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Long-term care for older people during the COVID-19 pandemic in decentralised Spain

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Introduction

Long-term care (LTC) for older people has been a traditionally underdeveloped social policy area in Spain, with national measures addressing situations of dependency and care needs in a rather fragmented way until the early 2000s. The creation of the System of Autonomy and Dependency Care (SAAD, by its Spanish acronym) in 2006, attempted to provide a coherent answer to increasing demands for dependency care. However, its effective implementation has been hindered by several structural problems, among others: vertical and horizontal fragmentation across actors in the health and social service domains, weak coordination, precarious employment conditions and shortages of professional caregivers. As highlighted in the following pages, the outbreak of the COVID-19 pandemic, which hit Spain early and severely, exacerbated these structural problems, (re-)opening a public and political debate on the weaknesses of the LTC system for older people in the country.

The chapter is structured as follows. Section 1 presents an overview of the evolution and key features of the LTC system in the country, while Section 2 provides the key facts and figures concerning the evolution of the COVID-19 pandemic and its impact on the Spanish health and care sectors. Section 3 delves into the institutional and organisational

measures adopted to prevent and minimise the impact of the health crisis on care homes for older people across the country. Taking stock of the lessons learnt, Section 4 engages with a two-decades-long debate about the future of the care home sector in Spain, stressing the need to strengthen the human, financial and institutional resources of this increasingly relevant policy domain and its coordination with the health system.

1. LTC policy and the care home sector for older people in Spain

Evolution of the system and current arrangements

Sharing the key features of the Mediterranean, family-based welfare and care regimes (Chapter 2 in this book), LTC in Spain has been a traditionally underdeveloped social policy area (Aguilar-Hendrickson 2020). From the 1980s onwards, different reforms were articulated at the national level, although in a rather fragmented way. The Law for the Social Integration of the Disabled (1982) and the National Gerontological Plan (1982) stand out. From an extra-sectoral point of view, other measures such as the General Law on Health (1986), the Concerted Plan for the Development of the Basic Provision of Social Services by Local Authorities (1988), or the Non-Contributory Pensions Act (1990), have also tried to address situations of dependency and care needs.

Consequently, until 2006 LTC was structured in two basic levels. On the one hand, a very restricted national social security system granting limited cash transfers to workers under 65 years of age with dependency due to work-related accidents, or to people with a disability of more than 65%. On the other hand, a residual system of regional and municipal social services to protect the most disadvantaged groups, and aimed at funding dependency care through institutionalised care homes. This second level was characterised by significant territorial heterogeneity in the scope of services (Arlotti & Aguilar-Hendrickson 2017). Due to these structural weaknesses, the public LTC system served only a small proportion of the population. Against such residual state intervention, the responsibility and tasks related to the care of dependent people fell mostly on informal female carers - family members and migrant workers, the latter often in an irregular situation (Da Roit et al. 2013; Spijker & Zueras 2020).

Despite these limitations, it was not until the 2000s that the issue of LTC entered the political agenda. Pressures from different venues - socio-demographic (ageing and growing dependency rate, progressive incorporation of Spanish women in the labour market), domestic (concerning the structure of organisation and provision), and international (LTC reforms taking place in other European countries) - triggered a substantial reform of the Spanish LTC system (Spijker et al. 2022). Facilitated by favourable macro-economic trends, and the relatively healthy state of Spain's public finances at that time, the reform was the result of a long process of political debate, and the development of *sui generis* coalition of interests between the different levels of government, social partners (employers and trade unions), social actors (such as NGOs), and professionals (see Moreno Fuentes 2015).[1] Such debate resulted in the adoption of the 39/2006 Act on Promotion of Personal Autonomy and Attention to People in a situation of Dependence (the so-called 'Dependency Law'), which established the current SAAD.

