Spain

Health Care & Long-Term Care Systems

An excerpt from

the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability,

published in October 2016
as Institutional Paper 37
Volume 2 - Country Documents

Economic and Financial Affairs
Economic Policy Committee

Spain

Health care systems

1.26. SPAIN

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

In 2013, Spain had a GDP per capita of 24.1 PPS (in thousands), below the EU average of 27.9. Population was estimated at 46.4 million in July of 2015 ([313]). After increasing steadily for past years, it has started decreasing in 2012 due to ageing.

Total and public expenditure on health as % of GDP

Total expenditure ([314]) on health as a percentage of GDP (8.9% in 2013) has increased over the last decade (from 8.2% in 2003), but is still below the EU average ([315]) of 10.1% in 2011. Public expenditure has increased though to a smaller extent: from 5.7% in 2001 to 6.3% of GDP in 2011. It is also below the EU average of 7.8% in 2013.

When expressed in per capita terms, total spending on health at EUR 2,085 PPS in Spain is below the EU average of 2,988 in 2013. So is public spending on health care: EUR 1,468 PPS vs. an average of EUR 2,208 PPS in 2013.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, from 2013 to 2060 health care expenditure is projected to increase by 1.1 pps of GDP above the average growth expected for the EU of 0.9 pps of GDP, according to the AWG reference scenario. When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 1.9 pps of GDP from now until 2060 (EU: 1.6).

Overall, for Spain no significant short-term risks of fiscal stress arise, though some variables point to possible short-term challenges. Risks appear, on the contrary, to be high in the medium term from a debt sustainability analysis perspective (2026). No sustainability risks appear for Spain over the long run notably thanks to reforms containing long-term expenditure pressures, in particular pension expenditures.

Health status

Life expectancy at birth (86.1 years for women and 80.2 years for men in 2013) and healthy life years (63.9 years for women and 64.7 years for men) are among the highest in the EU and well above the respective EU averages (83.3 and 77.8 years of life expectancy in 2013, 61.5 and 61.4 in 2013 for the healthy life years). ([316]) An infant mortality rate of 2.7 per thousand is lower than the EU average of 3.9% in 2013, having gradually fallen over most of the last decade (from 3.9% in 2003).

As for the lifestyle of the Spanish population, the data indicates a considerable fall in the proportion of the regular smokers (from 28.1% in 2003 to 23.9% in 2011), although the share is still above the EU average of 22.4%. Over the same period the proportion of the obese in the population has increased (from 13.1% in 2003 to 15.7% in 2008 and 16.6% in 2011), while the alcohol consumption shows a very small reduction from 10.2 litres per capita in 2003 to 9.8 litres in 2010.

System characteristics

Overall description of the system

The Spanish health care system is fully devolved to the regions. Despite the decentralised character of the system, eligibility depends on the general regulations of the Central government. Autonomous communities (ACs, i.e.: regional governments) are in charge of the process of accreditation of coverage which is decided in each case by the Social Security authorities dependent on Central government. All of them respect the principle of universality of health care in the

([313]) Data source: http://www.ine.es/inebaseDYN/cp30321/cp_inicio.htm

([314]) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + HC.R.1.

([315]) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year.

([316]) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database. Data on life-styles is taken from OECD health data and Eurostat database.

framework of the Spanish Constitution and State General Health Care and Social Security Laws, extending it not only to the Spanish citizens contributing financially to the system, but also to EU temporary residents and non-residents (non-EU residents, including illegal immigrants are not fully covered) . There is also a Common Basket of services of the National Health System that has to be delivered to the whole population covered.

Coverage

Through the Royal Decree 16/2012, the Spanish health system was reformed to cover those who are insured as part of the system (including both Spanish and overseas citizens). This covers workers affiliated with the Seguridad Social, pensioners as well as recipients of social benefits. Coverage can also be provided, if requested, to non-insured Spanish, EU and EEA citizens who are legal residents in Spain whose annual income is below 100,000 euros and who are not covered by any other health insurance. Illegal non-EEA immigrants are only covered free of charge for emergency care, with the exception of children and pregnant women, who are fully covered.

Administrative organisation and revenue collection mechanism

The system is a unique combination of central, regional and local management and financing of health care. It is mostly tax-funded. Public expenditure accounts for 70.4% of total expenditure on health, out-of-pocket expenditure 22.8% and the rest is private health insurance (2013 figures).

The reform in 2001 marked the finalisation of the devolution process, which meant that all of the 17 regions were granted complete freedom to manage their own health services. Health funding was integrated within the general financing system through tax cession; and ear-marking of funds was phased out. The new system since the 2009 reform ([317]) follows the same structure of regions financing implemented in 2001 aimed at reinforcing the basic principles: elements of taxation ceded to regional administrations and assignments from the state's general budget. As a result of this reform, 90% of regional revenues stem from taxes.

Under the 2009 reform the financing of health services is as follows:

Specified shares of taxes are ceded to the ACs: 50% of personal income tax and VAT and 58% of the main excise taxes (hydrocarbons, alcohol, and tobacco). The system since 2001 includes regional direct control over taxes on gifts and inheritances, properties and property transfers and gambling taxes. ACs can also raise their own taxes.

The Fundamental Public Services Guarantee Fund guarantees that health care, education and social services are equally provided regardless the place of residence. It is made up of 75% of the taxes ceded to ACs plus state transfer. This is distributed to ACs on the basis of population, extension, dispersion, insularity (as before) plus the *equivalent protected population* (split into subgroups by age).

The Global Sufficiency Fund guarantees that ACs have enough resources to finance all their competences. It is fully financed by the central government. Consequently, ACs can use the remaining 25% of ceded taxes plus this State fund to meet their competences.

Finally, in order to promote economic convergence and development of those ACs with lower income per capita, the system relies on two new Convergence Funds fully financed by the Spanish state's budget transfers (the Competitiveness Funds and the Cooperation Funds), over which the central administration holds more discretion.

At the central level the Ministry of Health is responsible for: general coordination and basic health legislation; definition of benefits package guaranteed by the NHS; pharmaceutical policy and medical education, while the Inter-territorial Council of the NHS has a coordination role. At regional level, the ACs hold health planning powers and the capacity to organise their own health services in their regions.

The level of expenditure on administration is relatively low. Public and total expenditure on health administration and insurance as a

([317]) Law 22/2009 that regulates the financing system of Autonomous Communities of common regime and Cities with Autonomic Statute.

percentage of GDP (0.14% and 0.27%) are below the respective EU averages (0.27% and 0.47% respectively in 2013); so is public expenditure (2.3%) on health administration and health insurance as a percentage of total public current health expenditure (EU average of 3.5% in 2013).

