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Long-Term Care Policies in Spain: Welfare State and Resilience in the European Context

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Abstract: This paper analyses the long-term care system in the context of Spain's aging population from a comparative and multilevel perspective. Starting with the European regulatory framework, it examines the main characteristics of long-term care systems in Europe and the challenges of establishing a welfare system in Spain amidst two consecutive crises: the economic and financial crisis of 2008–2014 and the pandemic crisis of 2020–2022. To achieve this, in addition to a thorough review of international literature, the study utilises legislation and reports from the European Commission, the Council of Europe, the World Health Organization, databases from the National Institute of Statistics and the Ministry of Social Rights, and Spain's Ministry of Health. The article concludes that Spain's long-term care model has evolved over time and has established a universal system characterised by territorial inequality. This inequality stems from regional preferences for service provision versus monetary compensation and their varying degrees of reliance on direct management or involvement of private organisations.

Keywords: long-term care; welfare policies; resilience; human rights; COVID-19

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1. Introduction

The ageing of the population is a process that affects the vast majority of countries in the world and is unprecedented in human history. It consists of an increase in the proportion of older people relative to the total population, while the proportion of children and working-age people decreases. This is mainly due to the reduction in the overall fertility rate and the crude mortality rate, especially the infant mortality rate. In other words, ageing can be considered a side effect of controlling demographic determinants (fertility and mortality). Another factor influencing demographic balances is migration, which in most cases rejuvenates the composition of the receiving country's population.

The globalisation or democratisation of ageing (Bourdieu and Kesztenbaum 2007) is also an achieved goal, that is, a widespread increase in life expectancy resulting from development and advances in public health, education, and welfare. Alongside this global ageing, there is a second global phenomenon: the feminization of ageing (National Academy on Ageing 1994). Women outlive men in all the countries of the world, and as a result, there is a greater presence of women in the later stages of life. The indicator that highlights this phenomenon is the sex ratio: at birth, the ratio is 104–107 men for every 100 women, but for the population aged 65 and over, it is 68 men for every 100 women (United Nations 2022).

Spain is one of the countries with the highest life expectancy at birth. At the beginning of the 20th century, it was 35 years (Pinilla-Pareja and Gisbert 2006), and it has continuously increased throughout the century, reaching 85 years for women and almost 80 for men (79.59) in the year 2000.

Other phenomena associated with ageing and the phase of demographic transition (Thompson 1929) in countries like Spain are the already noted changes in sex ratios (feminization of ageing) and the decrease in the availability of family members (the kin availability indicator). This is due to the sharp decline in mortality, the coexistence of more

generations within the same family but fewer children as potential caregivers, and finally, in aged countries with low net immigration, the medium-term effect is a decrease in the population (Martínez-Franzoni 2007), as is happening in some countries around the world.

While the described ageing does not necessarily imply limitations (Pardo 2022), and being an older person does not equate to being vulnerable or dependent (Díaz-Tendero 2019), the increase in life expectancy is not always accompanied by good health and autonomy.

Long-term care (LTC) is aimed at people who have had a significant and permanent loss of intrinsic capacity or are at risk of losing it, to help them maintain a level of functional capacity consistent with their basic rights, fundamental freedoms, and human dignity (World Health Organisation 2015). These care services, which should be the paradigm of public policy with a human rights approach, are framed, like any social policy, within the welfare state.

Beyond the concept of the welfare state as an ideal type, the welfare regime refers to how different social and political actors produce welfare to meet social risks through the classic triumvirate—state, market, and family (Martínez-Franzoni 2007)—and the alternative actors producing welfare by other means (Seelkopf and Starke 2019). Mediterranean regimes are distinguished from the liberal, social–democratic, and corporatist ones classified by Esping-Andersen (1989) and from the liberal Nordic or corporative models in the role played by the family and its interpenetration in all areas of social policy development (Moreno and Marí-Klose 2017).

The Spanish case of long-term care, as part of the Mediterranean welfare model, as noted by Díaz-Tendero and Cruz-Martínez (2023) maintains the multilevel structure of other areas of public policy, where regional governments manage the system, and the central government regulates the fundamental aspects (Moreno Fuentes 2015; Ruano and Díaz-Tendero 2022; Hernández-Moreno 2023). Moreover, all autonomous communities, to a greater or lesser extent, have resorted to the participation of private operators for the construction or management of health or social care infrastructures (Díaz-Tendero and Ruano 2023).

