13%	9.4%	20.5%	11.7%	5.1%
LTC spending as a share of GDP[18]	1.0%	3.0%	2.6%	2.5%	4.4%	2.6%
Institutional care cost for individuals aged 65+ with severe needs as a share of median income	115%	172%	112%	113%	486%	234%

Source: Own elaboration from OECD (2024), Costa-Font & Raut (2022) and NHS England (2024).

[18] The share of LTC spending relative to GDP shows a slight variation compared to section 2.3. This difference arises because this table uses OECD data for all countries, enhancing comparability. However, the OECD's figures include certain expenditures classified as healthcare-related in Spain, not LTC.

According to the form of financing, LTCS can be financed Ex-ante, Ex-post or both (Table 2, first row). In general, ex-ante financing is based on insurance, which is generally organised through a social insurance set by the Government (as in Germany, the Netherlands, Japan or South Korea). In most OECD countries, there exists also private ex-ante financing (private insurance) to complement the public package of benefits[19,20]. Ex-post funding has several forms. Ex-post public funding is tax-based, and utilises general taxation to fund the services (Norway, Sweden, Denmark, Finland, Scotland or Spain). Ex-post private funding depends on the users and their families. In addition, ex-post financial products to pay for LTC have been developed (i.e. through reverse mortgages). Private ex-post financing is used to support complementary care in regions with a well-established LTCS —whether based on social insurance or tax funding—that still fall short of fully meeting all care needs, or become the main sources in countries without public LTCS, like in Turkey or Mexico.

Another essential feature that enables to group LTCS internationally is the coverage (see Table 2, third row). Some systems have universal access (as seen in Spain, Belgium, France, Germany, the Netherlands and the Nordic countries) and others are means-tested (such as in the UK). These differences in the access translate in the percentages of population coverage (Table 2, fifth row). In 2021, the average percentage of adults aged 65 and over receiving LTC services across OECD countries was 11.5% (OECD, 2024). Among countries with universal access, Spain had a share of 12.4%. This is higher than the Netherlands (11.7%) and France (9.4%), yet remains below nations such as Belgium (13%), the Nordic countries (ranging from 13.1% to 15.7%), and Germany (20.5%). On the other hand, countries with means-tested systems (UK) have only 5.10% of the 65+ population covered by their national LTCS. Finally, countries with predominantly private systems such as the US have a 1.7%. A common trend among OECD countries is the increase in the proportion of LTC recipients since 2011. In Spain, this figure has grown from 7% in that year. However, some exceptions exist, notably the Netherlands (which decreased from 20.4% to 11.7%) and the United States (from 3.3% to 1.7%). Furthermore, in 2021, Spain had the second highest share of adults aged 65 and over receiving LTC at home (83%), only surpassed by Israel, while the mean for the OECD was 72%. Spain has also succeeded in reducing the share of unmet LTC needs among older adults living at home (OECD, 2024).

In terms of LTC spending as a share of GDP (Table 2, sixth row), in 2021 Spain stood at 1.0%[21], while the average for all OECD31 countries is 1.8%. This is similar to Portugal (1.0%), Italy (0.9%), and right below South Korea (1.1%) or the US (1.3%) (OECD, 2024). This share is far away from other countries such as the Netherlands (4.4%), Belgium (3.0%), the UK (2.6%), France (2.6%) or Germany (2.5%). In these latter countries, a significant portion of LTC spending is devoted to nursing homes, which suggests that a shift toward deinstitutionalization could help reduce overall costs (OECD, 2024). In contrast, Spain's relatively low LTC expenditure means that, despite its universal system, the breadth of coverage is often accompanied by limited benefits in terms of service provision and service intensity.

[19] It is an option in Spain, but it is irrelevant. Only 65,743 in 2020. (Acosta, 2021)

[20] In some cases, such as in the United States, they can become the primary option for long-term care.

[21] Difference in share over GDP with other data in this document is because of different calculation methods, affecting what is included as LTC-spending between OECD and Spanish institutions.

The menu of benefits provided by LTCS across different countries varies significantly (Table 2, fourth row). The benefits can be classified into three main categories: universal cash subsidies, home care support, and institutional care support, with the latter two provided either in-kind or through vouchers. Countries like Spain, the Netherlands, Belgium, and Germany offer a comprehensive menu including all three categories, and including both direct cash subsidies and support for home and residential care. However, in the Netherlands, residential care support is primarily restricted to individuals with severe needs. France, on the other hand, provides vouchers for accessing either home or residential care. The United Kingdom does not offer direct cash subsidies, instead utilising personal budgets for in-kind services.

