
Case study

Spain

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Abstract

The public long-term care system in Spain, known as System for Autonomy and Care for Dependency (*Sistema para la Autonomía y Atención a la Dependencia*, SAAD), was introduced in January 2007. The system is universal and financed mainly through taxes, with funds from the central and regional governments (Autonomous Communities, ACs), and to a lesser extent through co-payments. Long-term care is coordinated within the Territorial Council of the SAAD – a cooperation body where the central government, the ACs and the local governments are represented. Managing the SAAD is a responsibility of the ACs, which can decide whether to allocate funding to provide additional services.

Chronic underfunding of the system has been a major problem of the SAAD. The Great Recession hit Spain particularly hard in 2008, just after the implementation of the SAAD, causing important budget cuts. The subsequent benefit and coverage adjustments in the SAAD resulted in long waiting lists for those who had been formally recognized as dependants (and were thus eligible for such benefits). Budget constraints in public financing for long-term care benefits combined with the demand for care have resulted in low benefits in addition to low prices paid to providers; thereby ensuring quality of care is a challenge. Moreover, large discrepancies exist between the Spanish regions (ACs) in benefit generosity, coverage and co-payments.

Spain is ageing rapidly, second only to the Republic of Korea among OECD countries. It will rank among the oldest among OECD countries by 2050. In the long term, rapid population ageing will put more pressure on the financial sustainability of the public long-term care system and place pressure on adequate provision of care for older persons in Spain. Moreover, differences in population ageing across Spanish regions are striking. Under the current financing scheme, ageing will exacerbate the current inequalities in the provision of long-term care services and benefits among regions in Spain.

The Spanish public long-term care system has taken significant steps in providing coverage and care for the recipient population, but it faces important challenges. These include long waiting lists for those formally recognized as dependants; large inequalities among regions in the provision of long-term care services, benefits and co-payments; lack of transparency of the system; and insufficient funding and inadequate financing arrangements. These factors result in low prices paid to providers and possibly low quality long-term care services for recipients.

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Glossary and abbreviations

Term	Abbreviation	Definition
Autonomous Communities	ACs	The Spanish regions. There are 17 in Spain, and they correspond to the OECD's Territorial Level 2 administrative jurisdictions or the EU's NUTS 2.
Base for payment	-	The base or unit of activity on which prices are set. Common base for payments is FFS, diagnosis related groups, per diem, and capitation.
Capitation	-	A prospective fixed lump-sum payment per person enrolled for care with a provider within a given period (typically one year) covering a defined set of services, independent of whether the services are provided.
Co-payment	-	A fixed payment paid by an individual for health or long-term care services that is not covered by insurance, regardless of the kind of services provided.
Diagnosis Related Group	DRG	Payment paid to hospitals per admission or discharge, whereby patients are classified into groups (DRGs) based on diagnosis and procedures.
General State Administration (<i>Administración General del Estado</i>)	AGE	Refers to the Spanish central government.
Fee-for-service	FFS	A fixed payment for each unit of service without regard to outcomes. It is typically paid retrospectively by billing for each individual service or patient contact.
Global budget	-	A prospective lump-sum payment to a health care provider to cover aggregate costs over a specific period for a set of services independent of the actual volume provided.
Gross Domestic Product	GDP	The standard measure of the value added created through the production of goods and services in a country during a certain period. As such, it also measures the income earned from that production or the total amount spent on final goods and services (less imports).
Individual care program	-	Once an applicant is recognized as dependant, an individual care program is prepared by the AC's Social Services, which includes a list of appropriate services for the degree of dependency, as well as the corresponding entitlement to allowances. This program is established with the participation of the beneficiary through consultation and opinion seeking and, where applicable, with the beneficiary's family.
Institute for Older People and Social Services (<i>Instituto de Mayores y Servicios Sociales</i>)	IMSERSO	A public body of the Ministry of Social Affairs (since 2020, the Ministry of Social Rights and 2030 Agenda) that coordinates and manages the AGE's long-term care policies and programmes, amongst others.

Term	Abbreviation	Definition
Official State Gazette (<i>Boletín Oficial del Estado</i>)	BOE	It enables the central government to publish mandatory laws, regulations and other acts approved by the parliament.
Pay for performance	-	Payments to health care providers for meeting specific performance targets, such as process quality or efficiency measures, or penalties for poor outcomes, such as medical errors or avoidable readmissions.
Per diem	-	A fixed amount per day for inpatient stay, which may vary by department, patient, clinical characteristics, or other factors.
Public Income Indicator of Multiple Effects (<i>Indicador Público de Renta de Efectos Múltiples</i>)	IPREM	A reference index for social assistance benefits in Spain. Its monthly amount has been at €537.84 since 2017.
Spanish National Health System	NHS	The statutory quasi-universal health care system in Spain, which is mainly funded from taxes and where care is predominantly provided within the public sector. Provision is free of charge at the point of delivery, with the exception of outpatient prescriptions of pharmaceuticals and some ancillary goods.
Scale of Dependency (<i>Baremo de Valoración de Dependencia</i>)	BVD	A scale used for measuring limitations with various (instrumental) activities of daily living and for evaluating the degree of dependency that determines the eligibility for dependency benefits.
System for Autonomy and Care for Dependency (<i>Sistema para la Autonomía y Atención a la Dependencia</i>)	SAAD	The public long-term care system in Spain, which was introduced in January 2007 with the passage of the 39/2006 Act. The system is universal and financed mainly through taxes, with funds from the central government (AGE) and regional governments (ACs), and to a lesser extent, through co-payments.
Information System of the SAAD (<i>Sistema de Información del SAAD</i>)	SISAAD	A database where the ACs introduce information concerning the management of the SAAD in their territory. The central government is responsible for the SISAAD.
Territorial Council of the SAAD	-	A co-operation body where the AGE, ACs and local governments are represented and where long-term care is coordinated. Based on the recommendations from this Council, the AGE sets the basic legislation that is common to all ACs and serves as a framework for their own legislation.

Sources: Barber, Lorenzoni and Ong (2019), Bernal-Delgado et al. (2018), IMSERSO (2020), OECD (2019).

1

Overview

The public long-term care system in Spain, known as the System for Autonomy and Care for Dependency (*Sistema para la Autonomía y Atención a la Dependencia*, abbreviated as SAAD), was introduced in January 2007, with the promulgation of the 39/2006 Act (BOE 2006) or the “Dependency Act”. The system is universal and financed mainly through taxes, with funds from the central and regional governments (Autonomous Communities; ACs), and to a lesser extent through co-payments (see section 3).

Prior to this Act, care for older persons was provided through the basic social services of the ACs and municipalities, and through specific programmes for people with disabilities. These services met the long-term care needs of the population only partially. It is estimated that just about 12% of elderly dependants received any kind of publicly financed support in 2000 (compared to about 72%-80% today, depending on whether applicants on wait lists are included or not; see below). The role of the public sector was secondary, provided only in cases where informal care was not possible or insufficient and the level of support linked to the economic capacity of the recipient. Furthermore, as responsibilities for social services were decentralized to the ACs and municipalities, geographical differences widened (European Commission 2019).

The purpose of the Act was twofold. First, to promote personal autonomy and ensure sufficient attention and protection of *all* dependants in Spain through adequate collaboration of all public administration levels. Second, to reduce the burden of family members who were primary (informal) caregivers and to formalize the employment status of these non-professional carers, most of whom are women.¹ Informal carers received special pension rights, and their contributions to Social Security were financed by the State’s General Budget.

The initial demand for care was overwhelming, but most needs were covered with the different cash and in-kind benefits that were included in the SAAD (see section 2). By early 2012, close to 1 million applications were accepted (70% of the assessed applications). However, about half of the benefits granted were cash benefits for informal care (Territorial Council of SAAD 2012), which were intended to be used under special circumstances only (see section 2). The SAAD thus rather unexpectedly consolidated informal care. Attempts have been made to reverse this situation in recent years by promoting the use of service benefits over cash benefits for informal care (see section 5).

Chronic underfunding of the system has been a major problem of the SAAD. The Great Recession hit Spain particularly hard in

1 By the end of January 2020, close to 90% of these non-professional carers were women (IMSERSO 2020a).

2008, just after the implementation of the SAAD, resulting in important budget cuts. In 2012, the central government - in agreement with the regional governments (ACs) - introduced adjustments to the SAAD to meet public deficit objectives. For instance, the inclusion of people with moderate levels of dependency (Degree I) was postponed until July 2015. In addition, the ceiling of financial benefits for dependants and informal carers were reduced, and co-payments were increased (BOE 2012a).

These benefit and coverage adjustments resulted in long waiting lists for those who had been formally recognized as dependants (and were thus eligible for such benefits). By mid-2013, the benefit coverage for dependants was reduced to 63%. Effective coverage has remained low. According to official SAAD statistics, by the end of 2016, just 71% of the 1.23 million dependants entitled to benefits were actually receiving them (IMSERSO 2017a). Public expenditures on long-term care increased with the introduction of the SAAD from 0.5% of GDP in 2005 to 0.7% in 2007 and have stayed constant since then (OECD 2020a).

Budget constraints in public financing for long-term care benefits combined with the demand for care have resulted in low levels of benefits and low prices paid to providers, undermining the provision of high-quality care (see section 8). Moreover, large discrepancies exist among the Spanish regions (ACs) in benefit generosity, coverage and co-payments.