Budget control is performed the same as in any other public institution. However, in the public health sector the usual tool for management is that of contract-programmes or management contracts. In the health system these contracts have the following general characteristics: they define the quantitative and qualitative objectives, the budget and the evaluation system. The time period referred to in the contracts tends to be one year. The contracts are made between the Regional Ministries and the Health Services, and between the Health Services governing bodies and the health care areas or facilities.

Role of private insurance and out of pocket co-payments

Private expenditure and out-of-pocket expenditure constitute respectively 29.6% and 22.8% of total expenditure on health in 2011. The share of out-of-pocket payments shows a slightly declining path (23.8% in 2003) up to a low of 19.2% on 2009 but has steadily increased since then up to 22.8% in 2013 and remains above the EU average of 14.1%. This is partly due to the 2012 reform to pharmaceutical co-payments explained in more detail below. Since primary and specialist care services are provided without cost sharing, out-of-pocket spending accounts mainly for cost-sharing in the area of pharmaceuticals, medical aids and prostheses, optical and dentist services, as well as private use of private medical and hospital services.

Cost-sharing from patients is limited to medicines. The structure of pharmaceutical co-payments has been reformed in 2012 and has different features for pensioners and non- pensioners, although in both cases there are three bands according to income (below EUR 18,000 annual income, between EUR 18,000 and EUR 100,000 and above EUR 100,000). Non-pensioners need to pay 40%, 60% and 80% of the price of medicines, with no upward limit. Pensioners pay 10% for the first two bands and 60% for the upper band, with an upward monthly limit of 8, 18 and 60 EUR. There are exemptions for those people on some social benefits, in receipt of non-contributory pensions, disabled, unemployed not on receipt of unemployment benefits and persons who have suffered occupational accidents. There is no reimbursement system; patients pay their share at the pharmacy which bills the rest to regional health services.

Civil servants' mutual funds require co-payments of 30% of the price of pharmaceuticals from all their beneficiaries (including the retired ones). Particular groups are always exempt from the full co-payments: AIDS patients and chronic diseases (both 10%, with EUR 2.64 ceiling).

In addition, the concerns voiced regarding the length of the waiting lists have resulted in the implementation of indicators and minimum basic and (countrywide) common requirements for waiting lists for specialists, diagnostic and therapeutic trials and surgery.

Types of providers, referral systems and patient choice

The Spanish health care system is focused on primary and ambulatory care. Primary health care (PHC) is an integrated system composed of PHC centres and multidisciplinary teams providing personal and public health services in well-equipped centres. PHC is provided by general practitioners (GPs) and primary health care paediatricians, who play an important role as gatekeepers and referral points to specialists. These in turn refer patients to hospital care. Single-handed practices are restricted to small villages and to the private sector. PHC is to a great extent publicly funded and run. ([318]) Inpatient care is provided in hospitals which are mostly publicly owned. The NHS also contracts services from private non-profit providers.

The number of practicing physicians per 100 000 inhabitants (381 in 2013) is above the average in the EU (344 in 2013). In Spain, GPs are a type of specialist (Family and Community Medicine). There are about 75 GPs per 100 000 inhabitants, below the EU average (78.3 in 2013). The average

([318]) The only public-private mix is the formula of health associations used in Catalonia by delegating powers to private companies within certain geographic areas.

number of consultations per inhabitant per year (frequentation) ([319]) is, at 7.4, above the EU average of 6.2 (2011).

The number of practising nurses at 514 per 100,000 inhabitants in 2013 shows a significant increase (431 in 2003) but is far lower than the EU average (average of 837 in 2013). It should also be noted that the ratio of nurses to physicians is 1.34 in the latest available year, one of the lowest in the EU (average 2.4), indicating a likely imbalance in the health care workforce.

Given two-stage referral procedure (GP-specialist-hospital) access to inpatient care is closely controlled. This has allowed authorities to reduce capacity and activity of hospitals over the last decade. In 2013, overall capacity of hospitals was considerably lower than in most other EU countries, with 228 acute hospital beds per 100,000 inhabitants, compared to the EU average of 356 beds.

Inpatient hospital discharges per 100 inhabitants in 2013 were, at 9.9, below the EU average of 16.5. There were 6,465 day case discharges per 100,000 inhabitants in 2013, below the EU average of 7,031. As a result, the ratio of day cases to longer stays is amongst the highest in Europe, evidence of a relatively efficient use of hospital resources.

Acute care bed occupancy rates in 2011 were 75.8%, slightly above the EU average of 70.2%.

Average length of stay has fallen from 6.9 in 2003 to 6.1 in 2013, slightly below the EU average of 6.3.

This is a reflection of the progressive shift towards ambulatory specialised care, which is resulting in procedures being performed without overnight stay that previously required admission to the hospital. Such an increase in day-hospital places is found in both absolute numbers and in rates per 100,000 inhabitants. Note that in terms of hospital activity 39.4% of all discharges are day case discharges, far above the EU average of 30.4% in 2013.

([319]) National Health System of Spain Annual Report 2011, page 36;
https://www.msssi.gob.es/organizacion/sns/planCalidadSNS/pdf/equidad/informeAnualSNS2011/Informe_anual_SNS_2011.pdf

This however puts pressure on the GP to act as effective gatekeeper and also to co-ordinate the care received by patients effectively.

Treatment options, covered health services

There is a Common Basket of services of the National Health System that has to be delivered to the whole population covered. Beyond that, specific additional services may be provided by different regions to their citizens.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Primary health care staff are paid a salary plus a capitation component (amounting to 15% of the total), which takes into account the demographic structure and the geographical dispersion of the population covered by their services.

Hospital doctors and specialists in ambulatory care units have a status similar to that of civil servants and are almost exclusively paid a salary. Both GP and hospital doctors have an additional component for professional development (professional career), and in some cases, a small additional productivity component related to performance. Other health care professions (nurses, midwives, social workers and public health professionals) are paid by salary as well.

The basic salary is regulated by the national government, although each AC has the right to vary some additional components.