In terms of informal caregiving, Spain has a below-average share of informal caregivers among the population over 50 years old, with only 12% of people in this age group providing care in 2019. This is lower than in Belgium (23%), the UK (19%), Germany (18%), the Netherlands (16%) and France (15%), though slightly below the OECD average of 13%. Spain's figures are also comparable to Italy (11%) or Finland (12%) (OECD, 2024). The profile of informal caregivers in Spain differs from that of other countries in terms of gender. Spanish caregivers have the second-highest share of women, with 76% of caregivers being female, only behind Hungary. This is notably higher than in Germany (64%), the OECD average (60%), the UK (60%), France (56%), Belgium (55%), and the Netherlands (55%) (OECD, 2024). Additionally, 33% of informal caregivers in Spain have another job, a percentage higher than the OECD average of 29% or Belgium (20%) and France (22%), but lower than in the Netherlands (46%), the UK (40%), and Germany (35%) (OECD, 2024).

The cost of institutional care varies significantly across countries (Table 2, seventh row). In Spain, the cost of institutional care for individuals aged 65 and over with severe needs was 115% of the median income in 2022. This is similar to the figures in Germany (113%) and France (112%), but much lower than the OECD average of 210% (OECD, 2024). Other countries, such as Belgium (172%) and the UK (243%), also report higher costs than Spain. In contrast, countries like the Netherlands (486%) and Denmark (485%) have much higher costs, indicating that institutional care in these nations can be prohibitively expensive without significant public support. The funding mechanisms for LTCS also vary across these nations: in Spain, LTC is primarily funded through a combination of federal and municipal taxes, along with co-payments. Belgium finances its system through health insurance, general revenue, co-payments, and income tax credits, while France relies on social contributions, local taxation, and personal funding. Germany uses a LTC insurance system (public or private), while the Netherlands also relies on a similar insurance system. In the UK, LTC is funded through general taxation, local business and property taxes, and individual payments. Each country's funding structure plays a significant role in the affordability and accessibility of LTC services.

These differences in funding sources and spending levels are reflected in the number of workers in the LTC sector and their compensation levels. For example, Spain has a share of 4.9 LTC workers for every 100 people aged 65 and over, which is lower than countries like the Netherlands (8.2), Germany (5.5), and the OECD average (5.7) (OECD, 2024). The remuneration of LTC workers in Spain is also relatively low, at about 63% of the average national wage for institutional care and 60% for home-based care. These levels are similar to other countries like

Ireland and Italy, but considerably lower compared to the Netherlands, France, Germany and Belgium[22].

The disparity can be attributed, in part, to the comparatively lower qualification levels of the workforce in Spain relative to countries such as the Netherlands or the United Kingdom. Consequently, the differences in workforce characteristics extend beyond staff-to-patient ratios and include the composition of personnel (Rodríguez-Cabrero et al., 2018).

As the demand for LTC rises, ensuring that the system remains both affordable for users and financially sustainable becomes increasingly difficult. Without sufficient public financial support, out-of-pocket costs for older adults will continue to climb, making LTC inaccessible for many families and placing significant strain on household budgets. Therefore, securing long-term funding sustainability is essential to protect older adults from financial hardship and to ensure the system can meet growing care needs effectively and equitably.

A trend towards reducing LTC beds in institutions and hospitals between 2011 and 2021 reflects a broader shift towards deinstitutionalization. Many countries have increasingly focused on promoting home and community-based care, in response to individuals' preference to remain at home as long as possible. However, for those with intensive needs or living in remote areas, institutional care may still be necessary. This global trend towards deinstitutionalization highlights the need to balance home-based care with sufficient residential care capacity for those who require it. This trend is clearly observed in the reduction of LTC beds in institutions and hospitals, with notable decreases of more than 9.7% in countries like the Nordic nations, the UK, the US and France. Spain, with a more modest reduction of -4.3%, aligns with the OECD average decrease of -4.7% (OECD, 2024).

3. Lessons learned

3.1. Funding and Financial sustainability

A primary challenge for the Spanish LTCS lies in securing sustainable funding. Despite the magnitude of the expenditure, the Spanish LTCS has consistently faced insufficient funding. This has greatly reduced the system's ability to reach its objectives and meet population's LTC needs (Del Pozo-Rubio et al., 2022). Three key funding-related events have shaped the financial evolution of the Spanish LTCS.