Spain is ageing rapidly, second only to the Republic of Korea among OECD countries. By 2050, Spain will rank among the oldest countries in OECD. For instance, the share of people 80 years or older is projected to more than double by 2050 to 9.5% of the total population on average in comparison with 16% in Japan and Spain (OECD 2017). Approximately 75% of the total applications received by the SAAD come from individuals aged 65 and older; nearly one out of four applicants are high dependant (Degree III); and over half of the beneficiaries in SAAD (54%) are 80 years or older (IMSERSO 2020b).

In the long term, rapid population ageing will put more pressure on the financial sustainability of the public long-term care system and further challenge the adequate provision of care for older persons in Spain. The projected public expenditure on long-term care as a percentage of GDP is steadily increasing in Spain and approaching to the EU average. It is projected to increase 1.4 times as much as the EU average, to about 2.2% by 2070 (European Commission 2018).

Differences in population ageing across Spanish regions are striking. For instance, in 2014 the percentage-point difference between Territorial Level 3 (TL3) regions with the lowest and highest shares of people 65 years and older across all OECD countries was widest in Spain, ranging from 9% in the region of

Fuerteventura to 30% in Ourense (Figure 6.2 in OECD (2017))². Older regions have a lower potential for economic growth in the long run. Under the current financing scheme (see section 3), this will tend to exacerbate the current inequalities in the provision of long-term care services and benefits among regions in Spain.

The Spanish public long-term care system has taken significant steps in providing coverage and care for the dependent population, but it faces important challenges. These include long waiting lists for those formally recognized as dependants; large inequalities among regions in the provision of long-term care services, benefits and co-payments; low transparency of the system; and insufficient funding and inadequate financing arrangements, resulting in low prices paid to providers and possibly low quality long-term care services for dependants.

2 Providers of care for older persons

2.1 Definition, scope and components

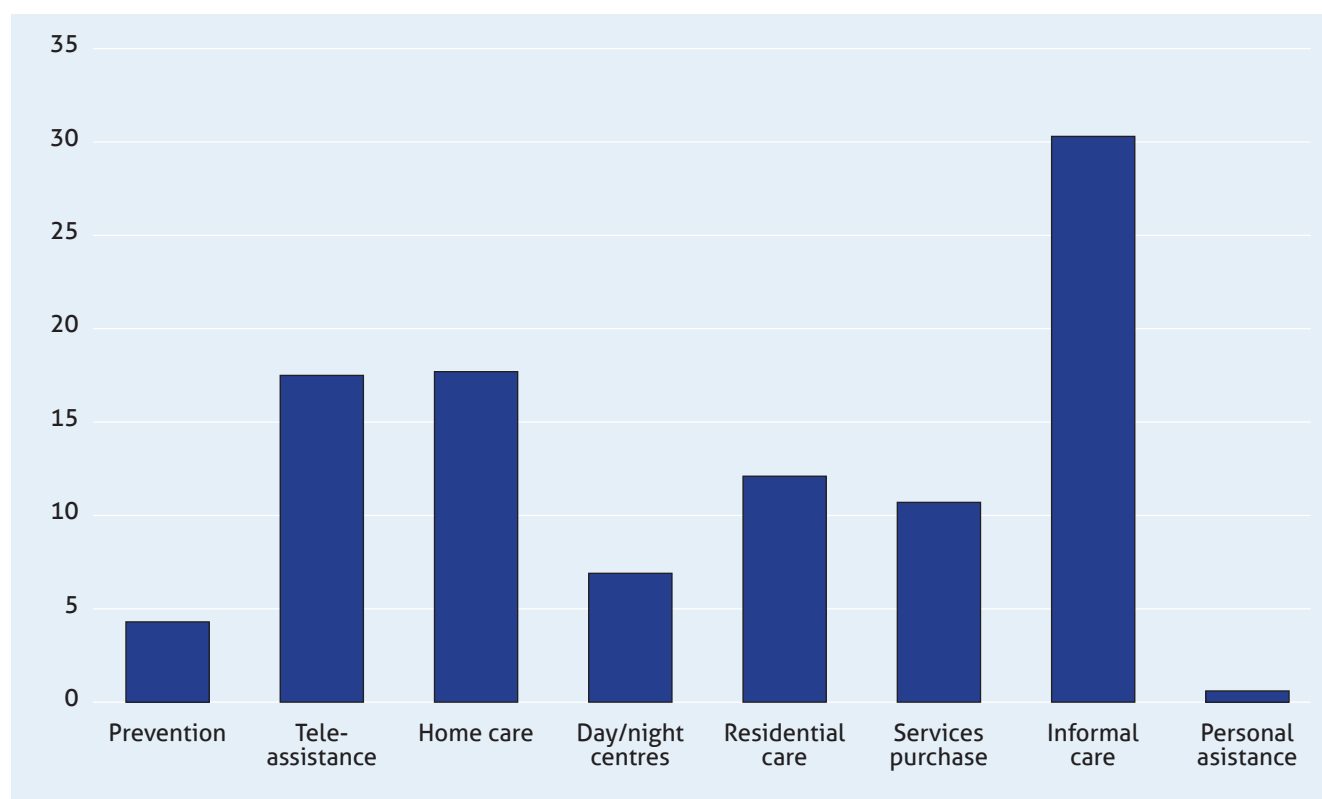
Long-term care in Spain is provided mainly within the SAAD. According to SAAD statistics, in December 2019 there were 1.9 million applicants to SAAD benefits. Close to 92% of them (1.74 million) had been examined, and 80% (1.39 million) of those examined were eligible for benefits from the SAAD based on their degree of dependency. In particular, 23% were recognized as high dependants (Degree III), 30% as severe dependants (Degree II) and 27% as moderate dependants (Degree I) (see section 3 for a definition of the degrees of dependency). However, only 1.12 million were receiving benefits. The remaining 0.27 million (20%) were on a waiting list (IMSERSO 2020b).

The SAAD includes different type of services and financial benefits. The service benefits include prevention, tele-assistance, home care, day/night centres and residential care. There are cash benefits for informal care, personal assistance, and an allowance linked to the purchase of services (see later in this section for more details). Figure 1 shows the distribution of these benefits in the SAAD by 31 December 2019. Three out of 10 benefits in SAAD are cash benefits for informal care, which continues to be the most widely used benefit. Next in order of importance are two service benefits, tele-assistance and home care, each with a share close to 18% of all benefits. Residential care and cash benefits for the purchase of services are also important, with a share of 12% and 11%, respectively. Less than one in 10 benefits correspond to day/night centre services (7%). Prevention services and cash benefits for

² TL3 are small regions. The OECD divides subnational regions in its 35 member countries into two territorial levels that match administrative jurisdictions. Territorial Level 2 (TL2) denotes the upper administrative tier of subnational government, and Territorial Level 3 (TL3) the lower tier. Across the OECD, there are 391 large TL2 regions, which contain 2197 TL3 (or small) regions.

personal assistance are the least used, with a share of 4% and 1% of all benefits, respectively.

Figure 1
Distribution of service and financial benefits in the SAAD by 31 December 2019 (in %)



Source: Author's elaboration based on IMSERSO (2020b).

Services in the SAAD are provided through its own network (the "SAAD network"). Providers from this network must be accredited by the regions (ACs). The central government, by means of the Territorial Council of the SAAD (described in section 3), sets state-wide criteria with respect to staff qualifications, minimum care worker per beneficiary ratios, and requirements of material resources, equipment and documentation (BOE 2012a). The SAAD network includes public centres and services in the ACs and municipalities, as well as national reference centres for the "promotion of personal autonomy and care for dependent persons" and accredited private partner centres. ACs have total freedom to set up this network of providers where non-governmental organizations and not-for-profit institutions are considered priority partners compared with for-profit providers (Bernal-Delgado et al. 2018).

The provision and minimum content of services in the SAAD is regulated by law. For instance, some services have stipulated the minimum intensity for each of the three degrees of dependency (BOE 2012a, 2013, 2015). Priority in access to services is determined by the applicant's degree of dependency and economic capacity. Services are co-paid according to the type of service required and the ability to pay (see section 3). The numbers of coverage for tele-assistance,

home care, residential care centres and day care centres (which are the main long-term care services in the SAAD, see Figure 1) refer to users of social services 65 years and older in Spain. It is important to note that not all of these users are included in the SAAD³.

– **Tele-assistance:**

The main goal is to provide safety and support to dependants to promote their autonomy and facilitate their stay in their home environment. For instance, the technical equipment allows the user to press an emergency alert to contact a service centre, which enables an emergency response to situations such as falls.

This service has the highest number of users. By 31 December 2019 there were 937 990 users 65 years and older, which implies a coverage rate of 10.2% (IMSERSO 2020c)⁴. This coverage rate varies substantially across regions, from 1.0% in Extremadura to 15.6% in Andalucía, but has been steadily increasing since the early 2000s. For instance, the coverage rate was 4.4% in 2006, just before the introduction of the SAAD in Spain.