The approval of the Dependency Law significantly transformed the previously existing LTC policy framework in the country. Access to the SAAD became configured as a subjective, universal right to social protection for any person who can prove stable residence in Spain for at least five years (regardless of age), and who presents one of the degrees of dependency envisaged in the law. Differently from the previous configuration, the LTC

system is mainly oriented towards service provision, including prevention services for dependency situations and promoting personal autonomy, remote care service, and home care service. Exceptionally, the system also foresees cash transfer programmes for purchasing care services on the market, hiring an assistant, or financially compensating a family member or a non-professional caregiver.

Despite the norm's preference for direct service delivery, historical institutional inertias of regional and local social service schemes, budgetary constraints experienced during the Great Recession, the change of political cycle in 2011, and the ideological preferences of some regional policy-makers, all contributed to the salience of cash transfers (see Deusdad et al. 2016). Yet, this initial trait of the new LTC system has been progressively changing in recent years towards a growing role of service provision. Thus, in 2009 cash transfers accounted for 58,22 per cent of the system's benefits, but in 2022 they represented 42,29 per cent (compared to 57,70 per cent of direct service provision; IMSERSO, 2022a).

LTC multi-level governance and funding mechanisms in Spain

With the 2006 Dependency Law, the governance of the SAAD has been structured as a complex multi-level system of shared competencies. The central government is responsible for regulating the basic conditions of the system to ensure equal access throughout the national territory, and the management of the information system (SISAAD). Autonomous Communities (ACs) remain responsible for the operational structure and day-to-day running of the system, responsible for granting benefits, assessing the degree of dependency, and the accreditation of Centres and Services, among other issues. Since 2013, the role of the municipalities has varied significantly depending on the delegated competencies attributed to them by regional laws. In general, local authorities supplement the benefits basket (mostly home care) with their own resources, and with funds transferred to them by from regional governments.

To strengthen coordination across levels of administration, the Dependency Law created the SAAD Territorial Council, which is composed of the central government's Minister for Social Affairs, the corresponding regional ministers, as well as by local authorities (via the Spanish Federation of Local Governments, FEMP). This Council is responsible for establishing the criteria for the distribution of funding, the intensity of services, the conditions and amounts of financial benefits, as well as for defining the scale for the recognition of the situation of dependency. Each AC must transpose the agreements reached by the Territorial Council into its own regional legislation. Since its creation in 2007, this intergovernmental body has shown high levels of activity and institutionalisation. Its meetings have become regular throughout different legislative periods, showing central governments' willingness to use this type of cooperation instrument (Ministry of Territorial Policy 2022). However, the ideological opposition that often exists between central and regional governments, and the different levels of political commitment and 'institutional loyalty' of regional authorities to the deployment of the Dependency Law, have often created coordination problems and difficulties in ensuring equity in access to the benefits of the SAAD across the country (Marbán Gallego 2019).

For what concerns the financing of the LTC system, the SAAD is funded by the central government and the ACs with funds obtained through general taxation, complemented by a co-payments system based on the type and cost of the service and users' income and wealth levels. There are three levels of public funding. The central government is supposed to assume and guarantee a minimum level of funding for the whole State, transferring the corresponding funds to the ACs according to need, the social characteristics

of the territories, the number of people requiring care assistance and other specific geographic conditions. Supplementary funds are agreed upon by the central and regional governments.[2] Each level of the administration is supposed to contribute in a similar manner. Finally, there is an additional level set and financed by each AC voluntarily and from their budgets. In relative terms, in 2020, the central government bore 15.1 per cent of the overall cost of the system, users (through co-payment) 20.6 per cent, and ACs the remaining 64.3 per cent (AEDGSS 2021). These percentages are far from the initial forecasts established in the Dependency Law since the central government was expected to bear about one-third of the system's total costs.

Main features of the LTC system for older people in Spain

Although there is no official register of residential centres for older adults in Spain, statistics compiled by *Envejecimiento en Red-CSIC* indicate that in September 2020, there were a total of 5,567 centres, accounting for 384,251 beds.[3] This means that there were 4.2 beds for every 100 older people, although with significant differences across ACs (Abellán-García et al. 2021a). It is estimated that in September 2020 these facilities represented the habitual place of residence for 312,668 older adults (Abellán García et al. 2021b).