The first is linked to an inaccurate design: there is a lack of financial sustainability within the LTCS (Peña-Longobardo et al., 2016). Expenditure forecasts were substantially underestimated. In 2012, when it was expected to have the system consolidated, the costs rose to nearly 7, doubling the original estimate of 3.5 billion. This figure is underestimated because it does not account for the benefits of individuals with Moderate level of LTC needs (as Grade 1 was still not implemented). While the projected number of users was accurately assessed, the disproportionate distribution of LTC Grades—particularly the higher proportion of individuals with Major LTC needs— contributed to substantially increased costs (Oliva et al., 2023).

The second factor is attributed to a lack of financial commitment by the Central Government. The LTCS is financed through general taxation, rather than with a dedicated and regular source

[22] Average hourly wages of personal care workers, as a share of the economy-wide average wage, or institutional care (i), and for home-based care (ii); are similar in Spain, Ireland (i: 65%, ii: 62%), and Italy (i: 62%, ii: 59%). Higher shares are observed in the Netherlands (i: 95%, ii: 91%), France (i: 71%, ii: 69%), Belgium (i: 74%, ii: 68%), and Germany (i: 67%, ii: 64%), while the UK reports lower levels (i: 56%, ii: 57%).

of funding. This reliance on general taxation implies that the level of funding is partly attributed to political decisions of central and regional governments. Originally, it was expected that two-thirds of Spanish LTCS expenses would be covered jointly by the central government and the autonomous communities through general taxes, while families would pay the remaining one-third through co-payments. However, these forecasts soon proved to be unrealistic. The central government's support stayed below expected levels for most of this period, leaving autonomous communities to take on most of the financial burden (Oliva et al., 2023). All these contribute to undermining the system's financial sustainability.

The third issue arose from spending cuts introduced in 2012 during the Great Recession, under the Royal Decree 20/2012. This led to the average co-payment level rising to 50% of the service cost, much higher than the expected one-third (Del Pozo-Rubio et al., 2017). These Legislative changes further reduced per capita spending on social transfers by 10% (Oliva et al., 2023). Bermejo et al. (2021) documented the effects of these austerity measures on the Spanish economy (through its impact on production). They used Structural Decomposition Analysis (SDA) and Input-Output (IO) methodologies, for the period from 2009 to 2015. Although they found that public LTC spending boosted economic production, the stricter policies of 2012 significantly reduced this impact on production.

These financial strains have been described as "chronic underfunding" of the system (Costa-Font et al., 2021). This, in turn, has significantly limited the system's capacity to deliver the intended benefits to LTC recipients (Oliva et al., 2023), and has led to unequal performance of the Spanish LTCS across the various autonomous communities (CCAA) (Correa & Jiménez-Aguilera, 2016). As a result, the planned gradual implementation schedule became unfeasible; waiting lists grew steadily, benefits were reduced, and users' contributions increased significantly, as previously discussed.

Del Pozo-Rubio et al. (2019) noted that out-of-pocket payments increased the risk of impoverishment by 18.9%. They also observed an increased likelihood of catastrophic spending, defined as expenses exceeding 40% of a household's non-subsistence income on LTC. Families often bear additional financial burden by covering extra care services, as co-payments for institutionalised services are high and formal LTC options at home are limited. This results in increased reliance on informal caregiving.

3.2. The impact of the Spanish LTCS on the Economy

Another area of research has focused on studying the effect of the LTCS on the economy. In particular, one approach has examined the returns on LTC expenditure. Using 2012 data, Del Pozo-Rubio et al. (2022), found that each million euros invested in services (including in-kind and vouchers) generates 41.91 jobs (68.4% direct, 9.2% indirect, and 22.4% induced[23]). In contrast, cash benefits[24] (create only 16.88 jobs per million euros spent (53% direct, 24.5% indirect and 22.5% induced). Overall, the authors estimated that LTC spending supports 151,353 jobs, with 104,513 tied to services and 46,840 to cash benefits. These findings highlight the greater economic impact of services on job creation compared to cash benefits, underscoring

[23] As defined by the authors, direct impacts refer to the immediate effects on output resulting from an initial exogenous shock in demand. Indirect impacts arise from inter-industry connections. Induced impacts comes from changes in income and subsequent consumption patterns triggered by the initial shock.