– **Home care:**

Home care comprises personal (health) care and assistance (social) services. The intensity of home care varies with the beneficiary's degree of dependence from up to 20 hours/month for those with moderate dependence (Degree I) to 21-45 hours/month for those with severe dependence (Degree II) and up to 46-70 hours/month for those with high dependence (Degree III). The intensity of care and the amount of hours devoted to personal care and assistance services is determined within the beneficiary's individual care program by the ACs based on a dependency assessment. Assistance services are normally provided along with personal care services. The provision of these services separately needs to be justified in the individual care program (BOE 2013).

By 31 December 2019, there were 454 068 users aged 65+ in Spain, which implies a coverage rate of 4.9% (IMSERSO 2020c). This coverage rate increased steadily during the 2000s, reaching a maximum of almost 5.0% in 2009, decreased afterwards until 3.6% in 2014, but has recovered since then. As for tele-assistance, the coverage rate varies substantially across regions from about 1.7% in Murcia and País Vasco to 9.3% in Madrid⁵.

In addition to coverage, the quality of the service matters. In terms of hours of care by the user, on average, 20.6 hours

3 The data are taken from IMSERSO (2020c), the latest annual report of the Institute for Older People and Social Services (*Instituto de Mayores y Servicios Sociales*), which is a public body of the new the Ministry of Social Rights and 2030 Agenda; formerly the Ministry of Social Affairs.

4 The coverage rate is defined as: (number of users aged 65+ / population aged 65+) x 100.

5 For País Vasco, however, this coverage is inaccurate, as it assumes zero users in one of its three provinces for which there is no information available (see IMSERSO 2020c).

per month are provided, of which 64% are devoted to personal care services, 34% to assistance services and the remaining 2% to other duties. Across regions, the intensity of hours of care is highest in Galicia, with 39.0 monthly hours per user.

– **Residential care centres:**

These services are provided only for severe and high dependants with Degrees II and III, respectively (BOE 2013). Residential care centres offer comprehensive and continuous personal, social and health care, adapted to the beneficiary's type and degree of dependence, on a temporary or permanent basis. The intensity of these services is specified in the dependant's individual care program. Institutional long-term care service providers include regional and municipal centres, as well as private accredited sector institutions.

As of 31 December 2019, there was a supply of 389 031 places distributed along 5542 residential care centres, which implies a coverage rate of 4.2% (IMSERSO 2020c)⁶. This coverage rate was above 5% in six ACs, with the highest value corresponding to Castilla y León (7.8%) and the lowest one to Murcia (2.3%).

The majority of offered places by December 2019 were publicly funded (62%), but a large majority of centres were private (74%). In 2001, the share of private centres was even larger (86%) and that of publicly financed places was substantially smaller (26%). There has been a large increase in the supply of places, in particular of publicly funded ones. 155 723 new places were created between 2001 and 2015, of which 116 941 corresponded to publicly funded ones (IMSERSO 2017b). The coverage rate increased from 3.1% in 2001 to 4.6% in 2010, decreased then slightly to 4.3% in 2014 and has remained stable since⁷.

– **Day care centres:**

Day care centres offer full- or part-time psychosocial support during the daytime to elderly dependants. These services are meant to improve or maintain the best possible level of personal autonomy of the dependants and to provide support to their families or caregivers. They are adjusted to the specific needs of the dependants, and their intensity is specified in the dependant's individual care program. However, for moderate dependants (Degree I), the intensity of day-centre services is set at a minimum of 15 hours per week (BOE 2013).

As of 31 December 2019, there was a supply of 99 163 places distributed along 3674 centres, which implies a

6 The coverage rate is defined as: (number of places / population aged 65+) x 100.

7 This is consistent with data from OECD (2020b) on the number of beds in residential long-term care facilities per 1000 people aged 65 and over. These numbers show that in Spain this ratio declined from 47 in 2011 to 44 in 2017, remaining just above the OECD average, which was 43 in 2017, but well below that of countries such as France (51) and Germany (54).

coverage rate of 1.1% (IMSERSO 2020c)⁸. This coverage rate varies substantially across regions, from 0.6% in Aragón to 2.8% in Extremadura.

By December 2019, the majority of offered places were publicly funded (60%), but the majority of centres were private (57%). In 2001, the share of private centres was larger (65%) and that of publicly financed places was smaller (55%). There has been a large increase in the supply of places, in particular of publicly funded ones. 71 758 new places in day care centres were created between 2001 and 2015 in Spain, which corresponds to an average of 5126 new places per year (IMSERSO 2017b). As a result, the coverage rate has been steadily increasing since the early 2000s (it was, for instance, 0.3% in 2001 and 0.7% in 2006).

- **Night care centres:**

Night care centres are intended to support dependants in need of care during the night. As for day care, these services are meant to improve or maintain the best possible level of personal autonomy of the dependants and to provide support to the dependants' families or caregivers. They are adjusted to the specific needs of the dependants and their intensity is specified in the dependant's individual care program.

- **Promotion of personal autonomy:**

This service is aimed at promoting and maintaining the dependant's personal capacity. Its intensity in terms of hours per month is set at a minimum of 12 for moderate and severe dependants (Degrees I and II) and at a minimum of 8 for high dependants (Degree III). This service includes, amongst others, the following sub-types whose minimum hours of care per month are also stipulated by law and indicated in brackets: early attention (6 for Degrees I, II and III), and promotion, maintenance and recovery of functional autonomy (15 for Degree I, 12 for Degree II, and 8 for Degree III) (BOE 2013, 2015).

- **Prevention of dependency:**

This service includes different programs to prevent situations of dependency or to avoid a worsening in dependency status. It is offered to all dependants, but it is a priority service for those with moderate dependency levels (Degree I). Prevention services are included in tele-assistance, home care, day care centres and residential care (BOEs 2013).

8 The coverage rate is defined as: (number of places / population aged 65+) x 100.

Hospitals also provide care for older persons. In particular, long-term care can take the form of inpatient care in dedicated long-term hospital beds, in addition to services provided in the SAAD, as discussed above. The Spanish National Health System (NHS) has 10 899 long-term care beds that represent 9% of public beds and 77% of long-term care beds in the country, according to 2014 data. Additionally, private hospitals (usually not-for-profit) hold 3102 beds that might be used to complement public supply. Typically, hospital long-term beds cover palliative care needs, either in chronic patients or patients with cancer (MSSSI 2014).

Skilled nursing facilities offer intermediate socio-health care to patients that are transitioning from an episode of acute hospitalization to their homes or residence. These patients are characterized by a medical and social dependence and, importantly, by a possibility of functional recovery. Older persons are the main recipients of this type of care, which is typically provided in medium- and long-term beds. The average stay care ranges between 2 and 6 weeks (IDIS 2016). This type of care releases resources from acute hospitals, generating savings to the overall health care system.

There were 14 884 medium- and long-term beds in Spain in 2014⁹, resulting in a coverage rate of 0.32 beds per 1000 inhabitants. Between regions, this coverage rate varied from 0.02-0.03 in Andalucía and Galicia to 1.11 in Catalunya¹⁰. The majority of beds were privately funded (60%) and about equally distributed along for-profit and not-for-profit places.

Primary care provides preventive services to elderly patients and other population groups. It is mainly delivered by public health care centres within the statutory NHS with specialized family doctors and staff nurses. Care for older people includes programmes for early detection of frailty, as well as follow up of terminally ill patients. This latter service is provided in close coordination with other specialized services. Moreover, as an effort to increase care continuity and coordination between primary and secondary health care levels, some ACs are enhancing the role of primary health care in the implementation of case-management programmes meant to deal with more fragile patients (Bernal-Delgado et al. 2018).

No specific care programmes for older persons were found in outpatient care in the Spanish NHS.

Besides service benefits, the SAAD includes financial benefits based on the beneficiary's degree of dependency and economic capacity, which are discussed here for completeness (BOE, 2012a, 2013). These are mainly linked to supporting the provision of services outside the SAAD network. Three types of allowances are available:

9 This number is obtained from *Catálogo Nacional de Hospitales 2014* (MSSSI 2014) by selecting centres that are classified within the categories of "Rehabilitation" and "Geriatrics and long stays" (see IDIS (2016) for more details).

10 Defining the coverage rate as the number of places per 1000 persons aged 65+ results in a similar ranking, with the highest value being 6.03 in Catalunya and the lowest ones being 0.11-0.13 in Andalucía and Galicia.

- **Financial benefits for care recipients to purchase services:**
This allowance is meant for care recipients to purchase a service outside the SAAD network when no public or private partner centre is available. Benefit levels for new recipients from August 2012 range from €300 per month for degree I, to €426.12 per month for degree II and €715.07 per month for degree III. For those with an earlier recognised degree and level, they range from €400 per month for degree II, level 1, to €831 per month for degree III, level 2, in 2012 (sub-levels within each grade were eliminated in 2012; see section 3).
- **Financial benefits for care recipients receiving informal care:**
This allowance is for care provision within the family when a relative is acting as the principal informal carer. It would only apply when the recipient is being cared for at home if physical and living conditions for care are met (see section 5 for more details). Benefit levels for new recipients from August 2012 range from €153 per month for degree I, to €268.79 per month for degree II and €387.64 per month for degree III. For those with an earlier assessed degree and level, they range from €255.77 per month for degree II, level 1, to €442.49 per month for degree III, level 2, in 2012.
- **Financial benefits for paid personal assistance:**
This allowance is to support the hiring of professional services in order to promote the care recipient's personal autonomy, access to work and education, and help with activities of daily living (ADL). Hiring expenses for the carer must be documented and the carer needs to have appropriate professional qualifications (state certifications). Benefit levels for new recipients from August 2012 range from €300 per month for degree I, to €426.12 per month for degree II and €715.07 per month for degree III. For those with an earlier recognised degree and level, they range from €609 per month for degree III, level 1, to €812 per month for degree III, level 2, in 2012.