According to the typology developed by Kraus et al. (2011), Spain has a moderate level of organisation, financial generosity, and public spending, and like Portugal, it has high private financing. Damiani et al. (2011) also classify Mediterranean countries by their low level of formal care and consequently high level of informal care, primarily financed by citizens (Díaz-Tendero and Cruz-Martínez 2023). Spain is also characterised by a high dependence on informal caregivers. In other words, the long-term care sector can be defined as familiarised, where the source of welfare mainly comes from the family (Kraus et al. 2011).

Once the context of care policies is understood, the main purpose of this article is to analyse the Spanish care model in its European context from a human rights perspective, especially considering that in Spain, long-term care policies are a shared responsibility between the state and the regions (autonomous communities), which are responsible for part of the funding and implementation. This has led to models of territorial inequality based on each regional government's priorities and the prevalence of systems based on private sector collaboration and universal service provision models, far from the latest recommendations advocating for person-centred care (Díaz-Tendero and Ruano 2023).

The following sections outline the information collection methods used. Subsequently, the main characteristics of European long-term care models and the European regulatory framework will be presented, concluding with an analysis of the Spanish case and its results.

2. Materials and Methods

In the preparation of this work, the most recent European and Spanish literature on the subject has been thoroughly reviewed, alongside various documents from national and supranational organizations. This paper thus examines the situation of long-term care policy through organizational criteria and the development of comparable services in neighbouring countries, employing an inductive approach primarily based on the

documentary analysis of secondary sources. This methodological strategy aims to analyse a case study (the Spanish system) from both a contextual and comparative perspective.

To achieve this objective, in addition to reviewing specialized literature on the topic, the regulations issued by supranational organizations such as the Council of Europe (Recommendations 2022/C 476/01 and CM/Rec (2014/2)) and the European Commission (Regulations 883/2004; 987/2009; 2017/492) have been analysed as the overarching regulatory framework. Furthermore, prospective reports from the United Nations and the World Health Organization on global population trends, and the correlating factors between aging and health, have been consulted.

Drawing on this general contextual data, this analysis delves into the key factors that determine the existence of distinct long-term care models in Europe. The data have been sourced from the 2021 European Commission report on care supply and markets, which provides an overview of the state of long-term care systems in the EU, as well as recent reforms in the wake of the COVID-19 pandemic. Additionally, the European Care Strategy (2022), which highlights some of the central issues affecting care policies across the European Union, has been considered. These European Commission reports have been cross-referenced with information from the "Survey of Health, Ageing and Retirement in Europe (SHARE)" regarding the economic situation of dependent individuals. By analysing the pooled data from SHARE Waves 1 to 5 and 6, and ELSA Waves 2 to 7, this supranational, multidisciplinary, and longitudinal database provides insights into cross-country differences in long-term care policies, enabling a reflection on their impacts through ex-ante harmonisation of the tool to mitigate biases when comparing different care systems. Finally, the data from these quantitative databases has been compared with the findings of Pavolini (2021) and Zalakain (2022) on the various models of social protection and the organisation of long-term care services in Europe.

The final phase of the study was dedicated to analysing the long-term care system in Spain, placing it within the European context. To this end, national and regional legislation on dependency and care in Spain has been reviewed, and official databases from the National Statistics Institute on dependent individuals and their evolution between 2019 and 2023 have been consulted, alongside data from the Institute for Migration and Social Services (IMSERSO) on the evolution of key indicators in the "System for Autonomy and Dependency Care (SAAD)" between 2019 and 2023. Reports from the "COVID-19 and Residences" (Long-Term Care Facilities, LTCF) working group of the Ministry of Social Rights and Agenda 2030, providing information on the impact of the pandemic on long-term care facilities between 2020 and September 2022, have also been examined. These quantitative data have been cross-referenced with the 2021 report published by the Economic and Social Council, an advisory body to the Spanish government on socioeconomic matters, which explores the SAAD.

Finally, in addition to the data from these official sources, reports from specialised non-profit organisations such as the Pilares Foundation, the Spanish Society of Geriatrics and Gerontology, and the State Association of Directors and Managers of Social Services, which have provided annually updated information on the evolution of the dependency system since the approval of the Dependency Law in December 1996, have been consulted.

Regarding the comparative units of analysis covered in the paper, it should be noted that the results derived from the comparison exercise provide general features of the systems in European countries, which would require further in-depth research in future fully comparative studies on each of the elements of comparison. However, this lack of exhaustiveness does not prevent the recognition that the results obtained reveal clear differences between countries or clusters of European countries and serve as a valuable starting point for future specialised research. In this respect, when the authors refer to the Nordic countries, they are referring to the nations that make up the Scandinavian welfare model (Denmark, Finland, Iceland, Norway, and Sweden). When mentioning the Mediterranean countries, they are referring to the southern nations that developed their welfare states more recently (since the 1970s and 1980s), such as Spain, Portugal, Italy, and

Greece. And when citing the Eastern countries, they refer to the former socialist countries now integrated into the European Union.