[24] Majoritairly composed by subsidies per informal caregiving.

the importance of investing in service provision to maximise employment outcomes. This result aligns with findings by Díaz Díaz (2014), who found that each million euros invested in LTC in Cantabria generated 24 direct jobs, increasing to 36 when including indirect and induced jobs. According to Ramírez-Navarro JM et al. (2024), in Catalonia, the direct employment rate for LTC services in Catalonia is 56 workers per 10,000 inhabitants, compared to the Spanish average of 71. Similarly, the recovery rate —measured as direct returns (IRPF, contributions, VAT) per million euros of public LTC spending— is 40.6%, slightly below the national average of 41.2%.

The impact of LTC on the labour market has also been studied from a gender perspective, with particular attention to the participation of women in the workforce. LTC spending has measurable impacts on labour-market participation, particularly for women over 40, and on health care spending. Costa-Font & Vilaplana-Prieto (2023), in their analysis of OECD countries, found that a 1% increase in female labour participation led to a 1.5% increase in LTC expenditure and a 0.9% reduction in health care expenditure (HCE), primarily driven by reduced inpatient and medication costs, though with significant variation across countries.

The Recovery and Resilience Plan (RRP), implemented in 2021 following the COVID-19 pandemic, promoted a shift in the LTCS toward deinstitutionalization. This deinstitutionalization aligns with approaches such as 'personalization,' as evidenced by Guillen et al. (2019). The RRP aims to promote person-centred care through community services and home-based support, addressing both the vulnerabilities in residential care and a broader societal demand for home-based care for individuals with LTC needs. The plan emphasises home adaptations and the expansion of home care services to enhance quality of life, reduce reliance on institutions, and create sustainable employment (Bermejo-Patón et al., 2023). Deinstitutionalization is expected to generate diverse economic benefits, including increased direct and indirect jobs (lowering the ratio of caregivers to individuals with LTC needs), while enhancing social contributions and income distribution. Although projections estimate significant job creation from RRP investments, outcomes will depend on the balance between service provision and cash benefits. Service has a greater economic impact, generating more jobs than cash benefits. However, the full macroeconomic impact of the RRP's shift to deinstitutionalization remains to be assessed, and further research is needed to guide policymakers on service prioritisation and long-term benefits (Bermejo-Patón et al., 2023).

3.3. Effects of LTC benefits

LTC benefits aimed to enhance the wellbeing of people with LTC needs and their families. Yet, whether this objective has been achieved (or not) has not been tested as the implementation of Spanish LTCS has not considered gathering data on recipients' wellbeing. Measuring wellbeing in a population with LTC needs is not easy and cannot be performed with general population tools, such as the EuroQol 5D (EQ5D)[25]. The reason behind is that general population tools are not sensitive to changes in wellbeing in populations suffering from lack of autonomy. Hence, specific scales such as the Adult Social Care Outcomes Toolkit (ASCOT)[26] has been developed and validated (Rand et al. (2015), van Leeuwen et al. (2015), Towers et al. (2016)). However, the Spanish Government will is to reverse this deficiency and by 2022 they announced the creation of a common system for evaluating the quality of LTCS services (Resolution of July 28th, 2022).

[25] A standardised measure of health-related quality of life developed by the EuroQol Group to provide a simple, generic questionnaire for use in clinical and economic appraisal or population health status surveys (EuroQol Research Foundation, 2024).

[26] A family of measures (self-complete or interview questionnaires) designed to assess the quality of life (QoL) of people using adult social care services (S. Rand, 2024).

To the date, the government is still planning how to define, develop and implement it (Zalakain, 2024).

Despite the absence of a national strategy to validate and systematically assess the beneficiaries' wellbeing, some regional initiatives, based on the ASCOT, are being developed. Rodríguez-Míguez & Casal (2024) have initiated a process of ASCOT's adaptation and validation for Spanish context. After elaborating the translation into Spanish, and validating it using a sample of 200 people, they tested the instrument's capacity to capture dimensions of care in relation to other already validated scales. Then and using a sample of 1000 people, a survey was conducted to elicit the weights to construct the ASCOT tool for Spain. In this line, in Guipúzcoa, through the Evaluation 2030 programme (Diputación Foral de Gipuzkoa, 2022), an analysis of the impact on the well-being of people who receive formal care benefits at home or in residential centres is being developed, led by J. Zalakain (SIIS Documentation and Studies Centre). The aim is to serve to promote the design of quality standards for a future care evaluation agency in the Gipuzkoa province, in the North of Spain.