There are limitations to combining the different benefits covered by SAAD (BOE 2012a). Service benefits cannot be combined. The exception is tele-assistance, which can be combined with all service benefits apart from residential care or its equivalent financial benefit to get this service. The ACs can allow specific benefits for the promotion of personal autonomy and home care to be combined as long as their sum of hours of care is within the dependency degree-specific limit of maximum home care hours (BOE 2012b). The ACs can further establish the compatibility between service benefits for home care, day and night centres, and financial benefits for informal care and personal assistance (BOE 2013). Tele-assistance can be provided as a single benefit for moderate dependants only. For severe and high dependants, it has to be provided along with other benefits, except if the beneficiaries were receiving this service already in an earlier stage as moderate dependants (BOE 2018a). Finally, financial benefits cannot be combined or

with service benefits, except those for the prevention of dependency, promotion of personal autonomy and tele-assistance.

2.2 Link to Universal Health Coverage entitlements

Coverage in the statutory Spanish NHS is virtually universal, mainly funded from taxes, and care is predominantly provided within the public sector. Provision is free of charge at the point of delivery, with the exception of outpatient prescriptions of pharmaceuticals and some ancillary goods, where co-payment is set considering a maximum ceiling of monthly payment and fixed according to annual household income (Bernal-Delgado et al. 2018). Long-term care services in the form of inpatient care or primary care services for older persons (as discussed earlier in this section) are thus free of charge in the Spanish NHS.

Benefits from the SAAD are universal but means-tested for both service and financial benefits. While the central and regional government budgets cover most of the costs of the SAAD, co-payments have become increasingly important over the last years and equalled 18% of the total cost of the SAAD in 2018 (see section 3). Co-payment is progressive up to a maximum of 90% of the cost of service and financial benefits, depending on the beneficiary's economic capacity (and degree of dependency or cost of the service for some benefits). ACs can increase further these co-payments (see section 8).

3

Financing and systems issues

The system is funded through taxation and financed with resources from the central government and ACs. The central government allocates funds to each AC based on the number of dependants and their degree of disability and the proportion of service benefits over financial benefits for informal carers¹¹. As explained below, the ACs can decide whether to allocate additional funding to provide additional services.

3.1 Care coordination

Long-term care is coordinated within the Territorial Council of the SAAD. This is a cooperation body where the central government, the ACs and the local governments are represented. By means of this council, the central government and the ACs agree on a framework for intergovernmental cooperation, the intensity of services, the terms and amounts of financial benefits, the criteria for co-payments by the beneficiaries, and the scale of dependency that is used for the recognition of dependency. Based on the recommendations from the Territorial Council, the AGE sets the basic legislation that is common to all ACs and serves as a framework for their own legislation. Local authorities take part in the Territorial Council of the SAAD and can also complement the set of benefits, mainly by financing community services. In practice, though, they play a subordinate role in the system (Rodríguez-Cabrero et al. 2018).

Managing the SAAD is a competence of the ACs. Long-term care services are fully operated by the ACs, which includes planning, accreditation, quality assurance, financing and pricing. The Spanish long-term care system is thus highly decentralized and is often considered a “system of regional long-term care services”. Many differences in its application can be observed across the different ACs. For instance, whereas 2.4% of the population in Spain has been recognized a degree of dependency and receives a benefit from the SAAD, this share varies between ACs from 4.4% in Castilla y León, to about 3% in Castilla-La Mancha, País Vasco and Cantabria, 1.8% in Illes Balears and C. Valenciana, and only 1.1% in Canarias (IMSERSO 2020b).

¹¹ The ratio of service benefits over financial benefits for informal care was introduced as an additional criterion for funding allocation in 2012 to promote the use of service benefits, as they have a higher potential than financial benefits for informal care for creating jobs and developing a “sector” of long-term care (see section 5).

3.2 Source of financing

Long-term care in Spain is financed mainly through taxes and, to a lesser extent, through co-payments and charges (BOE 2008a). Tax contributions are paid by the AGE and by the ACs.

There are three levels of protection in the SAAD. The basic level corresponds to a minimum level of care and is entirely financed by the AGE. The ACs receive funding from the AGE depending on 1) the number of dependants and their degree of disability, and 2) the proportion of service benefits over financial benefits for informal carers. The second criterion was introduced in 2012 to promote the use of service benefits with an initial weight of 10% in the AGE's funding allocation that was increased to 50% after five years. There is a guaranteed minimum level of protection per SAAD beneficiary that results from this basic level of protection which varies from €190.13 per month for high dependants (Degree III) to €84.49 per month for severe dependants (Degree II) and €47.38 per month for moderate dependants (Degree I) (BOE 2017). The agreed level tops up the basic level and is financed with matched contributions from the AGE and the ACs. This level takes into account factors such as the geographical dispersion of the dependants and the number of returned emigrants who return usually after retirement to their AC of origin and are therefore potential dependants. The additional level is entirely financed with additional and voluntary contribution from the ACs to provide additional protection.

In 2018, contributions from the ACs and AGE covered respectively 66% and 16% of the total cost of the dependency system in Spain, with co-payments covering the remaining 18% (see Table 1). There are, though, important differences across regions in these shares. For instance, the share of co-payments vary from 11% in the region of C. Valenciana to 22% in Madrid. The regions' contributions vary from 61% in Castilla y León to 74% in C. Valenciana. In addition, the AGE's budget contribution varies from 11% in Cantabria to 20% in Castilla y León, Extremadura and Galicia.

The total costs of the system per person 65 years and older (which is the main group of applicants to the SAAD; see section 1) were overall €926 with large differences between regions (€504 in Canarias and about €1300 in Cantabria and País Vasco). These regional differences do not seem to be related to differences in the shares of people aged 65+ (the correlation coefficient between columns (8) and (10) in Table 1 is low, 0.12), but to differences in the shares of beneficiaries (the correlation coefficient between columns (8) and (9) is high, 0.78). The total cost of the system by beneficiary was overall €7922, again with large regional disparities, ranging from about €6600 in Andalucía and Murcia to €10 404 in Cantabria.

Table 1

Total costs of the dependency system by regions (ACs) in Spain (in millions of euros, 2018, except the last two columns, which are in euros per person)

ACs	Total cost of SAAD	Total AGE	Total ACs	Co-payment	Total AGE (%)	Total ACs (%)	Co-payment (%)	Pop. aged 65+ (%)	Beneficiaries of SAAD (% of pop.)	Total cost of SAAD per person aged 65+	Total cost of SAAD per beneficiary
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Andalucía	1 403	246	870	286	18	62	20	17	2.5	982	6610
Aragón	207	36	139	32	17	67	15	22	2.2	726	7085
Asturias	173	29	116	28	17	67	16	25	2.1	665	7855
Baleares	124	23	84	18	18	68	14	16	1.5	668	7150
Canarias	177	29	119	29	16	67	16	16	1.0	504	8185
Cantabria	164	18	120	27	11	73	16	22	2.7	1300	10 404
Castilla y León	685	135	418	133	20	61	19	25	3.9	1134	7338
Castilla-La Mancha	499	69	332	98	14	67	20	19	2.9	1300	8626
Cataluña	1 430	189	968	274	13	68	19	19	2.0	998	9226
C.Valenciana	583	85	434	64	15	74	11	19	1.5	607	7845
Extremadura	210	42	131	37	20	62	18	20	2.7	959	7177
Galicia	454	91	281	82	20	62	18	25	2.2	673	7558
Madrid	1 201	172	760	269	14	63	22	18	2.2	1025	8474
Murcia	232	36	166	30	15	71	13	16	2.4	1000	6629
Navarra	100	15	72	13	15	72	13	20	2.1	786	7338
País Vasco	638	74	457	107	12	72	17	22	3.0	1307	9808
Rioja	72	10	47	14	14	66	20	21	2.6	1097	8889
Spain	8352	1298	5513	1542	16	66	18	19	2.3	926	7922

Source: Adapted from Jiménez-Martín and Viola (2019) and the Association of Directors and Managers in Social Services (*Asociación Estatal de Directoras y Gerentes en Servicios Sociales*, <https://www.directoressociales.com/documentos/dictamenes-observatorio.html>). Population (pop.) and beneficiaries of the SAAD correspond to 2018 numbers and are taken from Instituto Nacional de Estadística (www.ine.es) and Instituto de Mayores y Servicios Sociales (www.imserso.es), respectively. Numbers for the autonomous cities of Ceuta and Melilla are not provided.

3.3 Characteristics of purchasers and providers

The main purchaser (health insurer) is the AGE along with the ACs. Within the general scheme, regional health services contract hospital care, primary care, preventive activities and long-term services with public and private providers.

There is no mandatory insurance for long-term care in Spain (see section 3.2), and the private insurance market of long-term care is very limited. Private insurers focus on covering the gap between public reimbursements and actual fees, as well as providing access to additional services (complementary insurance).