In terms of the public-private mix, it should be noted that the private sector plays a major role in the Spanish LTC system, with most beds (73.2 per cent) being located in privately owned care homes (Abellán-García et al. 2021a). However, a significant percentage of places in private care homes are financed by public resources through agreements signed between public administrations and private providers (the so-called '*conciertos*'). According to recent estimates, subsidised places account for 32.7 per cent of all private places (Muñoz Díaz et al. 2021).

Spanish care homes vary considerably in size, from very small centres to quite large facilities. The latter are of great importance: according to CSIC data, 51.3 per cent of places are in care homes with 100 or more beds (Abellán-García et al. 2021a). This fact is especially relevant to understanding the differential impact of the COVID-19 pandemic on Spanish care homes. The size (number of beds) and occupation level of these facilities have been proved to correlate positively to the lethality of COVID-19 during the first wave of the pandemic (Barrera-Algarín et al. 2021).

Another organisational feature of the Spanish care home sector relates to the characteristics of the workforce. Unlike the health sector, there is no official caregivers register in Spain. At the same time, estimates indicate the presence of approximately 320,000 workers in the sector, the vast majority of whom are women (83 per cent) (Jiménez-Martín & Viola 2020). Like other EU countries (OECD 2020), employment in the Spanish care sector is characterised by low wages, temporary contracts, high turnover, and part-time employment. Also, due to these unappealing working conditions, there are shortages of professional care workers. At the same time, a significant proportion of caregivers are low qualified (Hernández-Moreno & Pereira-Puga 2021). These weaknesses in staffing levels and in the degree of professionalisation of the sector are particularly problematic due to the multiple vulnerabilities that affect older people in care homes. Almost 80 per cent of residents are 80 years or older (IMSERSO 2020), increasing the probability of being dependent on caregivers. Likewise, they often suffer from co-morbidities. For example, in Murcia, a recent study shed light on the profile of older adults in care homes: 45.4 per cent suffer from severe dementia, 43.7 per cent are totally dependent, and 72.9 per cent use diapers (Novoa Jurado et al. 2022).

2. Evolution of the COVID-19 pandemic

From the state of emergency to the "new normality"

On 30 January 2020, the WHO declared the outbreak of the new coronavirus a Public Health Emergency of International Concern. The day after, the first official case of COVID-19 was confirmed in Spain. Following the multiplication of cases, the central government assumed the existence of community transmission on 9 March. On 11 March, the WHO formally declared the existence of a pandemic. Three days later, the Spanish government declared a 'state of emergency' by Royal Decree 463/2020. The decree empowered the Minister of Health as temporarily delegated authority to manage the crisis in health care, being able to adopt all measures deemed appropriate to reinforce the decentralised national health system (*Sistema Nacional de Salud,* SNS).

Throughout the first state of alarm (March-June 2020), the central government and the ACs made important coordination efforts in healthcare (González Gómez 2021). During that period, the Interterritorial Council of the SNS, the main intergovernmental political body in this domain, composed of the central government and ACs' health authorities, met 40 times. Technical committees (such as the Public Health Commission) were also very active, with some 70 meetings. Despite these coordination efforts, central government initiatives were often criticised for not including ACs in their decisions (the Ministry of Health approved more than 75 orders in little more than three months), and for the alleged ineffectiveness of its measures to manage the crisis. Moreover, some ACs, such as Madrid and Catalonia, showed an aggressive attitude towards the central authorities (Mattei & del Pino 2021), engaging in the politicisation of the pandemic for partisan competition reasons.