Beyond these ongoing researches with a local scope, some authors have used health outcomes to proxy wellbeing, which in turn enable exploring the effects of LTC benefits with broader and more representative samples (Costa-Font et al. (2018) and Hernández-Pizarro et al. (2024)). These researches have also allowed us to explore the interplay between LTCS and healthcare systems. The effects of LTC benefits on other spheres –including savings and caregiving– have been estimated (Costa-Font & Vilaplana-Prieto (2017), Costa-Font & Vilaplana-Prieto (2022c), Costa-Font and Costa-Font & Vilaplana-Prieto (2022b)). The impact on these outcomes are expected given the magnitude of this social protection programme. The Spanish LTCS has a +65-population coverage of 12.4% and, although the benefits' amounts are varied and usually remain insufficient to fully cover service costs, the average amount of benefits informal caregiver cash transfer and vouchers represents 19.1% and 45.7%[27], respectively, of the average pension.

3.3.1. The effects of LTC benefits on Health and Healthcare use

Health and indirectly the use of healthcare resources can proxy individual wellbeing as far as ill health and healthcare shocks impacts negatively on individual's wellbeing. Thus, health preservation and minimising avoidable health shocks (and their associated health care use) captures, at least, one important dimensions of wellbeing and quality of life. Aligned with this fact, Costa-Font et al. (2018) documented that the implementation of Spanish LTCS is linked to a reduction in the delivery of hospital care. This relation was present in both admissions and utilization (Length of Stay) between those receiving a caregiver allowance and, albeit less intensely, among beneficiaries of publicly funded home care, which amounts to 11% of total healthcare costs. Individuals living in residential care homes are excluded from the analysis. The effects were found to be stronger in regions that had an operative regional health and social care coordination plan in place.

Focusing in one of this region, Serrano-Alarcón et al. (2022) found that an average monthly LTC benefit of 365 euros, regardless of the type of benefit, reduced avoidable hospitalizations by

[27] Informal caregiving benefits average 240.17 €/month: 157.9 € (Grade I), 265.2 € (Grade II), and 369.6 € (Grade III), with regional variations. Vouchers for residential care provide on average 516.2 €/month (Grade II) and 575.7 €/month (Grade III) covering a fraction of the cost. Information on the monetary value of services and other benefits has not been computed at national level. Hence, this numbers underestimate the average monetary value of LTC benefits, when all benefits are considered. The average pension for Spain is 1259.6€ (Ramírez-Navarro JM et al. (2024), Gobierno de España (2024))

66% using administrative records in Catalonia. The access to LTC benefits decreased the number of emergency hospital admission (many of them caused by injuries) and could promote preventive healthcare, improving access to healthcare services such as cataract surgery. The authors also explored the effects on primary care and documented a reduction of 44% non-scheduled primary care visits, mainly associated to causes labelled as “housing, household and economic circumstances”.

Hernández-Pizarro et al. (2024) took a step further comparing healthcare use by the provision setting of LTC: home-based LTC vs institutionalised care. No statistically significant differences in hospitalization probability between institutionalized and home-based care recipients with comparable LTC needs after three years from becoming beneficiaries. By demonstrating the apparent equivalence of institutional[28] and home-based care in terms of hospitalization outcomes, this research supports the efficacy of patient and family decision-making in LTC choices.

In a recent study, and focusing on residential care, Javier Afonso-Argilés et al. (2023) identified that there were still many ambulatory care sensitive conditions (ACSC) or "avoidable hospitalizations" from the nursing home users in 2017. The ACSC accounted for 56.6% of cases in 5 units of emergency in Catalonia. Severe LTC needs and cognitive impairment were common with no significant differences between the ACSC and non-ACSC. The average cost per ACSC was 1,408.24€, and an estimated 60% reduction in ACSC, by improving care support in residential environments, could lead to cost savings of approximately 1.2 million Euros.

3.3.2. The effect of LTC of family’s decision (savings and caregiving) and their wellbeing

The national coverage and level of average LTC benefits are sufficiently large, and as a social protection policy, Spanish LTCS is expected not to have a neutral effect on savings and other family’s decisions. Costa-Font & Vilaplana-Prieto (2017) found that the expansion of Spanish LTCS led to a reduction in savings both at the intensive margin (amount saved) and at the extensive margin (probability of having savings or saving behaviour). This effect was larger among the elderly without kids and mainly concentrated among recipients of cash subsidies.