Public hospital funding is generally carried out prospectively through negotiation of a contract programme between the hospital and the regional authority third-party payer, setting out the objectives (in quantity and quality) to be achieved by the hospital and assigning financial resources to these objectives. The purchasing institution then monitors the contracts according to the agreed timetable. Until the 1990s a traditional retrospective reimbursement with no prior negotiation was a routine mechanism. Then, from 1991 first aggregate measures of activity (e.g. weighted health care unit) were defined which enabled comparison among hospitals. Over recent years some attempts have been made to develop a more sophisticated prospective payment system based on diagnosis-related groups or Patient

Management Categories. Some elements have been adopted in a few autonomous communities so far, but no general trend can be specified. Public hospitals are also allowed to have another, albeit minor, source of financing, by providing services to people or schemes not covered by the NHS. On the other hand, hospitals functioning outside the NHS may provide services to the public system, which are specifically regulated by individual agreements or contracts.

The market for pharmaceutical products

The Spanish pharmaceutical market is the fourth largest in the EU-28 and eighth in the world by value.

The pharmaceutical market is dominated by the state who is the main actor, responsible for regulating and authorising clinical trials, controlling the advertising of drugs, regulating the quality and manufacturing of pharmaceutical products, fixing the price of drugs, setting co-payments and establishing the list of publicly financed medicines. Once authorities decide on which products are to be reimbursed, they regulate the price of reimbursed products. The initial price decision is based on clinical performance, the cost of existing treatments, cost-plus calculations and international prices. International price referencing is based on ex-factory prices of all EU countries. Spain also uses reference pricing for reimbursement: the reimbursement level is the lowest price, calculated by cost of treatment/day for all the drugs of the same group. ([320]) The reference pricing mechanism in Spain tries to give a signal to the market by the regulator, aiming at manufacturers adapting their prices. Some other regulations (profit and commercial margins, limited operating hours) have been adopted to contain costs increase. Discounts and price freezes and cuts are some mechanisms used to directly control expenditure. ([321]) The use of generic medicaments has increased in recent years since the regulation regarding the reference pricing system was adopted in 2003 which meant important public savings.

Pharmaceutical regulation is an exclusive responsibility of the national administration, though the role of autonomous communities in modulating consumption is paramount, given their full responsibility for pharmaceutical management (through programs to improve prescription's quality and the relationship with pharmacists).

Total and public expenditure on pharmaceuticals (1.6% and 0.86% of GDP in 2013) have fallen from their 2010 peaks of (1.77% and 1.28%). Both are close to the EU average, with public expenditure being slightly lower and total expenditure slightly higher. Pharmaceutical spending as a proportion of public health spending fell from 22.3% in 2003 to 13.7% in 2013, still above the EU average of 12.5%. Surprisingly, although there was a marked fall in outpatient pharmaceutical expenditure after the economic crisis, hospital pharmaceutical expenditure, which was less closely monitored by the authorities, continued to increase over this period. The Spanish authorities have now required disclosure on hospital expenditure data from the regions, a welcome step that will increase transparency in this sector.

The regions have implemented several measures to promote generics prescription among physicians. However, despite these efforts in 2012 the generic market remains less developed than in other EU countries, with a generic penetration by value of 18.4 % and by volume of 39.7 % in 2012 (compared with 21% and 54% respectively for the EU as a whole).

Use of Health Technology Assessments and cost-benefit analysis

Health Technologies Assessment (HTA) is present both at national and regional level. The recent creation of the platform of HTA agencies (AUnETS) has marked a turning point in the direction of fostering coordination and synergies.

The regulation of the inclusion of new items in the NHS common benefits basket explicitly requires as a previous step the appraisal by the National HTA agency in cooperation with AUnETS.

([320]) Royal Decree Law 4/2010, March 26th

([321]) See "Analysis of differences and commonalities in pricing and reimbursement systems in Europe", Jaime Espin and Joan Rovira, 2007 for DG Enterprise and Industry.

eHealth, Electronic Health Record

The "Electronic Health Record of the National Healthcare System" (Historia Clínica Digital del Sistema Nacional de Salud, HCDSNS) was initiated in 2006 with the following objectives in mind:

To guarantee citizens' electronic access to their own health data and to the health data of those they represent that are available in digital format at any of the health services that make up the NHS, as long as they comply with the minimum security requirements laid down to protect their own data against illegal intrusion by those who have not been duly authorised to access such data.

To ensure the healthcare professionals duly authorised by each health service for such a function can access specific personal health data sets generated by a regional authority other than the one requiring the information, as long as the user or patient seeks the professional's healthcare services at a public NHS health centre.

To provide the NHS with a secure access system that guarantees citizens the confidentiality of their personal health data.

The HCDSNS system should be dynamic and simple as regards access and be at the service of citizens and professionals.

In June 2014, 20 million citizens from 15 of the 17 Autonomous Regions have shared, at least partially, their medical history, which could be consulted by healthcare professionals.

Health and health-system information and reporting mechanisms

The "Dirección General de Salud Pública, Calidad e Innovación" includes under its umbrella the "Subdirección General de Información Sanitaria e Innovación", la "Subdirección General de Calidad y Cohesión" and the Observatory of the NHS. These units concentrate the functions of assessment and monitoring at national level and also manage the discretional funding linked to the development of the "National Quality Plan".

Health information systems have been developed and are trying to improve coordination among regions. The "Institute of Health Information" is the repository of administrative databases and basic health-related statistics for the ACs, manages regional health data, the National Health Survey, the "Health Care Barometer" and the "National Mortality Register". All these sources of information have allowed for the building of the "Set of Key Indicators for the SNS" (INCLASNS); the chosen indicators cover demographics, health status and its determinants, health care resources supply, activity, quality, expenditure and citizens' satisfaction ([322]).

At consultation level, ICTs are improving coordination with the implementation of electronic medical records (currently implemented within the regions; there are pilot projects across the regions([323]) and improving cost savings with the electronic prescription of medicaments (better follow- up of patients and avoiding misuse).

Health promotion and disease prevention policies

Health planning is a competence of the regional health departments and as such, each one develops their regional health 4-5 yearly plans (HPs). They are the principal instrument for identifying intended courses of action and planning resources towards the achievement of previously defined health goals. All share the purpose of responding to identified health needs and offering strategies for health systems action, inspired by "WHO's Health for All" and HEALTH21 strategies. These plans in turn materialise in regional strategic plans, infrastructure plans, regional health strategies and health programmes.