3. Results

3.1. Long-Term Care in the European Context

Although the Member States of the European Union, in accordance with the principle of subsidiarity, design their own social protection models, the European Parliament and the Council of the European Union have not renounced adopting measures that facilitate cooperation among states, promote the exchange of information, and contribute to spreading the most innovative practises in long-term care. Similarly, European institutions aim to improve the coordination of social security systems and seek ways to harmonise such disparate models.

Thus, Principle 18 of the European Pillar of Social Rights, proclaimed in November 2017, recognises the right of everyone to access affordable and high-quality long-term care. Since the amendment of Regulation 883/2004, the European Commission has proposed considering long-term care as any benefit in kind, in cash, or as a combination of both, to support personal autonomy (European Council and European Parliament 2009; European Commission 2017) This is consistent with the rulings of the Luxembourg Court and the United Nations Convention on the Rights of Persons with Disabilities, which consider long-term care as sickness benefits (Martínez 2022).

The European Care Strategy, for its part, begins with a diagnosis of the care systems in Europe, concluding that one-third of families with long-term care needs do not use home help services because they cannot afford them; nearly half of people over 65 who need help do not receive it; and 38.1 million people will need long-term care in 2050, which is 23.5% more than in 2019. From the perspective of personal and material resources, the European Care Strategy highlights that more than 9.1 million people, mostly women, work in this sector; that a significant portion of the 52 million Europeans who provide informal care to their relatives cannot fully integrate into the labour market; and that states dedicate, on average, 1.7% of their GDP to long-term care, though with significant investment differences among them (European Commission 2022).

As a result of this diagnosis, the European Commission proposes increasing the supply of services and ensuring an appropriate balance between different types (home, residential, or in-kind care), regardless of the legal nature of the providers (public, private, or third sector); improving working conditions for professional caregivers and supporting informal caregivers; and enhancing the financial sustainability of long-term care systems.

In the same vein, the Council of Europe Recommendation of 8 December 2022, emphasises considering long-term care as social services of general interest and highlights their potential for job creation. It calls on states to ensure adequate social protection, establish high-quality criteria and standards for different care settings, and promote the professionalisation of the sector to guarantee fair working conditions. All this is based on the evidence that overall protection coverage is limited; that the skills and training required in the sector are increasingly complex; that there are significant differences in public investment among the Union states (ranging from less than 1% to more than 3% of the GDP, depending on the case); that growing demand also increases pressure on public spending; and that long-term care is often organised in complex systems of health, social care, and various support activities (European Council 2022).

3.2. Organisation of Services in European States

An analysis of the organisation of long-term care across European states reveals an extraordinary fragmentation of models regarding the key elements of the system: the incumbent level of government, the access model to services, the degree of coverage, the service portfolio, the type of providers, and the financial effort. Despite these profound differences, the main shared challenges can be summarised in ensuring sufficient coverage (both in terms of the number of people served and the intensity of care), finding an optimal

balance of health and social care services based on personal needs, professionalising the sector while providing adequate support to informal caregivers, and ensuring the financial sustainability of the system (Pavolini 2021; Zalakain 2022).

Focusing on the differences between the countries, only 10 out of 27 have an integrated public care system (Nordic countries plus France, Spain, Austria, Germany, and Belgium), while the others have separate systems between health services and social protection, or the different institutions responsible for economic benefits or in-kind benefits (Zalakain 2022).

Regarding the level of government responsible for long-term care, in Nordic countries, municipalities play a prominent institutional role due to their large population size, substantial resources from their tax base, and strong institutional capacity for public policy production. In smaller states like Malta or Cyprus, the central administration is responsible for these matters, and decentralised countries generally have a multilevel management system, with a central legislative and co-financing role and a regional level with significant operational responsibility.

In terms of access criteria to the system, the literature distinguishes between different degrees of "universalization" of coverage based on the economic capacity of the beneficiary. Countries opting for a universalist model are characterised by extensive public coverage with services and support aimed at the entire population (Nordic countries along with France, Germany, Austria, and the Netherlands), while more selective models tie access to the care system not only to the assessment of the dependent person's care needs but also their personal economic capacity (southern and Eastern European countries). However, intermediate situations between purely universalist or selective models can be found (Pavolini 2021), ultimately reflecting the dichotomy between more or less interventionist states in terms of social protection.