For hospital care, in addition to public providers, a certain amount of activity is contracted out to private providers, typically aimed at reducing waiting lists for surgical procedures or high-technology diagnostic tests, but also to complement long-term care services and palliative care. Private hospitals, however, play a subsidiary role in the Spanish health care system, with some notable exceptions in the ACs of Catalunya, Madrid and C.Valenciana (Bernal-Delgado et al. 2018).

Providers of long-term care services can be public or private (for profit or not), but they need to be accredited. Dependants who are eligible for specific financial benefits (in particular, those linked to services purchased outside the SAAD network; see section 2) will be able to spend these benefits only on accredited centres and services. Accreditation is granted by the ACs, but the minimum state-wide requirements are determined by the AGE based on the recommendation from the Territorial Council of the SAAD. These basic requirements include regulations regarding quality of employment and staff qualifications, material resources, equipment and documentation. Institutional long-term care service providers are required to have minimum ratios of workers per care recipient and type of worker for carers and geriatricians (BOE 2012a).

Most of the institutional and day care providers are private. For instance, by December 2015, 57% of day care centres were private (section 2) even though they are publicly subsidized at 60% (European Commission 2016). The share of private institutional care providers is even larger, with only 24% of residences being publicly owned (although an additional 22% of residents in institutional care centres receive a public subsidy to be placed in a private centre). Providers often receive substantial public subsidies in order to make their service more affordable for care recipients (European Commission 2016). There are large regional disparities in the distribution of beds and services offered (section 2) as well as in term of their prices (section 9).

3.4 Criteria for eligibility to care: entitlement, means-testing, characteristics of the individual

Benefits from SAAD are universal for all Spanish nationals who have been residents in Spain for at least five years; residence is required for at least two years immediately before the claim is filed. Exemptions to this rule are in place for Spanish returnees (BOE 2013). The claimant needs to be a resident in the region of application.

Eligibility depends on an assessment of the degree of dependency, evaluated on the basis of the Scale of Dependency (*Baremo de Valoración de Dependencia*) (BOE 2011). The scale measures limitations with various ADL related to feeding, personal hygiene, dressing and ambulating and instrumental ADL (IADL) such as preparing meals, cleaning and maintaining the house, health management and maintenance, moving within the community and decision-making¹². Each single activity receives a specific weight and a coefficient indicating the required level of support and supervision. The final assessment is expressed as a numerical score and is equal to the weighted average of all 51 included activities (besides the eight for measuring limitations with decision-making), each multiplied by the coefficient of required support and supervision. Individuals with a score below 25 are not entitled to any service or financial benefits from the SAAD.

There are three degrees of dependency, which are defined as follows¹³:

- Degree I (Moderate Dependency, 25 to 49 points in the Scale of Dependency): the individual requires help for several basic ADL at least once a day or needs help on a sporadic basis or limited to personal autonomy.
- Degree II (Severe Dependency, 50 to 74 points in the Scale of Dependency): the individual needs help for several ADL, two or three times a day but does not need permanent help from a carer nor extensive help to ensure personal autonomy.
- Degree III (High dependency, 75 to 100 points in the Scale of Dependency): the individual needs help for several ADL several times per day, and because of total loss of physical, mental, intellectual or sensorial autonomy, s/he needs permanent help from a carer or needs generalized help to ensure personal autonomy.

Responsibility for assessing the degree of dependency and benefit entitlement lies with the regions (ACs). Once an applicant is recognised as dependant, an individual care program is prepared by the AC's social services, which includes

12 Decision-making is evaluated only for people with a potential mental health condition.

13 Initially, there were two additional sub-levels within each grade, but these were eliminated in 2012, as they did not result in an improved assessment of individual dependency and there were no practical differences in caring by levels within the same degree of dependency. The goal was to improve access to benefits, assessment of dependency and management of the system (BOE 2012a).

a list of appropriate services for the degree of dependency as well as the corresponding entitlement to allowances (BOE 2013). This program is established with the participation of the beneficiary through consultation and opinion seeking and, where applicable, with the beneficiary's family.

Access to benefits is means-tested for both in-kind (service) and financial benefits (see section 8), and there are incompatibilities between different benefits (see section 2).

4

Base for payment by facility

The base for payment refers to the unit of activity upon which prices are defined and set. Similar to other countries, the base for payment method in Spain varies by categories of facility. The common thread is the adjustment of the payment level based on the level of the complexity of the health condition, physical functioning and medical needs (Barber, Lorenzoni and Ong 2019).

Most of the publicly funded health services in Spain use global budgets as the funding mechanism¹⁴. The system builds on a contractual agreement between the Regional Health Service and the provider (that is, hospitals, primary care settings, etc.). These agreements, known as *contratos programa*, regulate the quantity of services and the overall cost, but also introduce quality-oriented elements aligned with the objectives of the regional strategies on quality and safety: typically, waiting list reduction programmes, extension of day-case surgery and reduction of safety events. In addition, part of the compensation to providers might be based on outcomes set upon territorial objectives such as accessibility, responsiveness and attention to chronic patients (Bernal-Delgado et al. 2018).

4.1 Primary care

Global budgets, capitation¹⁵ and pay for performance¹⁶ are the funding mechanisms for primary care. Public health care centres within the statutory NHS mainly deliver primary care services. As in the case of hospitals, contractual agreements are set following a benefits package-based approach. Typically, the primary care management structure of the health care area signs an annual contract-programme with the Regional Health Service based on capitation criteria (with some ingredient of demographic structure and population dispersion), including some specification linked to the priorities of the Regional

14 A global budget provides fixed funding for a specific population group and offers more flexibility in allocating resources than other payment methods (Barber, Lorenzoni and Ong 2019).

15 Capitation consists of a prospective fixed lump-sum payment per person enrolled for care with a provider within a given period (typically one year) covering a defined set of services, independent of whether the services are provided (Barber, Lorenzoni and Ong 2019).

16 Pay for performance are payments to health care providers for meeting specific performance targets, such as process quality or efficiency measures, or penalties for poor outcomes, such as medical errors or avoidable readmissions (Barber, Lorenzoni and Ong 2019).

Health Service. This contract's specifications cascade down, translating into contracts with each primary care team (that is, the group of specialized doctors and nurses in charge of the primary care in each basic health zone). It is a negotiated process, in setting objectives and standards of care. For example, it has been the main vehicle in implementing rational drug-use programmes and in fostering the prescription of generic drugs (Bernal-Delgado et al. 2018).

Individual-oriented health promotion and preventive medicine services are mostly integrated as part of the primary care package of benefits (for instance, medical counselling and hypertension or diabetes control). Those services are funded as part of the primary care payment mechanisms. In turn, collective services such as vaccination campaigns or population screening programmes (breast, colorectal or cervical cancer) are funded via earmarked budgets (Bernal-Delgado et al. 2018).

4.2 Outpatient services

Outpatient services in hospitals within the statutory Spanish NHS are funded through global budgets (see section 4.3 for more details).

4.3 Hospitals

With some exceptions, public hospitals are normally funded through global budgets set against agreed spending headings. The main part of the budget is fixed by means of a formula that accounts for the number of discharges, the case-mix weight (generally episode-based all-patient diagnosis-related groups (AP-DRGs)) and a structure-related tariff. Some procedures are excluded from this financing formula and are paid following a fee-for-service (FFS) mechanism. Although from a budgetary perspective contractual agreements were implemented to shift from retrospective global budgeting to a prospective payment mechanism, the method is not properly acting in this way, as the financial body usually ends up assuming budgetary deviations through "operating grants" and risks are not truly transferred to the public providers. On the other hand, the degree of sophistication of the contract design itself and the extent to which the budget depends on performance is uneven across ACs (Bernal-Delgado et al. 2018).

In addition to public providers, a certain amount of activity is contracted out to private providers, typically aimed at reducing waiting lists for surgical procedures or high-technology diagnostic tests, but also to complement long-term care services and palliative care. These are generally prospective volume contracts with some ex-post correction clauses. Depending on the nature of the specific activity, the contractor determines the basis for payment; hence, long-term care activity is usually measured in terms of stays, whereas surgical interventions and diagnostic tests follow a FFS scheme (González López-Valcárcel, Puig-Junoy and Rodríguez-Feijoo 2016).

4.4 Skilled nursing facilities

Skilled nursing facilities in Spain are mostly located in the AC of Catalunya and are paid on a per diem basis (IDIS 2016). Reference costs for long-term care services within the SAAD are set by law based on recommendations from the Territorial Council of the SAAD. Legislation is shared by the AGE and ACs, where the national regulation (basic legislation common to all the ACs) frames the ACs' legislation. For skilled nursing facilities, these regulations were not specified, but have been set later by some ACs¹⁷. These reference costs are used to calculate co-payment levels based on the dependant's economic capacity. Payments are covered to some extent with financial benefits from the SAAD (see section 8).

4.5 Residential facilities

Residential care services use a per diem payment scheme. Reference costs for long-term care services within the SAAD are set by law based on recommendations from the Territorial Council of the SAAD. For residential care, the national reference cost increases with the degree of dependence and is set between €1100-1600 (of 2012) per month, but can be modified by the ACs (see section 3). These reference costs are used to calculate co-payment levels based on the dependant's economic capacity. There is a distinction between assistance services and board and lodging costs (B&L). Co-payments cover the first B&L, but costs of B&L are always covered (also for those on very low income, i.e. income levels below the IPREM; see section 8).