On 9 June, with more favourable epidemiological data on the table, the Royal Law-Decree 21/2020 established the conditions for the 'new normality', identifying the criteria that ACs and their territories had to comply with to progressively soften the restrictions set by the state of alarm. On 21 June, after the National Parliament validated six extensions, the state of alarm was lifted. A new phase in intergovernmental relations began at this point (Navarro & Velasco 2022). The ACs fully recovered their competencies in health matters, while the coordination powers of the Ministry of Health were strengthened.[4]

Differently from coordination efforts in healthcare, no similar dynamics took place in the LTC sector. Neither the Royal Decree 463/2020 and its successive renewals, nor State instructions appointed the Second Vice-President and Minister of Social Rights and Agenda 2030 as delegated authority to manage the COVID-19 crisis in the LTC sector and care homes. Instead, the Ministry of Health at the national level established the criteria for the management and coordination of care centres with other administrations. The ACs and local governments retained their usual powers of dependency management throughout the pandemic. In fact, the social service intergovernmental body (the SAAD Territorial Council) had much lower activity levels than its health counterpart (Hernández-Moreno 2021).

At the regional level, although the 'single command' in crisis management was usually centred in the Health departments, an intense dynamic of coordinated work developed in many ACs between the departments of Health and Social Services. For instance, socio-sanitary coordination plans and joint action protocols were drawn up in Galicia and Castile-La Mancha. In the Canary Islands and Asturias, the Regional Ministries of Social Rights and Health developed a shared system to monitor the epidemiological situation in all care homes. Yet, inter-sectoral coordination problems were clearly identified regarding which Ministry – national or regional - was responsible for the care home sector (including more technical issues such as collecting and publishing data on infections and deaths) (del Pino et al. 2021).

Key figures: impact on the health system and care home sector

In terms of deaths, Spain was one of the first and most severely affected countries during the pandemic in the EU. The Ministry of Health confirmed 46,252 deaths caused by the virus from the start of the pandemic, until November 2020 (Ministry of Health 2020), while the National Institute of Statistics (INE) reported excess deaths of almost 80,000 people in the same period.

Focusing on the healthcare domain, the pandemic represented an unprecedented shock for all healthcare systems worldwide. It strained their material and human resources, operational capacities and governance, including healthcare systems classified as high-performing and resilient to epidemic and pandemic outbreaks, such as the Spanish SNS (Legido-Quigley et al. 2020).[5]

Although Spain's diagnostic capacity was in line with the rest of the EU countries at the beginning of the pandemic, the lack of prepared laboratories, specialised personnel and medical products for testing delayed the response to the crisis in the face of the high incidence of the virus (European Commission 2021).

In terms of material resources, the shortage of personal protective equipment (PPE) - especially FPP2/FPP3 masks, goggles, and full PPE – as well as of medical products and therapeutics used in intensive care units (ICU), largely affected the operational capacity of the SNS, especially in the early stages of the crisis (Médicos sin Fronteras 2020). While difficulties in purchasing PPE were reported globally, Spain lacked national stocks and a nationally based industrial able to produce them (Cáceres Armendáriz & Sierra Alonso 2021), leaving the central and regional governments with unprecedented difficulties in finding such products in the markets.[6] Problems were also reported in relation to the availability of medical equipment, particularly mechanical ventilators, which are crucial in treating patients with COVID-19. As a survey conducted at the end of May 2020 indicates, healthcare professionals rated the quantity and quality of available equipment very negatively (3.46 out of 10 points) (SATSE 2020).

In a context characterised by these shortages, the incidence rate of the disease among healthcare workers was twice as high as in the general population (the highest rate in Europe), and accounted for 25 per cent of the total number of positive cases reported during the first wave of the pandemic (RENAVE 2020). This situation was aggravated by the fact that the SNS had to face the pandemic with a structural shortage of human resources, with only 3.4 medical and nursing professionals per 1000 inhabitants, a rate well below the EU average (5.74), and far from countries such as Germany (13.0), or Sweden (10.9) (Eurostat 2022).

