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EUROPEAN CARE STRATEGY IMPLEMENTATION

Spain's response

to the EU Council's recommendation of 8 December 2022 on access to high-quality and affordable long-term care

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AGE: General State Administration.

ASPF: Healthcare and Pharmaceutical Benefit.

AC: Autonomous Communities.

LTC: Long-term care.

LCS: Living Conditions Survey.

EDAD: Survey on Disability, Personal Autonomy and Dependency Situations.

LFS: Labour Force Survey-

Imserso: Institute for Older People and Social Services.

INE: National Statistics Institute.

CPI: Consumer Price Index.

ILO: International Labour Organisation.

WHO: World Health Organization

PEVS: Financial Benefit Linked to Services.

PECEF: Financial Benefit for Care in the Family Home and support for non-professional carers.

PEAP: Financial Benefit for Personal Assistance.

PIA: Individual Care Programme.

PRTR: Recovery, Transformation and Resilience Plan.

SAAD: System for Autonomy and Care for Dependency.

SAD: Home Help Service.

SATP: Allowance for Third Party Support.

SGIM: Minimum Income Guarantee Allowance.

SISAAD: SAAD Information System.

SMGT: Mobility Allowance and Compensation for Transport Costs.

SMI: Interprofessional Minimum Wage.

NHS: National Health System.

TA: Telecare.

EU: European Union.

1 Foreword

This document contains Spain's response to the recommendations made by the EU Council to Member States on 8 December 2022 regarding access to high quality and affordable long-term care.

This recommendation was the Council of the Union's response and endorsement of the European Commission's Communication of September that same year concerning a European Care Strategy. The Strategy responded in turn to the demands of various actors at EU and member state level. The European Parliament, the Council, the European Economic and Social Committee, the Committee of the Regions and civil society had called for the European Union to take a step forward in this area. An expansion of care was required to meet current and future care needs, added to improvements in quality, affordability and accessibility.

Accordingly, the Commission analysed, in the European Care Strategy, existing long-term care needs and proposed lines of action, while the Council, in its subsequent Recommendation, urged Member States to align themselves to respond coherently and in coordination to that need, taking decisive steps towards a better care model across the European Union.

This process has converged in Spain with work that was already underway for a profound and broad change of the care model and that had accelerated significantly as a result of the pandemic. The General State Administration, autonomous communities and local councils had been working on the transition towards community-based models, rights-based approach, which offer personalised care and place the person receiving care at the centre of any intervention, promoting their maximum integration and permanence in their home and environment, irrespective of their care and support needs.

This process received a definitive boost when, as of 2022, Spain began to prepare the *State Strategy for a new community-based care model: a process of deinstitutionalisation*, which has been presented on June 13, 2024. This temporal and purposeful confluence has made it possible to establish a coherent and integrated work between both planning processes, given that the Spanish strategy is clearly aligned with the recommendations of the Council of the European Union. Moreover, the analytical and highly participatory process generated to design Spain’s care policy has allowed this document to offer the Council an ambitious and comprehensive approach that includes a significant number of measures responding to all of the recommendations.

This document has been prepared following the structure proposed by the European Commission. The report begins with a brief sociodemographic analysis of Spanish society, and a basic description of social services. The following section, ***Diagnosis of needs and remaining challenges***, provides an assessment of Spain’s situation in relation to each section of the long-term care recommendation of the European Council, identifying the challenges in each of the three content blocks: adequacy, availability and quality of care; caregivers; and governance, monitoring and reporting.

The following section details ***stakeholder participation*** in the change of care model, in this case clearly linked to the broad participatory process and social dialogue that has taken place in the design of the Spanish care policy generated to prepare Spain’s Strategy. The next section, ***policy***

objectives and measures adopted or to be adopted extensively describes both the policy response to the EU Council's recommendations and its implementation in the form of concrete actions. Finally, the document closes with a reflection on some of the ***remaining challenges*** and certain lines of work that could be addressed through political dialogue and mutual learning with the European Commission and other Member States.

The implementation of the recommendation for long-term care, together with the State Strategy for a Community Care Model, represents a historic opportunity to transform Spain's care system.