Beyond access criteria, all European countries present a similar portfolio of the benefits for dependents, including home care, residential or semi-residential care, economic benefits, products, or personalised support. While residential care services dominate the service portfolio in some countries (France, Portugal, Eastern Europe), others emphasise home care policies (Sweden, Denmark, the Netherlands, Germany, Italy, Greece), aligning with recent deinstitutionalization trends aimed at prolonging autonomy through specific home-based aids. Some countries show a relative emphasis on alternatives to institutional care (Finland, Sweden, Norway), and recent years have seen emerging experiences of home care as an alternative to residential care (Spain, Czechia) (European Commission 2021).

Regarding the coverage of the dependent population, although coverage has increased in recent years due to the ageing European population, significant differences persist between countries. Nordic countries and Germany lead in long-term care coverage rates, which logically correlates with higher levels of public investment in such care (European Commission 2021). The overage disparities between the countries are reflected in recent data from Quashie et al. based on the SHARE survey concerning the economic capacity of dependents (Quashie et al. 2022; SHARE n.d.). According to this study, over 70% of low-income populations receive formal support at home in some countries (France, Belgium, Sweden, Denmark), whereas in Southern European countries like Spain or Italy, the lack of professional home care resources leads to greater institutionalisation in the public network for low-income individuals, with higher-income individuals resorting to private care services. This limited development of long-term care services and the primary reliance on economic benefits result in lower overall coverage and less equitable care, particularly in heavily welfare-oriented models such as those in southern Europe, which focus primarily on those with very low income, hindering access to private domestic or residential care for low- or middle-income dependent individuals, favouring informal care across all social strata and creating caregiver burden, especially for women (Salmerón et al. 2021).

The predominantly informal nature of care in southern Europe also corresponds to the low levels of professional qualification and precarious working conditions. While 8–12% of the workforce is engaged in social services in Nordic countries, the European average does not exceed 5%, dropping to 3% in Spain, according to the data provided by the OECD in

2021. Additionally, in Mediterranean countries, over half of the sector workforce are domestic workers compared to the European average of 1% (Pinazo et al. 2021). Nonetheless, most European countries regulate staffing levels loosely, with care provided by immigrant women being widespread and labour conditions worse than in comparable sectors of the economy (Zalakain 2022).

A trend dating back several decades but intensifying in recent years is the provision of services by private operators, both commercial and non-profit. While the planning, financing, and general management of the care system are public, private operators frequently deliver the final services. Quantitative data analysis clearly indicates a strong tendency towards outsourcing services to commercial enterprises or third-sector organisations, some of which are transnational (mostly French-owned), especially in the residential sector. However, the European landscape shows a variety of situations, with some countries having mostly public service providers (Sweden, France, Czechia), while others have mostly private operators in the long-term care sector (Belgium, Germany, Spain, Austria, Greece, Ireland). Indeed, Spain ranks second (58%) after Ireland (77%) in the proportion of commercial service companies in the sector (European Commission 2021).

To finance dependency care services, most countries rely on general resources obtained through non-dedicated taxes, although five cases primarily use mandatory social contributions (the Netherlands, Germany, Luxembourg, Greece, and the Flanders region of Belgium). Following the logic of insurance, access to services occurs when the risk materialises, with the benefits received not dependent on the contributions made but on the level of need. Ten countries combine contributions and tax resources (France, Portugal, and parts of Eastern Europe). However, the choice of the financing model does not depend on the universalist or selective nature of the system or on the higher or lower fiscal pressure of each country (Zalakain 2022).

This diversity in financing models sometimes combines with greater flexibility in resource allocation to foster alternative service delivery forms, moving away from rigid implementation schemes. For instance, Germany's long-term social insurance allows recipients to choose the type of home service (day or night care, nursing services) or opt for in-kind benefits or cash transfers for care by family members, or a combination thereof (Rossel 2023, pp. 19–24). Similarly, Nordic countries have evolved from a locally funded universalist model to flexible provision formulas based on home care, diverging from the traditional institutionalised model by combining social security benefits with transfers for payment to family caregivers.

This flexibility in service delivery is accompanied by initiatives throughout the European Union to enhance benefits by adapting to the particular conditions of dependents, improving working conditions for workers, and progressively implementing quality monitoring and evaluation tools. Figure 1 shows the main differences between long-term care models in Europe.