In operational terms, primary healthcare services, the main point of access to the SNS, and an important triage and follow-up point for COVID-19 patients, were severely overstretched in terms of care capacity due to staff shortages and the closure of many healthcare centres (Amnesty International 2021). Although telemedicine was strongly promoted to deal with limitations on face-to-face care, this shift in the modes of primary care provision raised issues of equity and inclusion (for mobile, migrant, rural and vulnerable populations), as it occurred in other countries (Sagan et al. 2021).

The pandemic also affected the operational capacity of ICUs (Ma & Vervoort 2020). Spain was below the OECD average in ICU beds per 100,000 inhabitants in 2019 (10.4 vs. 14.1). Peak occupancy was reached on 5 April (6,576 ICU beds), with some ACs such as Madrid and Catalonia reaching their maximum capacity during the Spring of 2020. To deal with this overwhelming situation, ICU bed capacity was increased by using resources from other hospital units (e.g. post-surgical awakening units), adapting inpatient or surgical beds, and making all ICU beds in private hospitals available to the SNS, as indicated by the declaration of the 'state of emergency'. These decisions allowed to quickly double the capacity

of ICU beds in public hospitals, from 4,446 beds to 7,930 in only two months (OECD 2021). However, this transformation implied inevitable costs for all non-COVID19-related hospital treatments.

Accordingly, another side effect of the pandemic refers to access to the SNS for patients with diseases other than COVID-19. During the first half of 2020, most of the scheduled surgeries were postponed or cancelled. In June 2020, patients waited an average of 170 days for surgery, almost two months longer than in December 2019. Delays for the first visit to a specialist increased by 34 days (Ministry of Health 2021a). In addition, 25 per cent of the Spanish population reported forgoing a necessary medical test or treatment during the first 12 months of the pandemic (Eurofound 2021). This situation led health professionals and authorities to worry about the worsening of certain diseases and delays in the diagnosis of new pathologies (Ministry of Health 2021b).

For what concerns the impact of the pandemic on the care home sector, it has been widely recognised that these facilities accounted for a significant proportion of COVID-19-related deaths during the first wave. However, reliable estimates are difficult to obtain due to issues of under-diagnosis and data reporting, among other factors. As reported by IMSERSO (2022b), between 14 March and 22 June 2020, 9,381 older people living in care homes died with confirmed COVID-19, while an additional 10,492 people died with compatible COVID-19 symptoms.[7] From a comparative perspective, Spain was one of the high-income countries which reported the highest proportion of care home resident population with COVID19-associated death (more than 5 per cent) (Comas-Herrera et al. 2021).

Beyond data about mortality, a significant number of older people residing in care homes suffered adverse effects on their health and quality of life due to the prevention and contention measures adopted in those facilities. Actions involving isolation and limitation of social contacts have been associated with the appearance of diseases related to sedentary lifestyles and the aggravation of pre-existing pathologies, as well as with motivational and affective disorders (SEGG 2020).

3. Minimising the impact of the pandemic in the Spanish care homes: preparedness, measures and efficacy

The Spanish 1978 Constitution establishes that the general coordination of healthcare and public health is an exclusive competence of the central government and, specifically, of the national Ministry of Health. The Centre for the Coordination of Health Alerts and Emergencies (CCAES), created in 2004, is in charge of preparing and developing Preparedness and Response Plans to address current or emerging public health threats. In addition, a National Early Warning and Rapid Response System (SIAPR, by its Spanish acronym) was set up in 2013, composed of regional liaison centres, responsible for coordinating response measures against potential health threats from a multi-sectoral point of view.

The Ministry of Health and the CCEAS developed several Preparedness and Response Plans within this framework (for influenza [2005], vector-borne diseases [2016], MERS-CoV coronavirus [2017], Ebola [2020], and West Nile fever [2020]), and ACs are in charge of developing and updating regional Preparedness and Response Plans. However, neither the National Strategies, nor the existing pre-pandemic Preparedness Plans, included guidelines directly related to the care home sector. Consequently, with the outbreak of the COVID-19 crisis, the central government urged care homes to develop contingency plans to combat the pandemic. Accordingly, Royal Decree-Law 21/2020 of 9 June listed several urgent prevention, containment and coordination measures to deal with the health crisis

caused by COVID-19. Likewise, several ACs draw up various documents to guide care homes dealing with the COVID19 pandemic (such as Aragon or Madrid), including the definition of contingency plans.