In terms of public intervention on lifestyle patterns, Spain has been quite successful in introducing anti-tobacco law (strict regulation of advertising and places to smoke) and enacting stricter rules on occupational health and accident prevention and in results regarding diminishing traffic accidents (through campaigns and legislation). In the area of pharmaceuticals'

([322]) The statistic portal of National Health System is publicly available in http://www.msps.es/estadEstudios/estadisticas/sisInfSanSNS/home.htm

([323]) ICT in the National Health System Ed. 2010 http://www.ontsi.red.es/articles/detail.action?id=4559&request_locale=en

consumption, education is being improved by anti-self-medication campaigns and the new adaption of packages to dose prescription. The pharmaceutical co-payments described above are also likely to reduce self-medication.

Recently legislated and/or planned policy reforms

A new voluntary budget rule on healthcare spending for application at regional level was approved in mid-June 2015. The new budget rule limits growth in healthcare and pharmaceutical spending in 2015 and 2016 to the reference rate of medium-term economic growth of the Spanish economy. If eligible spending exceeds that rate, then the region concerned would be prevented from offering health care services other than those included in the national basket of health services and would be asked to apply efficiency-enhancing measures. Regional governments can comply with the rule on a voluntary basis, and financial incentives to their participation have been devised by the Ministry of Finance and the Ministry of Health in consultation with the health industry. It is however unclear at this stage how many regions will comply with this new rule and therefore what

Challenges

Over the years, with a lower share of GDP allocated to health compared to other European countries, the Spanish NHS has shown the ability to yield sustained good results measured in different dimensions of performance:

- Population health status parameters and health care amenable outcomes.
- Coverage, access and financial equity parameters.
- Health care quality and safety.
- Users' satisfaction and system legitimated by the population.

Despite this positive achievement, the NHS is still striving to overcome certain challenges:

- Alignment of providers' incentives with the system's quality and efficiency objectives throughout the system (different levels of management, health professionals, non-health professionals, external providers …). For example, staff incentives could be improved and adaptation to chronic diseases and changes in demand
- Transition from an acute care-driven model to the management of chronic diseases, including mental disorders.
- Improve the integration of the different levels of care, increasing the resolution capacity of GP by boosting their case manager's role.
- Shifting to a user-centred model in a predominantly public provision structure, staffed mainly by civil servants and statutory personnel. It is necessary a cultural change aimed to increase the productivity of the health sector, and so on, in order to reduce waiting lists and to cope with patient's expectations.
- Improve the efficiency of pharmaceutical expenditure by increasing generic penetration and improving the transparency of hospital pharmaceutical expenditure.
- The issue of ageing workforce should be tackled, as in the rest of the EU, through the promotion of the medical education and more flexible salary regulation rewarding quality and efficient work. The imbalances in the health care workforce structure should also be tackled and the possibility of expanding the role of nurses in the provision of care considered.

Table 1.26.1: **Statistical Annex – Spain**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	803	861	931	1008	1081	1116	1079	1081	1070	1043	1031	9289	9800	9934
GDP per capita PPS (thousands)	25.5	25.6	25.7	26.6	27.3	26.4	24.7	24.7	24.5	24.4	24.1	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	1.4	1.6	1.9	2.5	1.6	-0.7	-4.5	-0.5	-0.1	-1.7	-0.7	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	13.2	2.5	2.8	3.7	2.8	4.4	2.7	0.0	-2.3	-3.2	-5.2	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	8.2	8.2	8.3	8.4	8.5	8.9	9.6	9.7	9.4	9.3	8.9	10.4	10.1	10.1
Total current as % of GDP	7.9	8.0	8.0	8.1	8.2	8.6	9.3	9.4	9.3	9.2	8.8	9.8	9.6	9.7
Total capital investment as % of GDP	0.3	0.2	0.3	0.3	0.3	0.3	0.3	0.2	0.2	0.1	0.1	0.6	0.5	0.5
Total per capita PPS	1637	1770	1895	2044	2180	2322	2383	2387	2303	2204	2085	2828	2911	2995
Public as % of GDP	5.7	5.8	5.9	6.0	6.1	6.5	7.2	7.2	6.9	6.7	6.3	8.1	7.8	7.8
Public current as % of GDP	5.5	5.6	5.7	5.8	5.9	6.3	7.0	7.0	6.8	6.6	6.3	7.9	7.7	7.7
Public per capita PPS	1079	1175	1262	1370	1464	1587	1677	1667	1691	1581	1468	2079	2218	2208
Public capital investment as % of GDP	0.2	0.2	0.2	0.3	0.3	0.3	0.2	0.2	0.1	0.1	0.0	0.2	0.2	0.1
Public as % total expenditure on health	70.3	70.6	70.9	71.6	71.8	72.9	75.0	74.3	73.4	71.7	70.4	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	13.5	14.1	14.8	14.6	14.5	14.7	14.7	14.3	14.2	13.0	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	99.5	:	:	98.3	:	:	:	:	99.9	99.9	:	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	23.8	23.4	22.9	21.9	21.2	21.0	19.2	20.4	20.6	22.1	22.8	14.1	14.4	14.1

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												**2009**	**2011**	**2013**
Population, current (millions)	42.5	42.5	43.3	44.0	44.8	45.7	46.2	46.5	46.7	46.8	46.7	502.1	504.5	506.6
Life expectancy at birth for females	83.0	83.7	83.6	84.4	84.4	84.6	85.0	85.5	85.6	85.5	86.1	82.6	83.1	83.3
Life expectancy at birth for males	76.4	77.0	77.0	77.8	77.9	78.3	78.8	79.2	79.5	79.5	80.2	76.6	77.3	77.8
Healthy life years at birth females	70.2	62.7	63.4	63.5	63.2	63.7	62.1	63.8	65.6	65.8	63.9	:	62.1	61.5
Healthy life years at birth males	66.8	62.6	63.3	63.9	63.5	64.0	63.1	64.5	65.4	64.8	64.7	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	67	62	61	57	56	53	51	49	103	102	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	3.9	3.9	3.7	3.5	3.4	3.3	3.2	3.2	3.1	3.1	2.7	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	1.70	1.73	1.77	1.80	1.83	2.00	2.18	2.17	2.23	2.21	2.02	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.13	0.15	0.15	0.15	0.15	0.17	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.19
Out-patient curative and rehabilitative care	2.56	2.58	2.58	2.59	2.61	2.75	2.91	2.92	2.91	2.92	2.76	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.72	1.70	1.67	1.60	1.58	1.63	1.75	1.77	1.66	1.53	1.60	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.22	0.23	0.25	0.27	0.30	0.33	0.35	0.37	0.37	0.36	0.37	0.31	0.31	0.32
Prevention and public health services	0.19	0.19	0.19	0.20	0.21	0.21	0.26	0.22	0.20	0.19	0.18	0.25	0.25	0.24
Health administration and health insurance	0.27	0.26	0.26	0.27	0.29	0.28	0.31	0.28	0.29	0.29	0.27	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	1.54	1.57	1.61	1.65	1.68	1.84	2.04	2.02	2.07	2.04	1.93	2.73	2.61	2.62
Day cases curative and rehabilitative care	0.13	0.14	0.15	0.15	0.15	0.16	0.18	0.18	0.18	0.18	0.17	0.16	0.16	0.18
Out-patient curative and rehabilitative care	1.45	1.46	1.47	1.51	1.55	1.68	1.83	1.82	1.81	1.77	1.68	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	1.23	1.21	1.18	1.15	1.13	1.17	1.28	1.28	1.18	1.04	0.86	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.01	0.13	0.12	0.13
Prevention and public health services	0.18	0.18	0.18	0.19	0.20	0.20	0.25	0.21	0.20	0.19	0.18	0.25	0.20	0.19
Health administration and health insurance	0.14	0.12	0.12	0.12	0.13	0.13	0.15	0.14	0.14	0.14	0.14	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.26.2: **Statistical Annex - continued – Spain**