4.6 Home-based care (health and social)

Reference prices per hour and type of home care services are fixed by the public administration. Home care comprises personal (or health) care and assistance (or social) services; these are funded with public benefits (in-kind or cash) and co-payments (see section 2). National reference prices for personal care and assistance services are set at €14 and €9 per hour of care respectively (in 2012 euros), but this amount can be modified by the ACs (see section 3). There is no adjustment to these prices by degree of dependency, but the intensity of home care increases with the beneficiary's degree of dependency (see section 3).

4.7 Day care

Day care services use a per diem payment scheme. Reference costs for long-term care services within the SAAD are fixed by the public administration based on recommendations from the Territorial Council of the SAAD (see above). For day (and night) care centres, the national reference cost is €650 per month (in 2012), but this amount can be modified by the ACs (see section 3). These reference costs are used to calculate co-payment levels based on the dependant's economic capacity.

¹⁷ For the AC of Catalunya, see <http://portaldogc.gencat.cat/utillsEADOP/PDF/8029/1776874.pdf>.

4.8 Hospice

In the case of hospice or palliative care, per diem fees are the most common payment scheme, and the unit price depends on the condition of the patient, the therapeutic complexity and the characteristics of the hospital. There is nevertheless no official information on the current situation of palliative care in Spain (Bernal-Delgado et al. 2018).



5 Informal care linked to cash transfers to families for dependants

Cash transfers for informal care are one of the benefits included in the SAAD (more specifically, this is referred to as “financial benefit for care provision within the family when a relative is acting as principal carer”; see section 3). The level of the benefit depends on the care recipient’s degree of dependency and her/his economic means. Informal carers have to sign an agreement with the IMSERSO and pay contributions to social security, even though these are financed by the State’s General Budget.

To be eligible for cash transfers (BOE 2012b, 2013), an alternative provision of care through service benefits is not possible due to a lack of provision of public or accredited private services in the dependant’s area of residence, and the dependant is cared for at home, which meets some minimum physical and living conditions for an adequate provision of care. The carer is the spouse or a close relative and has been caring for the dependant for at least one year before benefit application; if the carer is not a close relative, s/he is cohabiting with the dependant and has been caring for the dependant for at least one year before benefit application. Under specific circumstances, e.g. in areas with limited access to public or private accredited caring services, the carer can be also a neighbour as long as s/he has been caring for the dependant for at least one year before benefit application (cohabitation is required if the beneficiary has a severe or high dependency, otherwise cohabitation is not necessary, but the beneficiary’s area of residence has to be classified as a “rural area”).

There has been an over-use of financial benefits for informal care, which was foreseen as exceptional when the Dependency Act was passed in 2006 (Jiménez-Martín, Labeaga-Azcona and Vilaplan-Prieto 2016). For instance, by December 2010, almost half of the awarded benefits (48%) were financial benefits for informal care (IMSERSO 2011). One possible explanation for this is a preference for informal care, at least among some dependants in Spain. Another explanation is that informal care is less expensive than formal care for regional governments. A comparison between service (in-kind) benefits and financial benefits for informal care shows that the latter imply a lower expenditure for the ACs. In particular, a cash benefit for informal

care represents 77% of the cost of a public day care centre place and 52% of the cost of a public nursing home place (Jiménez-Martín, Labeaga-Azcona and Vilaplan-Prieto 2016).

Over the last years there has been a prioritization of in-kind (service) benefits over financial benefits for informal care, as the former are more labour-intensive and tend to pay above-average wages, which can help develop a “sector of long-term care” with “good jobs” (see section 3)¹⁸. This can be illustrated in the SAAD’s minimum level of protection, funded by the AGE, where the proportion of service benefits in comparison with financial benefits for informal care was introduced as an additional criterion for funding allocation in 2012 with an initial weight of 10% that was increased to 50% after five years (see section 3). As a result, the share of cash benefits for informal care over the total benefits in the SAAD had decreased to 34% by December 2016 (IMSERSO 2017a) and to 30% by December 2019 (IMSERSO 2020b).

There is, nevertheless, still a great reliance on informal care in Spain that falls heavily on women. Currently, women account for up to 90% of non-professional carers (IMSERSO 2020a). As female labour force participation continues to increase, it is expected that Spain will become increasingly reliant on formal care (Spijker and Zueras 2020).

6 **Process by which prices are determined (for the categories of facilities)**

6.1 Unilateral administrative price setting

Health and long-term care services in Spain – except pharmaceutical care – are in general fully governed by the ACs. This includes planning, accreditation, quality assurance, financing and also pricing. The ACs determine maximum official tariffs for health care services provided within the Spanish NHS and for those purchased from private providers, as well as maximum reference costs for long-term care services provided within the SAAD¹⁹.

Regarding the relationship with health care providers, the ACs’ Health Departments contract with both public and private providers in terms of number of services, quality and cost. In the case of public providers, the system is based on a contractual relationship (the so-called “programme-contract”) between the financing body and the health care provider (typically hospitals)

¹⁸ This was one of the initial goals when the Dependency Act was passed in 2006 and became even more relevant during the years of high unemployment rates that followed the Great Recession in Spain (the unemployment rates remained at 20% or higher during the years 2010-2016, with a peak of 26-27% in 2013 (INE 2019)).

¹⁹ Health care services purchased from private providers are paid according to these public predefined tariffs and contract accomplishments (Bernal-Delgado et al. 2018). Reference costs are used in long-term care services to calculate co-payment levels (see section 8). These costs are determined by the AGE based on the recommendations from the Territorial Council of the SAAD but can be modified by the ACs.

and is not properly a method of purchasing services, but a method to assign budgets to hospitals (see section 4). Since there is not a clear separation between purchaser and provider, financial risk is not transferred to providers. Unit prices (i.e. price per assistance unit or any other hospital production unit) are calculated from historical costs data, and although the system is said to be prospective, the financing body assumes budgetary deviations through specific grants (Bernal-Delgado et al. 2018; Sánchez-Martínez et al. 2006).

Prices paid by public purchasers to private providers in the context of contracting-out agreements do not reflect unit costs. Official maximum tariffs for all the services and processes that are liable to be subject of contracting-out are established. These tariffs - based on historical patterns rather than on cost accounting estimations - work as a reference point in contract negotiations. The ACs' Health Departments act as monopsonies, and the agreed prices are usually influenced by the institutional features of the market, such as the providers' power of negotiation or the degree of competition between them, and are not related to costs (Sánchez-Martínez et al. 2006).

7

Technical process of price setting (for the categories of facilities)

7.1 Process of data collection from providers

In Spain, a fee schedule consisting of an official tariff and reference costs establishes the payment rates for every covered health service and long-term care service provided within the SAAD, respectively.

In many cases, tariffs and reference costs are static based on some value established in the past and are not updated systematically.

In many cases, these tariffs and reference costs vary between ACs in an unsystematic way that is unrelated to differences in costs of care provision between ACs.

7.2 Costing methods

Price levels that are too low or too high create incentives for over- or under-utilization. This gives an incentive for purchasers to estimate prices that reflect the actual costs of the given service across a set of providers (Barber, Lorenzoni and Ong 2019).

Hospital cost calculations in Spain are mostly based on a full costing approach as opposite to other systems like direct costing or activity-based costing. Regional and hospital differences arise on the method used to allocate indirect costs to cost centres and also on the approach used to measure

resource consumption. Costs are typically calculated by disaggregating expenditure and allocating it to cost centres and then to patients and DRGs (Sánchez-Martínez et al. 2006).

7.3 From cost submission to price setting

One obstacle to cost assessment in Spain lies in the separation between costs and prices (Sánchez-Martínez et al. 2006). The process of setting prices for health and long-term care services is far from reflecting cost information (section 6). The paradox is that, although there are costing systems promoted by health authorities that enable public hospitals to calculate true unit costs, payments to hospitals are based on public tariffs, which do not aim to reward unit costs. Methods of payments generally ignore unit costs, either average or marginal, and in many cases, tariffs are not updated systematically. Hence, incentives from the provider's perspective to develop cost information systems are scarce.

Additionally, reference costs for long-term care services provided within the SAAD do not respond to costs but rather to budgets set by the ACs.

8 Methods of adjustments

This section includes price adjustments and add-on payments based on the facility and the beneficiary's characteristics. These are common when prices are set unilaterally or negotiated collectively to ensure that specific services or caring for specific populations are covered, particularly where there are additional costs of providing care or it is considered unprofitable (Barber, Lorenzoni and Ong 2019).

8.1 For health needs/beneficiary characteristics

Coverage in the SAAD is universal and means-tested (see section 3). The amount of financial and service (in-kind) benefits depends on both the beneficiary's degree of dependency and economic capacity.

Three degrees of dependency are considered: moderate dependence (Degree I), severe dependence (Degree II) and high dependence (Degree III). An individual care program determines the services or benefits that best match the dependant's needs (see section 3). Granted financial benefits and hours of in-kind benefits increase with the degree of dependence (see section 2).

Economic capacity is determined based on the dependant's income, net wealth, age and type of service benefit. In particular, the dependants' economic capacity will be equal to their income plus 5% of their net wealth if they are over age 65, plus 3% if they are 35 to 65 years-old and plus 1% if they are below age 35. In the case of receipt of residential care

services or the equivalent financial benefit to hire such a service, net wealth includes also the value of the house owned by the beneficiary, as long as there are no other dependants residing in that house (BOE 2008a).