Similarly, the introduction of Spanish LTCS including subsidies for caregiving increases the supply of informal caregivers and downstream transfers among those selecting this type of benefit, in line with exchange motivation for intergenerational transfers (Costa-Font, Jiménez-Martín, et al., 2022). The effects were attenuated with the reduction system’s generosity due to austerity measures. Costa-Font et al. (2022) has not found evidence that the provision of subsidised care services affect the supply of informal care, contrasting with the possibility of either substitution or complementary effects. This evidence leads to study possible labour-market implications of the expansion of Spanish LTCS for caregivers. Costa-Font & Vilaplana-Prieto (2022a) find that the introduction of the Spanish LTCS led to a 10 percentage points (pp) reduction in early retirement intentions overall, but the impact varied by benefit type: Caregiving subsidies reduced retirement intentions by 22.1pp for caregivers, while home care support increased them by 15.6pp.

As caregiving is associated with a negative impact on health (Bauer & Sousa-Poza, 2015) , the introduction of Spanish LTCS is expected to also affect caregivers’ wellbeing and life satisfaction. Costa-Font & Vilaplana-Prieto (2022c) has shown that LTC benefits have improved the wellbeing and life satisfaction of caregivers. In concrete, caregiving cash subsidies lead to a 14.2

[28] Based on residential care instead of nursing homes.

percentage point (pp) reduction in the likelihood of experiencing depressive symptoms, while home-based support services result in a smaller reduction of 8.6 pp. The effects, however, vary based on the level of care provided. For caregivers who provide intensive care (50 or more hours per week), the reduction in depressive symptoms is more than twice as large when the person they care receives other care services compared to only receiving cash subsidies for informal caregiving. Conversely, for caregivers providing fewer than 50 hours of care per week, subsidies lead to a sharper reduction in depressive symptoms.

All this evidence is reached using the Survey of Health, Ageing and Retirement in Europe (SHARE), which excludes institutionalised individuals. In addition, research on the effects on informal caregivers (Costa-Font & Vilaplana-Prieto (2022a) and Costa-Font & Vilaplana-Prieto (2022c)) only considers spouse and partners caregivers, who represent 60% of caregivers. Despite them representing the majority, evidence on the effects over offspring and other family member's caregivers is still unknown. They become important for policy making because the group of people with LTC without a partner or spouse able to care is large and may pose a challenge for their family to arrange the appropriate level of care[29]. The sample size tends to be smaller than research based on administrative data, but the sample is richer in control variables and outcomes measures. Finally, the main identification strategy used is a difference-in-difference where assignment to the treatment contains treated and untreated individuals due to the information available in the survey. Although this reduces the precision, all estimates are robust.

3.4. Spanish LTCS' design and its implication

Aside from conducting research on the effects of Spanish LTCS, some authors have focused on the analysis of the system and its design. This strand of the literature has focused on three main issues: the mechanism to determine the eligibility for LTC benefits, measuring equity in the system and the access of LTC benefits and the consequences of COVID-19 pandemic.

One of the challenges of LTCS is to assess the level of LTC needed to allocate the resources. One the one hand, the measurement of LTC needs using the official assessment scale has shown a moderate correlation with actual caregiving time, as recorded in Rodríguez-González & Rodríguez-Míguez (2021). Mental impairment was found to significantly increase care time requirements, highlighting its weight in LTC needs assessments. However, disparities exist between the scale scores and care time, suggesting potential misalignments between normative criteria and the realities of care demands. This research can contribute to better design the menu of LTC benefits associated to each level. On the other hand, Hernández-Pizarro et al. (2020) has identified unintended strategic effects linked to the mechanism to allocate LTC benefits. While the level LTC needs is measured with a continuous score (obtained using the official assessment scale and ranges from 0 to 100), the allocation of benefits depends on three grades, each of one grouping a set of scores. These structured discrete intervals of LTC benefits lead to strategic behaviour of the healthcare professional who is in charge of assessing LTC needs. The healthcare professionals adopt a pro-social behaviour adjusting the score, which allows the claimants to access higher levels of care benefits. In turn, this behaviour increases public LTC spending.

[29] Either because they are widow or their partner/spouse also has a lack of autonomy.