3.3. The Evolution of the Spanish Care System

Law 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care for Dependent Persons (LAPAD), encapsulates the essence of long-term care policies and its main objective: preserving autonomy through all means, even in situations of dependency. This law is the cornerstone of long-term care policies in Spain and the autonomous communities, from which the System for Autonomy and Care for Dependency (SAAD) was created. It is not a policy created ex novo by the law, but builds upon the social services already existing in the autonomous communities. This public policy consists of two elements: services and benefits.

As stipulated in Articles 14 and 15 of LAPAD, services are provided through the public offering of the social services network of the autonomous communities, using public or private centres and services that had been attending to older people prior to the law's enactment. The range of services includes prevention services for dependency situations, telecare service, home help service, day and night care centres, and residential care service.

Criteria	Types	Examples
Public care system	Integrated	Nordic countries, Germany, Austria, Belgium, France, Spain
	Separated	Eastern countries, most Southern countries
Incumbent government	National	Malta, Cyprus
	Multi-level	Regionally decentralised countries
	Local	Nordic countries
Access to the system	Universal	Nordic countries, Germany, Austria, The Netherlands
	Selective	Southern and Eastern countries
Service portfolio	Residential care	France, Portugal, Eastern countries
	Home care	Sweden, Denmark, The Netherlands, Germany, Italy, Greece
	Alternatives to institutionalisation	Spain, Czequia
Coverage	High, formal	Sweden, Denmark, France, Belgium
	Low, informal	Southern and Eastern countries
Operators	Mainly public	Sweden, France, Czequia
	Private/outsourced	Belgium, Germany, Austria, Spain, Greece, Ireland
Funding	Tax resources	Nordic countries
	Social contributions	Germany, The Netherlands, Luxembourg, Greece, Flanders region
	Taxes and contributions	France, Portugal, Spain, Eastern countries

Figure 1. Classification of long-term care typologies in Europe according to different criteria. Source: own elaboration based on Pavolini (2021), European Commission (2021), Zalakain (2022).

On the other hand, benefits are linked to service contracts in case the public offering is not available. Sometimes an economic benefit is used to pay for non-professional caregivers, who may even be family members of the dependent person; and for some others the benefit serves to pay for part of the costs of a service provided by a duly accredited private centre or entity when access to a public or contracted service is not possible (SEGG 2011).

Home care services, aimed at keeping elderly people in their habitual environment, include the telecare service and home help service. Telecare is designed as an independent or complementary service to home help, suitable for early stages of loneliness and dependency where a caregiver is not yet required. This system of care aims to facilitate the elderly staying at home by offering complementary services to telecare, assisting with domestic needs (cleaning, cooking, among others) and personal care services (activities of daily living).

A higher level of support is provided by day care services, establishments where people in situations of dependency receive psychosocial care, social services, medical care, rehabilitation, meals, occupational therapy, and other complementary services during the day. Therefore, these services combine individualised care aimed at maintaining users' autonomy, supporting families, delaying institutionalisation, and facilitating staying in their usual environment (Ministerio de Derechos Sociales y Agenda 2030 2020). Residential care

facilities represent the next level, a highly heterogeneous sector in terms of size, ownership (public/private/concerted), the type of location (rural/urban), proximity to primary care centres, or the availability of their own health services.

Benefits can take the following forms: Economic Benefit for Family Care (PECEF), aimed at contributing to expenses related to caring for a dependent person at home, on an exceptional basis; the Economic Benefit Linked to Service (PEVS), aimed at contributing to financing costs from a service provided by a duly accredited private entity when access to a public or contracted service is not possible (SEGG 2011). These benefits constitute a partial remuneration to the main caregiver and are characterised by their speed in granting and receiving by the beneficiary. Both telecare and home help services have a lower cost compared to more intensive services such as day and night care centres and residential care.

LAPAD was approved shortly before the onset of the 2007 financial crisis, which had a very negative impact on its implementation. One of the enduring effects of the crisis is territorial inequality, as the inability to develop new services only allowed for improvements in the provinces already equipped with them (Pardo 2022). Furthermore, the magnitude and elasticity of demand were not anticipated in relation to the rigidity of public service supply. The development of SAAD (System for Autonomy and Care for Dependency) has undergone various stages and vicissitudes, which can be identified in three phases: an initial phase from its launch until 2012, a slowdown phase from Decree-Law 20/2012 to 2015, and a slow recovery phase starting in 2015, as can be seen in the next figure.

Service by service analysis, as well as benefits, reveals that prevention services for dependency and home help services, for example, have grown since their implementation in 2006, although the invested time is not enough, requiring an average national increase of 20% in hours. Regarding day care centres, the number of places has continued to increase since 2006, with double the offering of places. This is also the case for the number of places in residential institutions, which grows year by year. Long-term care facilities with over 100 places account for 51% of the total residential places (Consejo Económico y Social 2021).