There is a co-payment, which depends on the beneficiary's economic capacity. The law establishes that beneficiaries must contribute financially to the funding of services through a co-payment defined in terms of the beneficiary's economic capacity (BOE 2012a). There is a minimum exempt from co-payment, which is referenced to the monthly amount of the Public Income Indicator of Multiple Effects (*Indicador Público de Renta de Efectos Múltiples*, abbreviated as IPREM), excluding residential care²⁰. Co-payment is progressive up to a maximum of 90% of the cost of service and financial benefits, depending on the beneficiary's economic capacity. ACs can increase these co-payments.

The Territorial Council of the SAAD determines a set of common (minimum) criteria to cover the cost of benefits to ensure the principle of equality between all dependants in Spain (BOE 2012a). There has been wide regional disparity both in the timing of the approval of co-payment and in the means test (del Pozo-Rubio, Pardo-García and Escribano-Sotos 2017; Jiménez-Martín, Labeaga-Azcona and Vilaplana-Prieto 2016). The most important difference is that five out of the 17 regions (ACs) consider only the beneficiary's income, while the other 12 include both income and net wealth to determine a dependant's economic capacity (BOE 2018b).

Besides the dependant's economic capacity, co-payments vary by type of benefit or facility:

Services benefits:

– Residential care services (BOE 2012b):

Co-payment varies with the dependant's economic capacity and with the cost of the service.

There is a distinction between assistance services and B&L. Co-payments cover first B&L.

The reference cost of residential care for co-payment increases with the degree of dependency and set between €1100-1600 per month in 2012. This amount follows negotiated prices of residential care places (*precios de concertación de plazas*) and can be increased by up to 40% if higher care intensity is required. It is updated annually with the IPREM.

Actual co-payment is determined by the following equation: $CP = EC - Min$, where CP and EC are, correspondingly, the beneficiary's co-payment and economic capacity, and Min corresponds to a minimum exempt from co-payment for personal expenses equal to 19% of the monthly IPREM (ACs

²⁰ The IPREM is used as reference index for social assistance benefits in Spain. Its monthly amount has been €537.84 since 2017. ACs can use a different index but, if this results in more generous service and financial benefits, the difference must be financed entirely with their own additional and voluntary contributions (see section 3).

may set a lower amount for Min). If the formula results in a negative amount, there is no co-payment. The costs of B&L are always covered by the corresponding public administration, at least to some extent.

A beneficiary's contribution may amount up to 90% of the cost of a public nursing home (BOE 2008a).

- **Home-based care services (BOE 2012b):**

The reference cost of home care is, correspondingly, €14 and €9 per hour for personal care and assistance services to cover housing needs in 2012.

- Actual co-payment decreases with the number of hours of care, as illustrated in the following equations for severe and high dependants (there is no formula for moderate dependants, who receive up to 20 hours per month of home care):

- if monthly hours of care are 21-45 (which corresponds to severe dependants):

$$CP = ((0.4 \times HC \times EC)/IPREM) - (0.3 \times HC),$$

- if monthly hours of care are 46-70 (which corresponds to high dependants):

$$CP = ((0.3333 \times HC \times EC)/IPREM) - (0.25 \times HC),$$

where HC is the cost per hour of the corresponding home care service.

The minimum monthly co-payment was set to €20 in 2012.

- **Day- and night-centre services (BOE 2012b):**

The reference cost of day and night centre services for co-payment was €650 per month in 2012 without meal or transportation expenses. This cost is in accordance with negotiated prices at private centres. This amount can be increased by up to 25% if higher care intensity is required and is updated annually with the IPREM.

Actual co-payment increases with the dependant's economic capacity as follows: $CP = (0.4 \times EC) - (IPREM/3.33)$.

If EC is below the IPREM, there is no co-payment.

A beneficiary's contribution may amount up to 65% of the cost of a place in a public day care centre (BOE 2008a).

- **Tele-assistance services (BOE 2012b)**

Actual co-payment increases with the dependant's EC, from zero when EC is lower than the monthly IPREM, to 50% when EC is equal to 1-1.5 times the monthly IPREM, and 90% when EC is higher than 1.5 times the monthly IPREM.

Financial benefits:

The final benefit will be equal to the legislated upper bound of the corresponding financial benefit when the dependant's EC is equal or less than the monthly IPREM.

- Financial benefit for paid personal assistance, which is intended to support the hiring of professional services (BOE 2012b)

The monthly benefit that the dependant receives (MB1) depends on the cost of the service (CS), a minimum exempt from co-payment for personal expenses equal to 19% of the monthly IPREM (Min) and the dependant's EC as follows:
 $MB1 = CS + Min - EC$.

- Financial benefit for care provision within the family when a relative is acting as principal carer (informal care) (BOE 2012b):

The monthly benefit (MB2) varies with the beneficiary's EC and degree of dependence as follows: $MB2 = (1.33 \times \text{Ceiling}) - (0.44 \times EC \times \text{Ceiling}) / IPREM$, where Ceiling is the legislated upper bound of benefits for informal care, which increases with the degree of dependency.

The resulting MB1 of financial benefits for informal care cannot be higher than the corresponding MB2 that would result if the informal care had to be purchased.

- Financial benefits for the care recipient to hire services

These are equal to €715 per month for high dependants and €426 per month for severe dependants (see section 2) and cover only a certain fraction of the cost of the service, namely, 85% of the cost of a day centre and 45% of the cost of a nursing home for major dependants (Jiménez-Martín, Labeaga-Azcona and Vilaplana-Prieto 2016).

8.2 Access, financial protection and quality

Geographical price adjustments are common to ensure that health facilities are adequately reimbursed and compensated for factors outside their control (Barber, Lorenzoni and Ong 2019). For instance, most of the publicly funded health services in Spain use global budgets as the funding mechanism, where part of the compensation from the ACs' Health Departments to the providers can be based on outcomes set upon territorial objectives such as accessibility, responsiveness and attention to chronic patients (see also section 4). A similar example can be found in the SAAD's second level of financing, with matched contributions from the AGE and ACs (also called the "agreed level"), which takes into account the geographical dispersion of the dependants. This "agreed level" considers also the number of returned emigrants to the ACs (who return usually after retirement to their AC of origin), as this increases the number of potential dependants.

Prices can be also adjusted to promote greater access for specific populations (Barber, Lorenzoni and Ong 2019). For instance, as discussed earlier in this section, in the SAAD, most service benefits include a minimum exempt from co-payment, which is referenced to the monthly IPREM (€537.84 per month since 2017). Private institutional and day care providers also often receive substantial public subsidies in order to make their service more affordable for dependants (see section 3).

Mean price for base for payment by provider (in national currencies)²¹

This section reports mean prices of the main long-term care services by base for payment to public and private providers in Spain.

– Tele-assistance:

Annual prices of tele-assistance services per user in Spain are higher if provided outside the SAAD network (€198.48 in 2015) than within the network (€181.86 in 2015). The corresponding amount of co-payment (see also section 8), both in euros and as a percentage, is also higher if the service is provided outside (€47.69 in 2015, or 24.0%) than within the network (€42.23 in 2015, or 23.8%) (IMSERSO 2017b). The latest numbers for 2019 (IMSERSO 2020c) do not distinguish between prices of services provided within and outside the SAAD network but show a decline in the overall annual prices per user (€176.42 in 2019) with an increase in the level of co-payment (€54.84 in 2019, or 31.1%).

There are large regional differences in prices of tele-assistance. To some extent, this is because some regions combine tele-assistance with other devices and benefits that enrich the service, such as fall, movement or smoke detectors. Annual prices per user in 2019 varied from €83.50 in Navarra to €299.30 in Extremadura, with co-payment being highest in Illes Balears (79.7%) followed by Navarra (67.2%) and zero in Castilla-La Mancha, Extremadura, La Rioja and C. Valenciana (in 2018) (IMSERSO 2020c).

– Home care:

Public prices of home care are higher if provided within the SAAD than by the municipalities (IMSERSO 2017b). On average, they were €14.61 per hour in 2019. A user's co-payment was on average 11.3% (IMSERSO 2020c).

Average hourly prices of home care in 2019 varied between around €9.00 in Extremadura and Galicia and €17.00 in Aragón and Illes Balears. As for co-payment, this was as low as 1.6% in Andalucía and as high as 44.2% in Murcia (IMSERSO 2020c)²².

– Day centres:

Prices per user in day centres are increasing with the user's degree of dependency. Prices also depend on the type of provider. For instance, on average, annual prices per user were €9077.02 in public centres with a co-payment of

21 Prices of services in this section are taken from the latest biannual report of IMSERSO published in 2017, which covers users of social services for older people in Spain, some of which are not included in the SAAD.

22 For Canarias and C. Valenciana, co-payment rates are missing in 2019. The latest numbers from 2016 showed rates that fall beyond the 2019 interval (51.23% in Canarias and 0.22% in C. Valenciana), while hourly prices were close the regional average (IMSERSO 2017c).

24.0% and €10 077.65 in private subsidized ("charter") centres with a co-payment of 21.6% per user in 2019 (IMSERSO 2020c).