García-Gómez et al. (2015) identified inequity in LTC use in Spain before 2007. Vidiella-Martin et al. (2024) examined whether the introduction of Spanish LTCS serves to mitigate and reverse this situation. Using administrative records of Catalonia, the authors construct socioeconomic horizontal inequity indices that reveal that inequity in the access of different LTC benefits. Cash subsidies intended for informal care are disproportionately concentrated among wealthier individuals, while those from lower-income backgrounds predominantly access formal care services (home care and nursing homes). This pattern suggests that cash benefits may enable wealthier individuals to access private care options more readily. Additionally, the research unravelled disparities in service provision, with in-kind services (vouchers) being more prevalent among worse-off (better off). Yet, these differences do not significantly affect overall access times to LTC (although lower-income individuals tend to experience longer wait times for telecare, and wealthier clients seeking in-kind nursing homes). Such variations may indicate differing preferences or constraints among socioeconomic groups. Interestingly, no significant socioeconomic inequity in the time spent navigating the administrative application process suggests in favour of the current design to allocate LTC benefits.

The COVID-19 pandemic, which began in 2020, brought to the forefront numerous deficiencies in integrated social and healthcare services, particularly emphasizing financial shortfalls that had already been identified. Although these issues were not new, the pandemic made them clearly visible, especially concerning elderly care in residential homes. To put some numbers, at the Spanish level, 13% of all nursing home residents died from COVID-19. For people over 80-years-old, the percentage was 22%. This may be due to the underfunding of the nursing homes in Spain, which has been the case since the financial crisis, impoverishing the quality of the LTC system (Costa-Font et al. (2021) and Via i Redons & Prades-Colomé (2023))[30].

Between the start of the pandemic and September 2021, 26.6%[31] care home residents in Catalonia (who were diagnosed with COVID-19) passed away. This number aligned with Costa-Font et al. (2021), which highlighted the relationship between the size of nursing homes and covid-19 related deaths. Their study found that regions with fewer staff per nursing home resident, larger nursing homes (or nursing homes places) and/or higher occupancy rates tend to have higher fatality rates in comparison to excess deaths. The results suggest that adding one more staff member per resident in a nursing home could lead to a 0.44 percentage point drop in the region's nursing home fatalities relative to excess deaths during the early stages of the pandemic.

[30] Two factors can be directly related to the reduction of the quality. First, high occupancy rate prevents from creating enough space for effective social distancing. Second, budget constraints have frequently resulted in fewer permanent staff being hired. This led to a greater dependence on temporary workers who often moved between different facilities or held multiple roles, which may have played a role in the rise of infections and deaths in nursing homes. (Costa-Font et al., 2021).

[31] 9,173 out of 34,491 home care residents, which makes a 26.6%. This percentage was the same for the general population of Catalonia over 80 years old. Hence, no significant differences were found in the mortality rates between elderly individuals in care homes and those living independently once infected but the share of infected people was higher (Via i Redons & Prades-Colomé, 2023)

4. Discussions

The Spanish LTCS has undergone significant evolution since its creation in 2007. Designed for universal access, the system was implemented in phases, initially prioritizing individuals with major (Grade III) and severe (Grade II) levels of LTC needs. However, plans to include moderate (Grade I) dependency were delayed until 2015, as the Great Recession reduced the system's resources and benefits' generosity. Austerity measures introduced during this period further strained the system, resulting in delayed service provision and increased reliance on family care.

The COVID-19 pandemic revealed and magnified systemic weaknesses in the LTCS, including poor coordination between healthcare and long-term care services, severe workforce shortages, and inadequate care infrastructure. In response, the 2021 Recovery and Resilience Plan introduced measures to improve service quality, reduce waiting lists, and foster job creation in the sector. Although waiting times for assessments and benefit allocations have improved since the peak of the pandemic, challenges remain, particularly in accessing in-kind services such as residential care, where supply constantly lags behind demand.

Funding constraints have persistently undermined the LTCS's sustainability and equity. Current public expenditure on LTC accounts for just 0.8% of GDP, significantly lower than the OECD average of 1.8% (Ramírez-Navarro JM et al. (2024) and OECD (2024)). Efforts to close these funding gaps, including increased central government contributions, have been inconsistent and insufficient to fully meet growing demand. Compared to Northern European countries, where LTC systems prioritize gender equity and formal caregiving, Spain's LTCS is more focused on affordability and accessibility (Costa-Font & Raut, 2022).