As for benefits, initially designed with an exceptional nature, their exponential use has been observed. As a consequence of this excessive and non-palliative use, as originally envisaged in the SAAD design, a Decree-Law was introduced in 2012, which introduced the changes in the regulations and reduced funding for benefits.

Analysing the relationship between supply and demand, it is found that the waiting list has been reduced for the group with moderate dependency, while for the severe or high dependency group, the reduction in the waiting list in public facilities is minimal (Asociación Estatal de Directores y Gerentes de Servicios Sociales 2024). Consequently, the decrease in waiting lists is for the group whose care involves lower costs due to their lower level of dependency, but does not affect the more severe cases, precisely those with higher care needs and a greater likelihood of passing away without receiving care (Asociación Estatal de Directores y Gerentes de Servicios Sociales 2024).

As of 2020, 20% of the dependent population did not receive care, and the national coverage rate, understood as the number of people served per 1000 inhabitants, was around 24.2%. Sadly, waiting lists decreased throughout 2020, largely due to deaths from the COVID-19 pandemic (Consejo Económico y Social 2021).

As of 31 December 2023, the distribution of services and benefits are as follows: services account for about 60% (including autonomy promotion, telecare, home help system, day centres, and LTCF), while benefits account for about 40% (PEFEC, PEVS, and others).

Although most regions receive similar allocations to provide SAAD services based on relative needs and service portfolio conditions (except for regions like the Basque Country and Navarra with particular funding systems), autonomous decisions by regional governments regarding funding, planning, priorities, and delivery models can lead to different achievements in long-term care (Díaz-Tendero and Ruano 2023).

The Shock Plan for the Improvement of the Dependency System, implemented since 2021, has resulted in increased funding for autonomous communities. The national administration spent, in 2023, twice as much as in 2020 in long-term care, as Figure 2 shows, but significant differences persist between the regions in terms of service offerings and the relationship between services and benefits. The main objectives of this plan are to increase the number of beneficiaries up to 260,000 (87,000 a year) and to improve the quality of the services provided (Asociación Estatal de Directores y Gerentes de Servicios Sociales 2024).

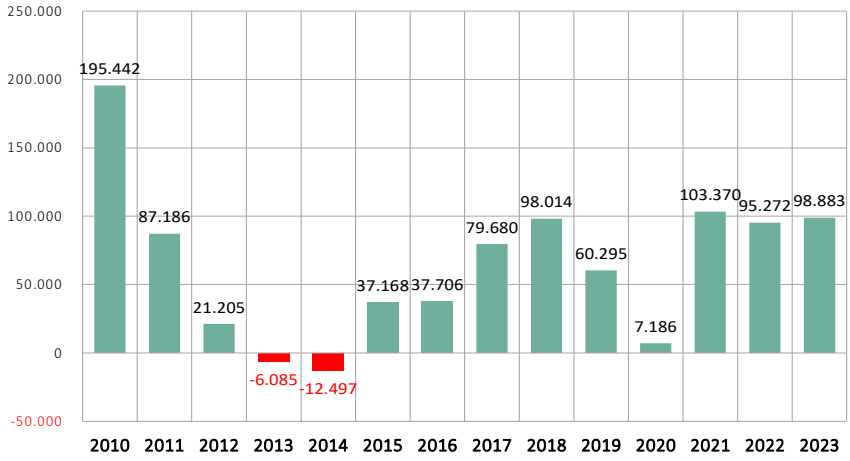

Figure 2. Average annual growth in services and benefits (2010–2023). Source: (Asociación Estatal de Directores y Gerentes de Servicios Sociales 2024).

4. Discussion

Regarding the organisation of long-term care services in European countries, their organisational diversity does not prevent the presence of basic common elements across almost all countries. Thus, all countries recognise a subjective right for those who meet the requirements; they provide some form of public coverage regardless of the access criteria they apply; they have a similar portfolio of services based on home care, residential care, or specific support services; and they employ mechanisms to assess the degree of dependence that translate into care plans.

Building on these commonalities in long-term care models, specialised literature attempts to categorise countries based on shared characteristics. This often results in the identification of a Nordic model (composed of Finland, Sweden, Norway, and Denmark, sometimes including the Netherlands); a second group consisting of Central and Eastern European countries; and a Mediterranean group. Meanwhile, some Western countries (France, Belgium, Austria, Germany, and Luxembourg) are associated with various models based on specific financing or organisational systems. However, this taxonomic effort sometimes loses its strength when delving into the organisational specifics of the services in each state.