It is a call to joint action, where collaboration between the government, autonomous communities and civil society will be crucial to achieve significant progress. Cooperation between these actors will allow the effective implementation of policies and strategies that respond to the specific needs of the population, promoting a more inclusive and equitable care system. Only through a coordinated effort can today's challenges be overcome and a future built where every individual receives the support they need to live in dignity and security.

This roadmap not only seeks to improve the quality and accessibility of care, but also to guarantee the dignity and well-being of all people. By putting individuals and their rights at the centre, it aims to create an environment where care services are universal, affordable and of high quality. This comprehensive approach recognises the importance of a robust care system not only as a pillar of social well-being, but also as an engine of economic development and social cohesion, ensuring that no one is left behind in the process.

2 Context and baseline

2.1 Spain: a long-living and ageing society

Spain has **one of the longest-living populations on the planet** and is the fourth EU country (EU-27) in terms of the number of people aged 65-plus. This positive achievement is explained by several factors, including healthy diet and lifestyle, a strong public health system, evolution of the welfare state, the pension system and health education and awareness.

According to data of the National Statistics Institute of Spain (hereinafter, INE), on 31 January 2024 our country had a population of 48,592,909 inhabitants, 49% of whom were men (23,807,546) and 51% women (24,785,363). Regarding the older population, 2023 data indicated that 20.15% were aged 65 and over (9,687,018 persons), 43.50% of whom were men and 56.50% women. This **difference between the sexes of the population increases with age**, such that of the 2,871,096 people aged 80 and over in our country, 37.11% are men compared to 62.89% women, revealing the longer life expectancy at birth of women (85.7 years) compared to men (80.4 years), according to the INE data for 2022.

According to this institute's forecasts, in 2035 the **life expectancy at birth** in Spain is expected to reach 83.2 years for men and 87.7 years for women, representing gains compared to the current values, of 2.8 and 1.8 years respectively. This upward trend would continue in subsequent years, such that the projected values in 2071 would be 86 years for men and 90 years for women. As for the **life expectancy horizon at age 65**, it is estimated to increase progressively, so that women aged 65 in 2035 would have an average life expectancy of 24.4 years and men of 20.9 years, while these values would rise to 26.3 years and 22.7 years respectively for women and men aged 65 in 2071 (see figure 1).

This increase in life expectancy does not, however, guarantee an improvement in the well-being of the population unless, at the same time, we have the capacity to enjoy this added life. Therefore, it is interesting to look at how another indicator is evolving: healthy life expectancy, which reflects life in good health. The concepts of **active ageing** and healthy ageing arise in relation to this quest for good health at the end of our lives. The former optimises opportunities for health, participation and safety to improve people's quality of life as they age, whereas **healthy ageing** promotes and maintains the functional capacity that provides well-being in old age, so that this stage of life can be enjoyed as fully as possible. In Spain, **healthy life expectancy at birth** stands at 62.8 years, and 10.5 years once a person reaches the age of 65. This figure has declined due to the morbidity generated by the Covid-19 pandemic, with healthy life expectancy standing before 2020 at 69.9 years at birth and 12.9 years at age 65. Thus, 7 years of healthy life expectancy at birth have been lost in these pandemic and post-pandemic years and almost two and a half years in the case of people aged 65 and over.