Composition of total as % of total current health expenditure	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
Inpatient curative and rehabilitative care	21.5%	21.7%	22.0%	22.2%	22.4%	23.2%	23.4%	23.1%	24.1%	24.1%	23.1%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	1.7%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	2.0%	2.0%	2.0%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	32.4%	32.3%	32.1%	32.0%	31.9%	31.9%	31.2%	31.0%	31.4%	31.9%	31.5%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	21.8%	21.3%	20.8%	19.8%	19.3%	18.9%	18.8%	18.8%	17.9%	16.7%	18.3%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	2.8%	2.9%	3.2%	3.3%	3.7%	3.8%	3.8%	3.9%	3.9%	3.9%	4.2%	3.2%	3.3%	3.3%
Prevention and public health services	2.4%	2.4%	2.4%	2.5%	2.6%	2.4%	2.8%	2.3%	2.2%	2.1%	2.1%	2.6%	2.6%	2.5%
Health administration and health insurance	3.4%	3.3%	3.2%	3.3%	3.5%	3.2%	3.3%	3.0%	3.1%	3.2%	3.1%	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	27.9%	28.1%	28.5%	28.7%	28.7%	29.4%	29.3%	29.0%	30.5%	31.1%	30.8%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	2.3%	2.6%	2.6%	2.6%	2.6%	2.6%	2.6%	2.5%	2.7%	2.7%	2.8%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	26.3%	26.2%	26.0%	26.3%	26.5%	26.8%	26.3%	26.1%	26.7%	26.9%	26.8%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	22.3%	21.7%	20.9%	20.0%	19.3%	18.7%	18.4%	18.4%	17.4%	15.8%	13.7%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	0.4%	0.3%	0.4%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.2%	0.2%	1.6%	1.6%	1.6%
Prevention and public health services	3.3%	3.2%	3.2%	3.3%	3.4%	3.2%	3.6%	3.0%	2.9%	2.9%	2.8%	3.2%	2.7%	2.5%
Health administration and health insurance	2.5%	2.2%	2.2%	2.2%	2.2%	2.1%	2.1%	2.0%	2.0%	2.1%	2.3%	1.4%	3.5%	3.5%

Expenditure drivers (technology, life style)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
MRI units per 100 000 inhabitants	0.73	0.77	0.81	0.88	0.93	:	:	1.25	1.34	1.48	1.53	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	:	:	:	:	:	:	0.5	0.5	0.6	0.6	0.9	0.9	0.8
CTS per 100 000 inhabitants	:	:	:	:	:	:	:	1.6	1.7	1.7	1.8	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	:	:	:	:	:	:	0.1	0.1	0.1	0.2	0.1	0.1	0.1
Proportion of the population that is obese	13.1	:	:	14.9	:	15.7	16.0	:	16.6	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	28.1	:	:	26.4	:	25.2	26.2	:	23.9	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	10.2	10.4	11.9	11.9	11.1	10.2	10.0	9.8	:	:	:	10.3	10.0	9.8

Providers	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Practising physicians per 100 000 inhabitants	324	346	357	365	359	358	363	380	388	382	381	329	335	344
Practising nurses per 100 000 inhabitants	431	432	439	449	464	486	500	521	528	524	514	840	812	837
General practitioners per 100 000 inhabitants	:	:	71	72	70	73	73	75	75	75	75	:	78	78.3
Acute hospital beds per 100 000 inhabitants	263	261	258	253	253	249	247	243	238	230	228	373	360	356

Outputs	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Doctors consultations per capita	9.5	:	:	8.1	:	:	7.5	:	7.4	:	:	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	4.2	10.8	10.8	10.7	10.7	10.6	10.4	10.2	10.1	9.9	9.9	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	:	:	:	3,026	4,382	:	5,784	6,206	4,069	7,216	6,465	6368	6530	7031
Acute care bed occupancy rates	79.0	79.0	79.0	78.0	78.0	77.7	77.6	76.4	75.4	75.8	75.8	72.0	73.1	70.2
Hospital curative average length of stay	6.9	6.7	6.7	6.6	6.6	6.5	6.4	6.3	6.1	6.1	6.1	6.5	6.3	6.3
Day cases as % of all hospital discharges	:	:	:	22.0	29.1	:	35.7	37.7	28.7	42.1	39.4	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	2013	2020	2030	2040	2050	2060	Change 2013 - 2060	EU Change 2013 - 2060
AWG reference scenario	5.9	6.2	6.6	7.0	7.1	6.9	1.1	0.9
AWG risk scenario	5.9	6.4	7.2	7.8	8.0	7.8	1.9	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %	EU - Change 2013 - 2060, in %
Population projections until 2060 (millions)	46.6	45.7	44.5	44.7	45.6	46.1	-1.0	3.1

Sources: EUROSTAT, OECD and WHO

Spain

Long-term care systems

2.26. SPAIN

General context: Expenditure, fiscal sustainability and demographic trends

Spain has a population of almost 46.7 million inhabitants in 2013 (according to Eurostat data). Over the next decades, this is expected to decrease to 46.1 million by 2060. With a GDP of more than EUR 1,031 bn, or EUR 24.1 thousand PPS per capita it is below the EU average GDP per capita of EUR 27.9 thousand.