There are large differences across regions. For example, annual prices per user in public centres in 2019 were lowest in Navarra (€3786.00), which had, however, the highest share of co-payment (99.4%) resulting in one of the highest levels of co-payment, only below those in País Vasco (€4976.24) and Illes Balears (€4030.41). Public annual prices in 2019 were highest in Illes Balears (€11 078.96), followed by Catalunya (€10 753.92) and C. Valenciana (€10 621.00). The share of co-payment in Catalunya was among the lowest (18%), only above that in Murcia (9.4%), which had also the lowest level of co-payment (€980.83). For C. Valenciana the share of co-payment was not available in 2019, but it was zero in 2017 (IMSERSO 2018)²³.

- Residential care centres

Prices per user in residential centres depend on the type of provider. For instance, in 2019, on average, annual prices per user were €20 685.73 in public centres with a co-payment of 36.3% (€7500.47) and €19 324.27 in private subsidised "charter" centres with a co-payment of 40.4% (€7809.78) (IMSERSO 2020c). Average annual prices have increased substantially in public centres since 2015 (by about 30%), but the share of co-payment has declined (by about 6 percentage points). Instead, in private centres, both annual prices and co-payment rates have increased since 2015 (by about 20% and 4 percentage points, respectively) (IMSERSO 2017b).

There are large differences across regions both in prices and co-payments. For instance, annual prices per user in public centres varied in 2019 between €10 460.15 in La Rioja and €28 144.72 in Madrid. Co-payment in public centres was highest in Navarra as a percentage (81.0%) but in País Vasco as a level (€13 109.65). The lowest level of co-payment corresponded to C. Valenciana (€5751.01), which had also one of the lowest relative co-payments (about 26%), only above that in Madrid (20.9%)²⁴.

23 Public annual prices and co-payment rates in a few other regions with missing information in 2019 were within the intervals discussed above in 2016-2017 (IMSERSO 2017c, 2018).

24 Public annual prices and co-payment rates in a few other regions with missing information in 2019 were within the intervals discussed above in 2016-2017, except for Extremadura which had the lowest annual price (€8794.92, in 2016) as well as one of the lowest co-payment rates along with Asturias and Canarias in 2016 (about 17%) (IMSERSO 2017c).

10

Infrastructure for costing and pricing

10.1 Institutional entities (to what extent existing bodies cover different aspects of care for older persons)

Long-term care is coordinated within the Territorial Council of the SAAD. This is a cooperation body where the central government, the ACs and the local governments are represented. By means of this council, the central government and the ACs agree on a framework for intergovernmental cooperation, the intensity of services, the terms and amounts of financial benefits, the criteria for co-payments by the beneficiaries, and the scale of dependency that is used for the recognition of dependency.

The Territorial Council of the SAAD is also responsible for the regular assessment of the system, whose results are published on the IMSERSO's webpage (www.imserso.es), and by the Institute for Older People and Social Services, a public body of the Ministry of Social Affairs (since 2020, the Ministry of Social Rights and 2030 Agenda). The central government is responsible for the Information System of the SAAD (SISAAD).

Based on the recommendations from the Territorial Council, the AGE sets the basic legislation that is common to all ACs. This includes minimum criteria for benefits and also reference costs of services. The ACs can modify these, but if this results in higher long-term care expenditures, the difference has to be financed with additional contributions from the ACs.

Managing the SAAD is a competence of the ACs. Long-term care services are fully operated by the ACs, which includes planning, accreditation, quality assurance, financing and pricing.

Local authorities take part in the Territorial Council of the SAAD and can also complement the set of benefits mainly by financing community services. In practice, though, they play a subordinate role in the system.

Health care services are coordinated within the Territorial Council of the Spanish NHS. As for long-term care services, the AGE sets the basic legislation that is common to all ACs, even though health care services are fully operated by the ACs, except for pharmaceutical care, which is governed by the AGE.

Both the Spanish long-term care and health care systems are highly decentralized.

10.2 Stakeholder consultation

Many stakeholders have an interest in the outcomes of price setting and regulation, particularly medical doctors and health care provider associations. Lack of formal consultation and stakeholder engagement can lead to stalemates in the price setting process. A balance must be found between maintaining

dialogue with stakeholders, including the health industry, while also observing objectivity and independence. To address this challenge, formal consultation processes have been implemented that involve stakeholders in the discussion of the base price and the cost elements that it covers (Barber, Lorenzoni and Ong 2019).

Within the Territorial Council of the SAAD, there is an advisory body which includes various stakeholders representing mainly public interests such as the State Council of Older Persons (*Consejo Estatal de Personas Mayores*), the National Disability Council (*Consejo Nacional de la Discapacidad*), the State Council of Non-Governmental Organizations for Social Action (*Consejo Estatal de Organizaciones no Gubernamentales de Acción Social*), and the Consultative Committee (*Comité Consultivo*). There are no specialists representing professional associations and industry in this advisory board.

The Territorial Council of the Spanish NHS contains various working groups that compose the Commission for Public Health: the committee on environmental health, the working group on epidemiological surveillance, the working group on occupational health, the working group on health promotion, and the committee on vaccination programmes.

Participation and recommendations from this advisory body and working groups are encouraged in order to reach the widest possible consensus in what concerns health care and long-term care legislation.

10.3 Information disclosure (prices and quality)

Price transparency, or publishing service prices charged by health care providers, is one means to help consumers make informed choices (Barber, Lorenzoni and Ong 2019).

Health care information in Spain is usually placed on accessible institutional websites using static documents and interactive tools. For instance, official tariffs for health care services, information about statutory benefits and hospital waiting times is easily available. However, other relevant information on quality of health care, such as that on hospital clinical outcomes, is less available (Bernal-Delgado et al. 2018).

Overall, there is limited information on prices and quality of long-term care services in Spain, with substantial heterogeneity across regions (ACs). Reference costs of long-term care services that are provided within the SAAD are not systematically reported for all ACs. Detailed budget information of the ACs' spending on social services in order to disentangle long-term care spending is also hard to find or not available. Official data on co-payments are also not available. The SISAAD (see section 3) does not have up-to-date information on the contributions made by the beneficiaries. The estimation of co-payment at the national level is therefore complex, because in practice each of the ACs has its own model of co-payment (European Commission 2019). The IMSERSO's biannual report on older

persons publishes aggregate mean prices for some facilities by type of provider (public or private) and region, as reported in section 9.

11

Evidence on the effects of price setting and price regulation on stated objectives

At the present time, there have been few evaluations of the Spanish public long-term care system, especially regarding the effects of price setting and price regulations on stated objectives of the system.

Most of the evaluations of the Spanish public long-term care system have looked at the financial sustainability of the system (e.g. Sosvilla-Rivero and Moral-Arce (2011)), at the over use of financial benefits for informal care over service benefits (Peña-Longobardo et al. 2016), and at the low impact on job creation that the introduction of the SAAD has had so far (BOE 2014).

One notable exception is the study by Costa-Font, Jiménez-Martin and Vilaplana (2018), which focused on the effect of changes in caregiving affordability on the delivery of hospital care in terms of hospital admissions and length of stay. The study used quasi-experimental evidence from the introduction of the SAAD in 2007 which, as discussed in this report, introduced a new caregiving allowance for informal care and expanded the availability of publicly funded home care services. It found evidence of a reduction in both hospital admissions and utilization among both those receiving a caregiving allowance and, albeit less intensely, among beneficiaries of publicly funded home care, which amounted to 11% of total healthcare costs. These effects were stronger when regions had an operative regional health and social care coordination plan in place. Consistently, the subsequent reduction in the benefit that occurred in 2012, five years after its implementation, was found to significantly attenuate such effects. Greater access to affordable long-term care may thus reduce both hospital care admissions and utilization. These results are important for policy insofar as they suggest that expanding long-term care services and support can provide additional savings in the provision of hospital care.

12

Best practices for other countries, in particular middle- and low-income countries

The Spanish public long-term care system, introduced in 2007, has taken significant steps in providing coverage and care for the dependent population.

The main challenges of the system appear to be the long waiting lists for benefits for those formally recognized as dependants, the large inequalities in the provision of long-term care services and benefits between regions; the lack of transparency of the system; and the insufficient funding and inadequate financing arrangements, which results in low prices paid to providers and possibly low-quality services for long-term care for dependants.

Based on the Spanish experience, the following best practices can be highlighted for other countries to consider when setting up a public long-term care system:

- Be explicit about the goals of the system (e.g. covering all dependants or only those with a major dependency).
- Contrast alternatives on how the system should be financed (taxes, individual-level contributions, a mix of the two, etc.).
- Assess as accurately as possible the overall number of potential dependants, distinguishing also high, severe and moderate dependants.
- Guarantee the coverage of all beneficiaries. Ensure that laws regulating care for older persons are enforced and do not result in, for instance, long waiting lists for persons who are already entitled to benefits or for persons that are waiting for medical assessment of their potential dependency.
- Establish prices that approximate the most efficient way of delivering care.
- Expand home care and community services, which are very cost-effective and whose demand is usually high (as dependants prefer to stay in their homes). This will also reduce waiting lists for access to services.
- Invest in data infrastructure, improve price transparency, and report quality information along with prices.
- In order to enhance the financial sustainability of the public long-term care system over time, project as accurately as possible the number of dependants by degree of dependency and by the relevant geographical unit that corresponds to the administration jurisdiction that will be operating the system.

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