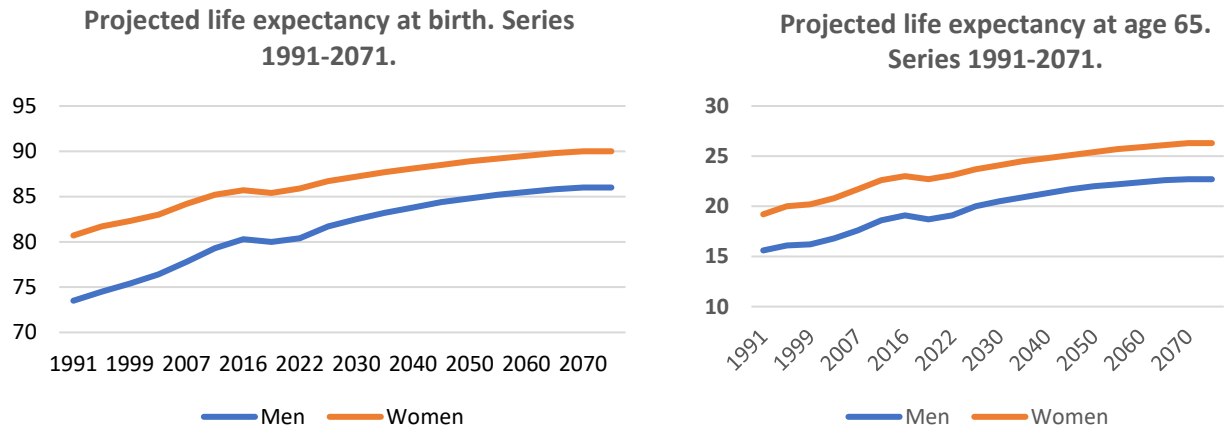

Figure 1: Projected life expectancy at birth and at age 65. Series 1991-2071.
Source: Population projections. INE. Mortality scenarios in Spain. Projected mortality tables 2022-2071. Life expectancy by age and sex.

The increase in life expectancy added to Spain having a fertility rate well below the replacement rate of 2.1, gives rise to our country's **ageing population**. This entails that a stable population pyramid cannot be guaranteed and, ultimately, that if these conditions are maintained there will be an increasingly aged population. According to the latest INE data for 2023, the ageing rate reached an all-time high of 137.3%. This means that there are now 137 persons aged 65 and over for every 100 persons aged under 16 (see figure 2).

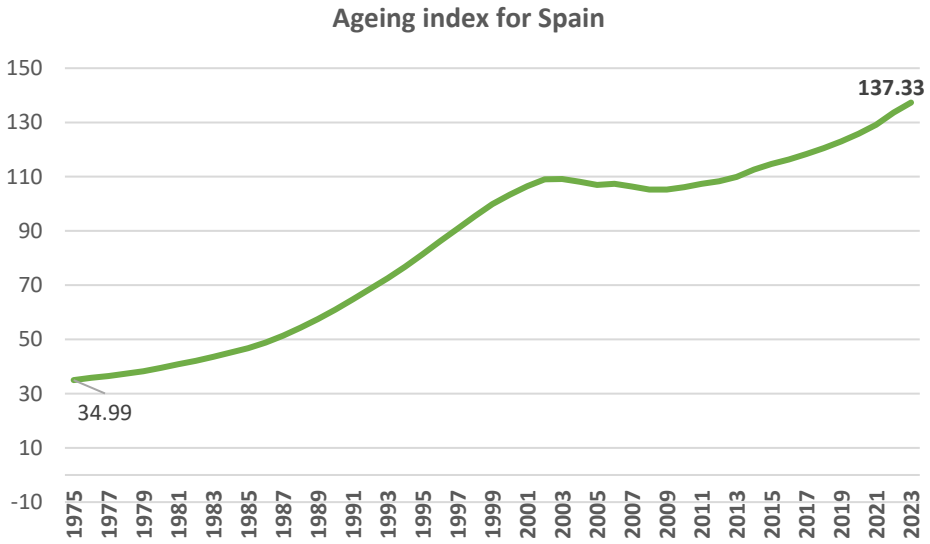

Figure 2: Ageing index.
Prepared by the authors based on INE population structure indicators.

INE's **population projection** for the **period 2022-2072** also reflects this **gradual ageing of Spain's population**. If the current trend continues, the largest population group in 2022, corresponding to those born between 1972 and 1981 (i.e. people aged between 40 and 49 in 2022), will still be

the largest in 2037 (with ages between 55 and 64). As these generations die out, we would see a rejuvenation of the population. Thus, around the year 2072, those born between 2002 and 2011 would be the largest group (with ages between 60 and 69).

At the same time, the percentage of the **population aged 65 and over**, which currently stands at 20.15% of the total, would reach a **maximum of 30.4% around 2050**, with approximately 16 million people, of whom 44.7% would be men and 55.3% women, implying a difference between the sexes of 10.6 percentage points. From then onwards, it would start to decline. Similarly, the percentage of the **population aged 80 and over** would account for 11% of the total in that year, reaching its **maximum (13%) around 2060**, corresponding to some 6.9 million people, of whom 40.8% would be men compared to 59.2% women, constituting a difference between the sexes of 18.4 percentage points. It is also expected to decline thereafter. The **dependency ratio** (ratio, as a percentage, of the population aged under 16 or over 64 to the population aged 16 to 64) would also **peak around 2050** (76.8%) and then gradually decline to 72.2% in 2072. Finally, **the population of centenarians**, i.e. people aged 100 years and above, would increase from 14,287 at present to 226,932 at the end of the projected period in 2072[1] (see figure 3).