Health Status

Life expectancy at birth for both men and women was, in 2013, respectively 80.2 years and 86.1 years and is above the EU average (77.8 and 83.3 years respectively). Similarly, healthy life years at birth for both sexes are 64.7 years (women) and 63.9 years (men) significantly above the EU-average (61.5 and 61.4 respectively). The percentage of the Spanish population having a long-standing illness or health problem is lower than in the Union as a whole (31.6% and 32.5% respectively in 2012). The percentage of the population indicating a self-perceived severe limitation in its daily activities has decreased since 2004, and is significantly lower than the EU-average (5.4% against 8.7%).

Dependency trends

The share of dependents in Spain is set to increase from 5.3% in 2013 to 8.6% of the total population in 2060, an increase of 64%. This is higher than the EU-average increase of 36%. From less than 2.5 million residents living with strong limitations due to health problems in 2010, an increase of 64% is envisaged until 2060 to slightly below 4 million. That is a much steeper increase than in the EU as a whole (36%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of 1.4 pps of GDP to about 2.4 pps of GDP by 2060. ([460]) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 2.9 pp taking expenditure to 3.9 pps of GDP by 2060.

Overall, for Spain no significant short-term risks of fiscal stress arise, though some variables point to possible short-term challenges. Risks appear, on the contrary, to be high in the medium term from a debt sustainability analysis perspective due to the stock of debt still high at the end of projections (2026). No sustainability risks appear for Spain over the long run notably thanks to reforms containing long-term expenditure pressures, in particular pension expenditures. ([461])

System Characteristics ([462])

It is arguable that the first long-term care system as a such in Spain was established in 2007, with the approval of the Law 39/2006 Ley de Promoción de la Autonomía Personal y Atención a las Personas en situación de Dependencia (Law of Promotion of the Autonomy and Care of People in a Dependent Situation, LAPAD), which established the System for Autonomy and Care for Dependency (SAAD).

Prior to Law 39/2006 of December 2006, LTC care was provided through the basic social services of regions and municipalities, and by programmes towards people with disability benefits. This provision only partly met the LTC needs of the population. The Social security system provided benefits for individuals with severe levels of disability as well as allowances through the non-contributory disability pension and family benefits for parents of disabled children.

It is estimated that only around 12% of elderly dependants received any kind of support that was publicly financed in 2000. The role of the public sector was secondary, provided only in cases where informal care was not possible or

([460]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf
([461]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf
([462]) This section draws on OECD (2011b) and ASISP (2014).

insufficient and the level of support depended on the economic capacity of the recipient. Furthermore, competences for social services had been decentralised to regional and local level, so important differences existed across territories.

The SAAD was created in 2007 in line with the LAPAD and the objective of promoting personal autonomy and ensuring the necessary attention and protection of all dependants in Spain, through the necessary collaboration of all public administration levels. A graduate calendar of implementation to cover all existing dependants was established with an original end-date of 2015, later to be delayed.

Within the SAAD dependency is split into three different degrees of dependency: Degree I – moderate dependency; Degree II – severe dependency; and Degree III – high dependency. Each degree is in turn divided into two levels of increasing severity. During the progressive implementation period, only Degree III could apply during the 2007 (the first year), then Degree II level 2 in 2008, Degree II level 1 in 2009-2010 and finally moderate dependants (Degree I) in 2011-2012 (level 2) and 2013-2014 (level 1) would follow. However, as explained above, this plan was delayed later.

Managing the SAAD is as for the previous LTC service provision, the competence of the regional Governments. As a consequence, many differences in its application can be observed across the different regions. Whereas 2.0% of population is recognised as being dependent in Spain, the ratio across regions varies from 2.7% in Andalucía and Cantabria, to only 1.4% in Navarra, 1.3% in the Comunitat Valenciana and only 1.1% in Canarias.

According to SAAD statistics, in July 2016 in Spain there were 1.21 million dependants. Specifically, 366,764 people were recognised as high dependents (30%), 454,751 as severe dependents (37%) and the rest (391,407, 32%) as moderate dependents. In total, 837,321 are receiving benefits, while the other 375,601 (31%) are on the waiting list.

On average each beneficiary receives 1.24 benefits (including in-kind and cash benefits), although this figure varies across regions. In terms of provision, the most important benefit is the cash benefit for home care. According to July 2016 SAAD statistics, 357,984 recipients (34.6% of the services provided) are receiving it. The incidence of in-kind benefits is relatively lower: residential care made up 14.4% of services provided, home care represented 15.8%, tele-care was 14.6% and day care centres 8.45%.

Public spending on LTC reached 0.7% ([463]) of GDP in 2012 in Spain, below the EU average of 1 % of GDP. 32.6% of public LTC spending is done via cash benefits (Above the EU average of 20%).

In Spain, 60.8% of dependents are receiving formal in-kind LTC services or cash benefits for LTC, above the EU average of 53%. Overall, 3.2% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

In-kind benefits are provided to 2.1% of the population. The expenditure for institutional (in-kind) services makes up 72.7% of public in-kind expenditure (EU: 61%), 27.3% being spent for LTC services provided at home (EU: 39%). Thus, relative to other Member States Spain has a focus on institutional care, which may be inefficient, as institutional care is relatively costly with respect to other types of care.

Administrative organisation

The system is funded through taxation and financed by funds from the central government and regions. The central government then allocates funds to each regions based on the number of dependents, their degree of disability and the level of assistance they require. Regions can decide whether to allocate additional funding to provide additional services.

Types of care

As mentioned in the previous section, the benefits provided include a range of in-kind and cash benefits. A list is provided in Chapter 15 of the

([463]) It should be noted that the definition of LTC expenditure used for these expenditure variables differs from the definition used for the Ageing Report 2015.

LAPAD, which details a wide range of services to be carried out through a social services public network of social services under the control controlled of the regional governments to be subsidised by the public sector.

Services include tele-care, home care, personal care help, residential care and day as well as night residential services. These services are provided by a network of public institutions of regional governments, local organisations, state reference centres and licensed private providers. Cash benefits are granted based on the recipient's degree of dependency and their economic means. According to the LAPAD, they include a home care cash benefit and a cash benefit for personal assistance.

1) Allowance for the care recipient to hire services. This allowance enables the care recipient to contract services from private licensed providers when the public sector is not able to provide this. Benefit levels range from EUR 400/month for degree II level 1, to EUR 831 for degree III, level 2, in 2012 for those who already have an assessed degree and level, and for new recipients from August 2012 it goes from EUR 300,00 for grade I to EUR 715,07 for grade III.