The Spanish LTCS faces significant challenges in securing financial sustainability, which affects its ability to meet the population's needs. Initial cost forecasts underestimated the actual expenses, particularly due to a higher-than-expected number of individuals with major and severe LTC needs (Oliva et al., 2023). The central government's limited financial commitment has further strained the system, leaving CCAAs to cover most of the costs. The reliance on general taxation, along with political decisions and austerity measures, has contributed to chronic underfunding (Costa-Font et al., 2021). Budget cuts during the Great Recession led to higher co-payments and reduced the economic benefits of public spending on care (Del Pozo-Rubio et al., 2017). As a result, waiting lists increased, and families experienced higher out-of-pocket costs, further increasing financial pressures (Del Pozo-Rubio et al., 2019). These systemic funding issues highlight the urgent need for reforms. Establishing dedicated funding mechanisms (to avoid relying on general taxation revenues, which are sensitive to economic cycles) becomes crucial to secure the LTCS's long-term viability and effectiveness.

Investment in LTC not only improves the beneficiaries' situation but also generates economic returns, particularly by boosting job creation and labour market participation. Care services create significantly more employment than subsidies for informal caregiving, as for every job associated with IC subsidies, there are 2.5 jobs created through care services (Del Pozo-Rubio et al., 2022). Spending on care also helps increase female labour force participation, reducing healthcare costs and promoting community-based care (Costa-Font & Vilaplana-Prieto, 2023). The Recovery and Resilience Plan (RRP) has driven a shift toward deinstitutionalization and home-based care, which could enhance employment opportunities and improve income distribution (Bermejo-Patón et al., 2023). However, further research is needed to fully assess the broader economic effects of these changes and determine the optimal balance between service provision and cash benefits.

LTC benefits are intended to improve the wellbeing of individuals with long-term care needs and their families, but this objective has not been thoroughly assessed, as the Spanish system lacks

data on recipients' wellbeing. Although there are regional efforts to adapt and implement tools, the Spanish government has yet to establish a nationwide system for evaluating the care services on recipients. In the absence of a national strategy, research using health outcomes as proxies for wellbeing suggests that LTC benefits can reduce healthcare utilization, including hospital admissions and primary care visits Costa-Font et al. (2018), Serrano-Alarcón et al. (2021) and Hernández-Pizarro et al. (2024). However, unmet needs still persist, and the potential for further reductions in healthcare demand remains. Without increased investment in the LTC system, these gaps will likely result in higher healthcare costs, as the consequences of insufficient care are absorbed by the healthcare system. Addressing these needs through a more comprehensive LTC system is crucial to preventing further strain on healthcare services and improving the wellbeing of individuals with LTC needs.

The design of the care system has raised concerns, particularly regarding eligibility criteria, equity in access to benefits, and the system's vulnerabilities, which were exposed by the COVID-19 pandemic. The official assessment scale used to measure care needs does not always align with actual care requirements, particularly for those with mental impairments (Rodríguez-González & Rodríguez-Míguez, 2021). The structure of the benefit allocation system encourages healthcare assessors to adjust scores strategically, leading to higher public spending (Hernández-Pizarro et al., 2020). Inequities persist in the access to benefits, with wealthier individuals more likely to receive cash subsidies, while lower-income individuals tend to rely on formal care services (Vidiella-Martin et al., 2024). The pandemic highlighted issues in residential care, particularly in underfunded facilities, where higher mortality rates were recorded. Larger, understaffed nursing homes had more fatalities, indicating the need for improved staffing levels and support for residential care (Costa-Font et al. (2021) and Via i Redons & Prades-Colomé (2023). Addressing these systemic gaps requires aligning assessments with actual needs, ensuring equity in benefit access, and strengthening financial and structural support for residential care.

All this evidence calls for a more integrated approach between healthcare and the LTC system to better approach individuals with LTC needs, especially for the elderly. On the one hand, real integration may serve to contain healthcare costs by avoiding suboptimal use of the system. On the other hand, joint initiatives from social affairs units and the healthcare system to face frail individuals may help to promote active ageing and reduce both LTC and healthcare burdens. In addition, it is also urgent to systematically gather information on beneficiaries' wellbeing to examine whether Spanish LTC achieve its primary goal. Last but not least, financial sustainability is still a challenge which requires to be tackled in front of demographic projections.

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