Throughout the first months of the pandemic, these protocols and contingency plans were continuously updated as new information and global guidelines became available (WHO 2020a, 2020b). However, the weak vertical and horizontal coordination between the multiplicity of actors involved meant that care homes were overburdened with regulations which were sometimes difficult to implement.

In a context of unclear guidelines, several measures were adopted by both ACs and directors of care homes for older people (del Pino et al. 2021), often following a trial-and-error approach. Many of these measures resulted from a proactive role of directors of care homes or employers' organisations, which often assumed a leadership role in managing the crisis – particularly in its beginning – in the absence of clear indications from public authorities.

The closing to external visits represented one of the first and most common measures adopted by directors of care homes, often before the publication of instructions from the competent regional authorities, as Table 1 indicates. Similarly, the sectorisation and isolation of residents according to symptoms constituted another fundamental measure to stop the spread of the virus. However, its feasibility largely depended on the level of occupancy and the architectural characteristics of each centre (size, existence of shared rooms, organisation of shared spaces, etc.) (Martín López & Durán López 2021), while its effectiveness was affected by the availability of both staff and diagnostic tests.

Table 1. Closing of care homes: indications from employers' organisations and Autonomic instructions

AC	Employers' organisation	First communication from the employers' organisation	Instruction from the competent authority
Catalonia	ACRA	25 February	12 March
Castile-La Mancha	ARTECAM	26 February	14 March
Aragon	ARADE	25 February	16 March
Valencian Community	AERTE	25 February	18 March
Castile and León	ACALERTE	1 March	13 March
Madrid	AMADE	6 March	15 March
Andalusia	CECUA	11 March	14 March

Source: CEAPs 2020

As mentioned before, the COVID-19 pandemic exacerbated pre-existing structural shortages in staffing levels in the Spanish care home sector, which dramatically increased due to sick

leaves (in certain centres, involving up to 75 per cent of staff). This, in turn, led to the overloading of the workload, tasks and responsibilities for available staff (Pérez-Raya et al., 2021). At the level of care homes, directors frequently adopted mechanisms of workers' rotation, sectorisation, and the concentration of working hours on fewer shifts to reduce potential contagion and turnover, as well as to facilitate the detection of positive cases among the staff (by allowing more time for potential symptoms to appear).

At the institutional level, several ACs created dedicated employment lists for people willing to work in the sector during the pandemic, or made available workers from other public sectors that were not operational (e.g., nurses from the education system) to care homes in need of personnel. While representing an important measure to deal with such shortages, however, ad hoc employed persons often lacked the necessary training to adequately perform their job, even more so in the context of a pandemic. From this perspective, materials published by the WHO (2020b), the Ministry of Health, and several ACs, as well as the ones drafted by the same care home staff, were fundamental to rapidly train workers – although with difficulties derived from the development and continuous updating of documents as new information arrived.

For what concerns the availability of diagnostic tests and PPE, the concentration of the demand in the international market, and the decision to prioritise their allocation to healthcare structures, largely conditioned the availability of these diagnostic and protective instruments in care homes, particularly during the initial months of the pandemic. Some larger facilities had anticipated purchases of PPE already in January 2020, learning from the lessons of previous epidemics when the system suffered from severe supply problems. Yet, most of them had to buy these materials at very high prices, reuse them beyond technical specifications, or even rely on non-approved PPE.

Specifically concerning diagnostic tests, the time elapsed between the request for PCR tests, and the possibility of performing them, was quite significant, ranging from several days to more than a week (especially during March, and the first half of April), and with relevant differences between ACs. In some cases, this time was even longer when it came to receiving the test results, revealing the difficulty of the system to perform and process a massive volume of tests simultaneously. In addition to the availability of tests, changes in the indications received by the health authorities, often in a matter of days, and frequently incorporating new evidence as it was produced, contributed to confusion among the staff, leading to inefficient and ineffective use of diagnostic tests.