Thus, while some differences in organisational models may be explained by unique demographic and health indicators, a significant part of the observed differences stem from the choice of one welfare state model over another and, consequently, from uneven policies regarding care. This factor alone explains why Nordic countries have taken primary responsibility for care matters, while families in Southern and Eastern European countries bear a heavier burden, leading to a greater emphasis on non-professional or informal care and economic benefits rather than service provision.

Regarding financing systems, whether through payments to private or public operators, most analyses on financing systems show a strong correlation between the public investment levels in long-term care and the extent of coverage for needs. In this regard, Sweden, the Netherlands, or Belgium not only invest the most in long-term care but also achieve the highest coverage rates, compared to countries like Poland or Bulgaria, where low public spending translates into very poor coverage rates. This aligns with the countries

characterised by a more interventionist welfare state model in the care sector, with investment levels ranging from 2% of GDP (France, Belgium, Finland) to 3.5% (the Netherlands, Sweden, Denmark), compared to the others dedicating less than 1% of their GDP (Spain, Portugal, and Eastern Europe) (Zalakain 2022).

In Spain, differences in the implementation of the SAAD (Autonomy and Dependency Care System) across autonomous communities are partly due to the level of development of social services prior to the Dependency Care Law of 2006. In other words, autonomous communities that already had minimally developed social service systems were able to channel resources to implement LAPAD (Care for Dependent Persons Law), while those lacking such services in 2006 opted for benefits (PECF) due to their quicker and more economical implementation compared to creating entirely new services, which require considerable investment in infrastructure and human capital. However, the pre-existence of these social services when the law was passed does not necessarily imply effective implementation. LAPAD mandated Home Help Services to be integrated as a specific dependency benefit. Yet, administrative, procedural, and conceptual difficulties persist in integrating this SAAD benefit into the social service structures of the autonomous communities, leading to coverage and efficiency issues.

Another dimension contributing to inequities in long-term care services, particularly in social policies overall, is the rural–urban divide. In rural areas, service dispersion is more pronounced, preventing older and dependent persons from continuing to live in their environment and exacerbating the phenomenon of rural depopulation.

While public policy can be confined to national or even regional levels, the right to care must necessarily be addressed within the framework of older persons' human rights, contextualised within the transnational movement advocating for the universal recognition of human rights in general and the rights of older persons in particular.

Both universal and specific instruments form the basis of the human rights approach applied to older persons, or the "elderly perspective", recognised by international, national, and sub-state law as an accepted conceptual framework capable of establishing a coherent system of principles and rules guiding doctrine, jurisprudence, and public policies in their design, implementation, and evaluation. In recent decades, there has been persistent advocacy for this approach from international governmental and nongovernmental organisations, academic sectors, and national and international civil society associations.

This approach is consistent with the concept of empowering older persons who are rights-holders and have responsibilities (Huenchuan and Rodríguez-Piñero 2010; Jessop and Peisah 2021; Latorre 2021). Previously, the predominant view of older persons focused on constructing old age as a stage of deficiencies and vulnerabilities. The elderly perspective acknowledges these realities but eliminates the forced association between old age and deficiencies or vulnerability. In this sense, the autonomy of older persons in exercising their rights is as crucial as their protection, as confirmed by literature (Doron 2003), including the aforementioned Autonomy and Dependency Care Law. In this regard, the approval of LAPAD represented the recognition of a new citizenship right—universal, subjective, and perfect: the right to care, although not exactly using that denomination.

Following this recognition of this subjective right, the advances of Law 15/2022, of 12 July, comprehensive for equal treatment and non-discrimination, are relevant as they include age as a criterion for discrimination in a deep and comprehensive manner. From its preamble, this equality law refers to multiple soft law instruments specifically aimed at the equality and non-discrimination of older persons. Thus, some regional parliaments, such as those in Andalusia, Castile and León, and the Canary Islands, have passed laws regulating the care and protection of older persons in particular.

The COVID-19 pandemic highlighted the deficiencies in public health and elderly care policies. Of the total deaths between March and June 2020, 66% were institutionalised older persons (Ministerio de Derechos Sociales y Agenda 2030 2020). These figures revealed the poor integration of primary health care services and residential care as one of the

structural defects that reduce the quality of life for older persons in long-term care facilities (LTCFs). Furthermore, the heavy presence of the private sector in the ownership of elderly LTCF and the large size of these institutions are two determining factors in the mortality due to the pandemic (Díaz-Tendero and Ruano 2023). Thus, some of the main barriers to effective management included the lack of coordination between health services and social services at the onset of the pandemic, the limited use of intergovernmental coordination mechanisms in social services, and the limited knowledge of public decision-makers about the residential sector.