2) Allowance for informal care. The informal carer needs to be a relative of the care recipient, although if services are not available in the area, the informal carer can be a resident of the same (or neighbouring) municipality. The allowance compensates to some extent the service provided by the informal carer. Benefit levels range from EUR 255,77 /month for degree II level 1, to EUR 442,59 for degree III, level 2, in 2012 those who already have a recognised degree and level, and for new recipients from August 2012 is from EUR 153,00 for grade I to EUR 387,64 for grade III.

3) Allowance for personal assistance. This allowance enables recipients individuals with a high degree of disability (Group III) to hire personal help to improve their personal autonomy, access to work/ education as well as to provide help with daily activities. A contract has to be provided and the carer needs to have appropriate professional qualifications. Benefit levels range from EUR 609 /month for degree III level 1, to 812 for degree III level 2, in 2012 those who already have a recognised degree and level, and for new recipients from August 2012 is from EUR 300,00 for grade I to EUR 715,07 for grade III.

Home-care provision includes prevention and promotion of personal autonomy, help with personal care and with instrumental activities of daily living. All persons below the minimum income threshold are automatically guaranteed home care.

Institutional LTC service providers include regional and municipal centres as well as private sector institutions. Providers are required to have minimum ratios of workers per care recipient and by type of worker for carers and geriatricians. Most institutions are private with only 24% of residences being publicly-owned (although 22% additional residents receive a public subsidy to be placed in a private centre). Providers often receive substantial government subsidies in order to make their service more affordable for recipients. There are large regional disparities in the distribution of beds and services offered as well as in term of their prices.

Day care centres are also largely private (65%) but are publicly subsidised at 60% and have seen large increases in the past (there were 36,000 new places between 2002 and 2007).

Eligibility criteria

Spain applies means-tested criteria, for both in-kind and cash benefits. In addition, users are not given a choice between cash and in-kind benefits nor can they accumulate them, and they do not have a discretionary use of cash benefits.

Benefits are universal and cover all Spanish nationals or those who have been residents of Spain for at least 5 years (of which at least the last 2 before filing the claim need to have been spent in Spain). Eligibility is determined through an assessment of the degree of dependency, evaluated on the basis of the Scale of Dependency (Established in the Royal Decree 740/2011). As mentioned before, there are three degrees of disability, with 2 sub-levels within each grade. They are defined as follows:

– Degree I (Moderate Disability): the individual requires help for several basic activities of daily living at least once a day, or needs help

on a sporadic basis or limited to personal autonomy.

– Degree II (Severe Disability): the individual needs help for several activities of daily living, 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): the individual needs help for several activities of daily living 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 generalised help to ensure personal autonomy.

The assessment is expressed as a numerical score according to the eligibility scale, and individuals with a score below 25 are not entitled to public services or allowances.

Again, the responsibility for the assessment belongs to the .regions. Once an individual has been assessed as being in need of care, an individual plan is prepared by the social services, including a list of appropriate services for the level of disability and dependency, as well as entitlement to allowances, in line with the legislation (Royal decree 1051/2013).

Co-payments, out of the pocket expenses and private insurance

All the potential recipients below a specified minimum income are guaranteed provision home care. Cost-sharing by recipients for the benefits they receive is determined according to their economic status up to a maximum of 90% of the service cost.

For all other services allowances are means-tested and the remainder needs to be paid by the care recipient or their relatives.

Role of the private sector

As explained in previous sections, the private sector is involved in the provision of several types of care. In institutional care it is the main provider, although often benefitting from subsidies meant to increase the affordability of services to recipients. .

Formal/informal caregiving

At present there is no allowance directly directed to family carers directly as the care allowance that exists currently is provided to the care recipient. Informal carers can benefit from pension rights and other social contributions if they subscribe a special agreement with the Social Security body. Assisting informal carers through training and provision of information is one of the objectives of the SAAD, and common standards were adopted in 2009.

All formal workers are required to hold relevant professional qualifications including carers in residential institutions, home carers, personal assistants as well as the directors of institutions.

Since 2015 professional profiles are determined as well as the duties to be performed and they are based on qualifications that need to be demonstrated by the appropriate Vocational Training Diplomas or Professional Certificate.

Since this Resolution there have been some calls by the regional authorities for guarantees on the expertise of these professionals, in order to certify that their qualifications fulfil the necessary requirements.

From the beginning of 2007 to the end of 2013, the number of long term care formal workers has increased by approximately 50.9%, with 116,507 new members being registered as working in the Social Security records.

Prevention and rehabilitation policies/measures

Some prevention services do exist and are subsidised. Home-care services also include prevention and promotion of personal autonomy.

Recently legislated and/or planned policy reforms

The Territorial Council of Social Services and of the System for the Autonomy and Care of Dependent Persons (SAAD), cooperation body where the Central Government, the Autonomous Regions and the Local Government are represented, in its session of 10 July 2012 has approved measures to improve the System and

make it more transparent, with better quality, improved care of dependent persons, and also to guarantee its current and future financial sustainability, with criteria that guarantee equality in the granting of the benefits throughout Spain, and with impact on employment, respecting the principles set down in the Dependency Act. These measures are applicable in the Autonomous Regions.

The Resolutions of said Territorial Council where said measures were approved have been expressed by the Government in the following general legislation for the whole of Spain and applicable by the Autonomous Regions in each one of its territories:

- Royal Decree-Law 20/2012, modifying Act 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care of people in situation of dependency.

- This regulation abolishes the classification by levels within each degree of dependency, since it lengthened the procedure and consumed added resources without giving rise to any differentiation in terms of the benefits acknowledged. It also established a calendar for grade I to 1 July 2015, to give priority care to people with greater degree of dependency and it established the maximum amounts of the financial benefits for each of the degrees of dependency.

- Decision of 23 April 2013, of the State Secretariat for Social Services and Equality, publishes the Resolution of the Territorial Council of Social Services and of the System for the Autonomy and Care of Dependent Persons regarding criteria, recommendations and minimum conditions for the preparation of Plans for Prevention of Situations of Dependency and the Promotion of Personal Autonomy, which includes a Catalogue of reference of social services.

- With the purpose of preventing the appearance or worsening of diseases or disabilities and their after-effects, by the coordinated development, between social and health services, of actions to promote healthy living conditions, specific preventive and rehabilitation programs aimed at the elderly and disabled people and those who are affected by complex hospitalisation processes.

- Decision of 25 July 2013, of the State Secretariat for Social Services and Equality, publishes the Resolution on common criteria, recommendations and minimum conditions of the comprehensive care plans for children under the age of three in situations of dependency or at risk in application of Act 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care of people in situation of dependency.