Due to the difficulties related to the isolation of COVID-19 infected residents within the same centre, some ACs set up specific structures to move these patients from the care homes where outbreaks had occurred (del Pino et al. 2021). This solution allowed care homes to reduce the risk of the spread of the virus among residents and staff, and the slow but progressive re-establishment of 'normal' daily routines and activities. Moreover, it represented a necessary measure to deal with difficulties in accessing overwhelmed healthcare facilities, and to overcome fragmentation and interaction problems between the care home sector and the different parts of the SNS.

Access to primary and secondary healthcare was drastically limited during the first months of the pandemic, as mentioned in Section 2. In some ACs, it was extremely difficult to access primary healthcare centres. These were either overcrowded by the general population, or directly closed (e.g., in the Community of Madrid, 7.8 per cent of primary care centres, and 53.3 per cent of local public practices, were closed in April). To deal with this limitation, some ACs opted for the 'medicalisation' of care homes, i.e., the sending of human resources and medical material to care homes. In contrast, in others the interaction of care homes with the SNS mainly took place with hospitals through the geriatrics service, as in Madrid or Valencia (Sáez-López & Arredondo-Provecho 2021).[8] Moreover, given the pre-existing shortage of healthcare staff in most of the homes, and the lack of medical training for care staff, nurses from the primary care centres often acted as crisis managers in the care homes themselves, supporting directors and staff in the development of contingency plans, coordinating positive and asymptomatic patients, or facilitating access to diagnostic tests, among other functions.

More generally, the pandemic exacerbated the structural, limited integration – or even fragmentation – between LTC and healthcare services in Spain, weakening the capacity of the system to rapidly and effectively manage the health crisis in care homes. Subordination of social services to healthcare services, fragmentation in the distribution of competencies and responsibilities, as well as the diverse organisational cultures and differences in status and social (self-)perception between healthcare and social professionals, have been identified as critical points of frictions and, at times, causes of blockage in the management of the pandemic. In this sense, the disregard for the peculiarities of care home facilities by health authorities when applying hospital organisation and management criteria had a clearly negative impact on the physical and emotional health of elderly residents and their families.

4. After the first wave: learning processes and challenges for the future

The first wave of the pandemic was critical, particularly for older people and workers in care homes. The subsequent waves produced a lower incidence of COVID-19 cases in these facilities, which experienced a different distribution of cases compared to the general population.

On the one hand, the incidence and mortality rates in care homes improved thanks to mass vaccination, as infections in vaccinated older people were more likely to be controlled without requiring hospitalisation (Fernández Riquelme 2021). As reported in an evaluation of the measures adopted in Catalonia (Parilla Valero 2022), vaccinations reduced the incidence of COVID-19 for older people in care homes during the third and fourth waves to levels below the average of the general population. With the arrival of the delta variant of the SARS-CoV-2 virus, the incidence and mortality increased, although nothing like during the critical moments of the first wave. According to the Catalan Health Department, vaccinations were the main reason for halting the incidence and mortality of the more contagious delta variant (Generalitat de Catalunya 2021).

On the other hand, some lessons from the first wave were learned and implemented, namely: i) the increase in the number of diagnostic tests; ii) the development of appropriate contingency plans by care homes to mitigate future contagions; and iii) the establishment of coordination mechanisms between the care home sector and primary health care by launching Nursing Homes Care Units. These liaison units might be used in the post-

pandemic era to avoid the existing fragmentation of care between hospitals and care homes, to strengthen face-to-face visits to care homes, telemedicine sessions, as well as the coordination between the national healthcare service and the care homes (Menéndez-Colino et al. 2021).