The access to health care services without discrimination was severely affected for older persons living in LTCF during the first wave of the COVID-19 pandemic, many of whom were not transferred to hospitals. It is estimated that approximately 20,268 persons died from COVID-19 in LTCF, according to data from the Autonomous Communities up to 23 June 2020 (Ministerio de Derechos Sociales y Agenda 2030 2020).

Various recommendations from medical societies and some regional protocols established priorities for accessing health resources that discriminated based on age, disability, and the health status of the sick person, despite the legal prohibition of discrimination for these reasons (Flores 2023).

Recently, Law 15/2022, of 12 July, comprehensive for equal treatment and non-discrimination, includes mentions of age and disability in its Article 15.2, as well as pre-existing conditions, as reasons why excluding access to health treatments is prohibited, unless duly accredited medical reasons justify it. This can be clearly understood as a regulatory response to the age discrimination experienced by thousands of older persons during the pandemic.

In contrast to the residential model, numerous social collectives denounce the scarcity of resources to guarantee adequate care in the home environment. To respond to the expressed desire of older persons to continue living at home, it is necessary to advance a proposal for comprehensive home care capable of incorporating and coordinating the different roles played by the stakeholders involved in this care: families, social services in general, home care services, primary and specialised health care, the domestic employment and care sector, personal assistants, volunteers, local services, and community participation initiatives. This entails a model of integrated social and health care focused on persons extending their lives in their homes as much as possible.

Spanish regions are responsible for managing, financing, and supervising long-term care institutions. In light of the dramatically poor outcomes of the pandemic, there is a need for robust assessment, supervision, and coordination mechanisms for social and health services. Traditional institutional residential care facilities are characterised by standardising care. Rather, they are places where people lose control over their own lives. In contrast, the person-centred integrated care model implies advocating for small-sized (not more than 15 residents) long-term care facilities and applying organisational and management formulas that aim to provide care as similar as possible to life at home.

All persons should receive the same health care, regardless of whether they live at home or in a residential facility, and they demand hospital home care in residential centres. It is necessary for alternative accommodation options providing professional care and interventions to be oriented towards person-centred care goals rather than mere custodial objectives (Rogers 1961; Rodríguez 2010).

5. Conclusions

Health and long-term care policies pose the greatest challenge in the realm of public policies and the protection of the rights of older persons in the European context. Specifically in Spain, the long-term care policy is a shared responsibility between the central government and regional governments, which handle both the co-financing of the system and its implementation.

Law 39/2006, enacted on 14 December, on the Promotion of Personal Autonomy and Care for Dependent Persons (LAPAD), serves as the cornerstone of long-term care

policies, from which the System for Personal Autonomy and Care for Dependence (SAAD) is established. It includes services and benefits for care at home and in residential settings.

The LAPAD coincided with the 2007 economic crisis, which hindered the implementation of SAAD, especially in regions without established services that would have needed to create them from scratch. This resulted in uneven implementation, with some regions strengthening their long-term care systems while others primarily relied on economic benefits as their main public care policy. Significant differences exist between the regions, and widespread difficulties persist in integrating the home help service into existing social service structures. Moreover, rural/urban disparities further exacerbate inequalities.

The COVID-19 pandemic exposed the shortcomings in public health and care policies for older people. Poor integration between the primary health care services and residential care facilities, the size of the residential facilities, the inadequate use of intergovernmental coordination mechanisms in social services, and limited knowledge among the public decision-makers about the residential care sector were contributing factors to the tragedy.

It is essential to advance a comprehensive home care proposal capable of incorporating and coordinating the roles played by various stakeholders involved in care: families, social services in general, home care services, primary and specialised health care, domestic employment and care sector, personal assistants, volunteers, local services, and community participation initiatives. This entails an integrated socio-sanitary care model focused on individuals.

From a human rights perspective, there was evident negative discrimination against older people based on age. In the realm of long-term care, analysis from a human rights approach is indispensable and complements public policy analysis, as human rights transcend the national sphere due to their supranational nature. This human rights approach applied to older persons provides a coherent system of the principles and rules guiding doctrine and jurisprudence, as well as the design of public policies, by empowering older persons as rights-holders.

To the extent that this paper offers a global perspective on the issue of the long-term care policies linked to the recognition of older adults' rights, future research should delve into the practical consequences of recognising these rights on the quality of older people. It should also analyse the experiences of the deinstitutionalization of care policies and the outcomes of implementing comprehensive care programmes tailored to the specific circumstances of individuals.

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