- The aim and purpose of this resolution is to promote their personal autonomy, so that they can enhance their capacity for development and wellbeing, enabling their inclusion in the family, school and social spheres.

- These Plans shall be developed by the Autonomous Regions and are aimed at children under the age of three certified to be in situation of dependency or at risk of developing it.

- These Comprehensive Care Plans also consider the necessary strategies aimed at facilitating the support and participation of the family, guardians and/or carers, as well as the specific characteristics of the environment.

– Royal Decree 1050/2013, of 27 December 2013, governing the minimum level of protection established in Promotion of Personal Autonomy and Care of Persons in a Situation of Dependence Act 39/2006, of 14 December 2006.

– Royal Decree 1051/2013, of 27 December 2013, governing the provisions of the System for the Autonomy and Care of Dependent Persons, as established in the Promotion of Personal Autonomy and Care of Persons in a Situation of Dependence Act 39/2006, of 14 December 2006.

- Order SSI/2371/2013, of 17 December, regulating the Information System of the System for the Autonomy and Care of Dependent Persons (SISAAD), which defines

the set of data necessary for the payment of the minimum level in addition to those that are necessary for management, statistics and studies.

All this new legislation seeks to clarify, make more transparent the Information System, to ensure their safety and to check and compare the data entered into the system by Regional Communities, and that these data are equal and homogeneous.

On the other hand, the above regulations and commitments culminate and consolidate the measures adopted by the Territorial Council. Other improvements are not foreseen in the dependency system, making possible to keep the SAAD with higher quality and a better professional care.

Challenges

Spain has taken significant steps to establish a social care system that provides coverage to the population. The main challenges of the system appear to be:

- **Improving the governance framework:** To establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities with respect to the provision of long-term care services; To set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; To strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; To establish good information platforms for LTC users and providers; To set guidelines to steer decision-making at local level or by practising providers; To share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes.

- **Improving financing arrangements:** To foster pre-funding elements, which implies setting aside some funds to pay for future obligations; To explore the potential of private LTC insurance as a supplementary financing tool; To determine the extent of user cost-sharing on LTC benefits.

- **Providing adequate levels of care to those in need of care:** To adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the breadth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and the depth of coverage, that is, setting the types of services included into the coverage; To reduce the risk of impoverishment of recipients and informal carers.

- **Encouraging home care:** To develop alternatives to institutional care by e.g. developing new legislative frameworks encouraging home care and regulation controlling admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage home care; To monitor and evaluate alternative services, including incentives for use of alternative settings.

- **Encouraging independent living:** To provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.

- **Ensuring availability of formal carers:** To determine current and future needs for qualified human resources and facilities for long-term care.

- **Supporting family carers:** To establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Ensuring coordination and continuity of care**: To establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- **Facilitating appropriate utilisation across health and long-term care:** To create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system; To steer LTC users towards appropriate settings.

- **Changing payment incentives for providers:** To consider a focused use of budgets negotiated ex-ante or based on a pre-fixed share of high-need users.

- **Improving value for money:** To invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; To invest in ICT as an important source of information, care management and coordination.

- **Prevention:** To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 2.26.1: **Statistical Annex – Spain**

GENERAL CONTEXT

GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	803	861	931	1,008	1,081	1,116	1,079	1,081	1,070	1,043	1,031	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	25.5	25.6	25.7	26.6	27.3	26.4	24.7	24.7	24.5	24.4	24.1	26.8	27.6	28.0	28.1	27.9
Population, in millions	41.8	42.5	43.3	44.0	44.8	45.7	46.2	46.5	46.7	46.8	46.7	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	0.5	0.5	0.5	0.6	0.6	0.6	0.7	0.8	0.7	0.7	:	1.0	1.0	1.0	1.0	:
Per capita PPS	96.8	112.0	125.6	141.6	150.4	154.6	169.0	184.9	161.0	163.9	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	1.3	1.4	1.5	1.5	1.5	1.6	1.7	1.5	1.5	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	83.0	83.7	83.6	84.4	84.4	84.6	85.0	85.5	85.6	85.5	86.1	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	76.4	77.0	77.0	77.8	77.9	78.3	78.8	79.2	79.5	79.5	80.2	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	70.2	62.7	63.4	63.5	63.2	63.7	62.1	63.8	65.6	65.8	63.9	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	66.8	62.6	63.3	63.9	63.5	64.0	63.1	64.5	65.4	64.8	64.7	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	26.2	24.0	23.7	25.1	29.8	30.3	29.5	23.0	26.2	31.6	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	9.2	9.0	8.5	9.1	5.4	5.7	5.4	4.7	5.1	5.4	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	180	208	235	262	267	272	307	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	181	258	334	411	419	427	693	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	0.8	1.0	1.2	1.4	1.5	1.5	2.1	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	:	:	:	:	:	280	385	423	427	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	322	340	338	336	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.26.2: **Statistical Annex - continued – Spain**

PROJECTIONS

Population	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
Population projection in millions	46.7	45.7	44.5	44.7	45.6	46.1	-1%	3%
Dependency								
Number of dependents in millions	2.45	2.66	2.94	3.35	3.76	3.97	62%	40%
Share of dependents, in %	5.3	5.8	6.6	7.5	8.2	8.6	64%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	1.0	1.2	1.3	1.6	2.1	2.4	147%	40%
AWG risk scenario	1.0	1.3	1.5	2.1	3.0	3.9	294%	149%
Coverage								
Number of people receiving care in an institution	307,300	354,020	387,101	470,022	589,292	717,580	134%	79%
Number of people receiving care at home	692,532	826,063	945,286	1,202,018	1,560,354	1,910,449	176%	78%
Number of people receiving cash benefits	490,357	573,724	644,428	796,502	1,006,566	1,222,908	149%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	3.2	3.8	4.4	5.5	6.9	8.3	161%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	60.8	65.9	67.2	73.8	84.0	97.0	60%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	68.3	68.5	66.2	66.3	68.0	67.4	-1%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	31.7	31.5	33.8	33.7	32.0	32.6	3%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	74.1	73.9	73.3	72.8	72.5	72.7	-2%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	25.9	26.1	26.7	27.2	27.5	27.3	5%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	75.6	77.4	71.0	72.3	78.4	76.5	1%	-2%
Unit costs of home care per recipient, as % of GDP per capita	11.7	11.7	10.6	10.6	11.2	10.8	-8%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	29.7	29.7	29.7	29.8	29.8	29.9	1%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)