Overall, the COVID-19 pandemic brought to the fore a two-decades-long debate about the future of the care home sector in Spain. The Congress of Deputies (2020) echoed various proposals by care home directors, formal caregivers and trade unions in the Resolution of the Reconstruction Commission. Among these, we can highlight the following:

- The need to adjust the care home conditions and regulations to the current profile of older adults. As described in Section 1, care home residents arrive older (due to their preference to remain at home as long as possible), and become more dependent as time passes. This necessarily requires more coordination between the healthcare and social service professionals. The limited coordination between sectors is considered one of the main elements that conditioned the quality of the response to the COVID19 pandemic in care homes (Novoa Jurado et al. 2022).
- The unanimous rejection by care home directors on the 'medicalisation' of care homes, claiming that these structures are the principal residence of older people that need care to live a life as close to normal and as autonomous as possible, and not necessarily healthcare. Rather than medicalisation, coordination between the two sectors is deemed central. Accordingly, the level of coordination achieved throughout the pandemic is considered a clear step in the normalisation of the links between care homes and the healthcare system (primary healthcare, hospitals, emergency facilities, public health, primary social services and care homes). A recommended output is the development of medium to long-stay hospitals that could accommodate older persons needing long-term medical attention.
- The need to professionalise care workers and to increase the offer of university training programmes for different profiles needed in the care home sector. Most importantly, the urgency to dignify and improve the working conditions and environment of care workers.
- The importance of considering the needs, perspectives and preferences of older people in the design of care homes, fostering an internal re-organisation of care homes into cohabitation units where older people live together in smaller groups and with similar profiles. Gallego et al. (2021) consider that these cohabitation units, combined with a reinforcement of home and community care, should be at the forefront of the transformation of the LTC system.

To achieve these goals, the reform of the care home sector for older people – and of the LTC sector more broadly – requires a compromise by the different levels of government to increase the financial resources currently allocated to care for older people. Although regional governments have made significant efforts to increase the number of formal caregivers and strengthen primary healthcare during the pandemic, these are considered insufficient by organisations and workers in the care and health sector (Amnesty International 2021). Moreover, according to trade unions, formal caregivers' wages and job quality must be improved, thus requiring more financial commitment to the sector. Hence, the big question

arises: how do we fund the fiscal space needed to implement these reforms and to transform the LTC sector in Spain? Three visible options arise, which should be evaluated regarding political and economic viability: increase taxation, redirect current expenditure to this sector, or a combination of both of those strategies.

End Notes

1. However, criticism were posed by some regional nationalist parties, and some ACs even reformed their regional Statutes of Autonomy to reaffirm their exclusive competences in the area of social services (such as Andalusia).

2. Through the National Reform Programme of 2012, the conservative central government suspended the supplementary funds and considerably reduced the minimum level of funding for the LTC system.

3. The number of beds is unknown for 11 of the 5,567 centres. The total number of beds does not take into account these 11 LTC facilities.

4. A reform in June 2020 of the Law 16/2003 on Cohesion and Quality of the SNS introduced the Declaration of Coordinated Actions, which allows the central government establishing binding measures for all ACs.

5. The SNS was considered the most efficient healthcare system in Europe, and the third one in the world (Bloomberg Index).

6. In July 2020, the central government, in the framework of the 'Early Response Plan for the control of the COVID-19 pandemic', established a national strategic stockpile as a support measure for ACs to guarantee the supply of commodities for at least 8 weeks. Yet, care homes were not included among the structures receiving priority in the allocation of this national stock.

7. These data refer to older adults living in care homes, regardless of the specific place of death (the care home where they lived, or elsewhere).

8. For example, the Community of Madrid created Geriatrics Liaison Units in public hospitals in the following phases of the pandemic. Along with the Spanish Society of Geriatrics, these units informed care homes about prevention, early detection, and sectorisation. At the time of finalising this chapter (summer 2022), the new protocols for interaction between care homes and the 22 hospitals in the ACs (which have restricted access to these healthcare services for elderly patients suffering from COVID-19) have been legally challenged by several regional courts.

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