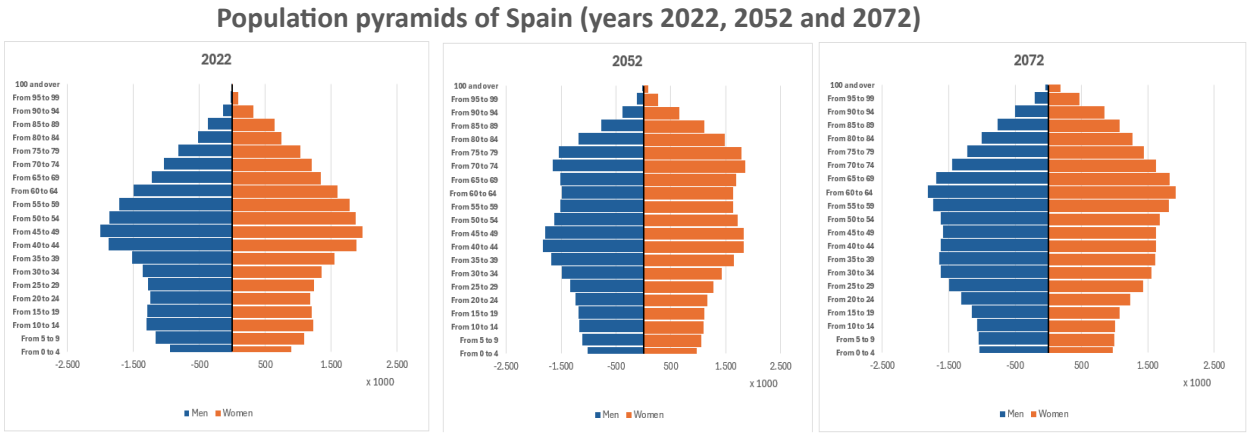

Figure 3: Population pyramids of Spain (years 2022, 2052 and 2072).
Source: INE Press Release of October 2022.

The expected gradual ageing of Spain's population poses a **major challenge for our welfare system**, as older people have a higher prevalence of dependency situations requiring care and support, as occurs in the case of people with disabilities.

2.2 The challenge of depopulation and rural areas

Another demographic phenomenon taking place in Spain is the **depopulation of rural** areas in favour of a concentration of the population in urban areas. In the last decade, 3 out of every 4 municipalities in Spain have lost population[2]. The depopulation phenomenon is eminently rural

[1] Data of the National Statistics Institute of Spain (Instituto Nacional de Estadística - INE). https://ine.es/prensa/pp_2022_2072.pdf.

[2] *The demographic challenge and depopulation in Spain in figures. https://www.lamoncloa.gob.es/presidente/actividades/Documents/2020/280220-despoblacion-en-cifras.pdf.*

and affects small municipalities most severely[3]. In Spain there are 6,813 municipalities with under 5,000 inhabitants, concentrating 5.72 million people, meaning that 84% of Spain's municipalities are home to 12% of the total population. The main causes of depopulation are: the ageing of the population which, added to the low birth rate, generates a lack of generational replacement, migration towards larger population centres where it is easier to find work, and the lack of basic services. At the same time, a slight migratory movement is observed of citizens from other countries who have seen the depopulation of rural zones as an opportunity to make a living in these areas of Spain.

In relation to this **migratory phenomenon**, we note that the group of people born abroad residing in Spain, numbering 8,775,213, has increased considerably in recent years, accounting for 18.2% of the total Spanish population in 2023 and being the main source of the population increase in the country. Of this group, 6,089,620 people maintain their foreign nationality and, of these, 5% are aged 65-plus. This percentage over the Spanish population is expected to increase as it gradually incorporates the younger cohorts (see figure 4).

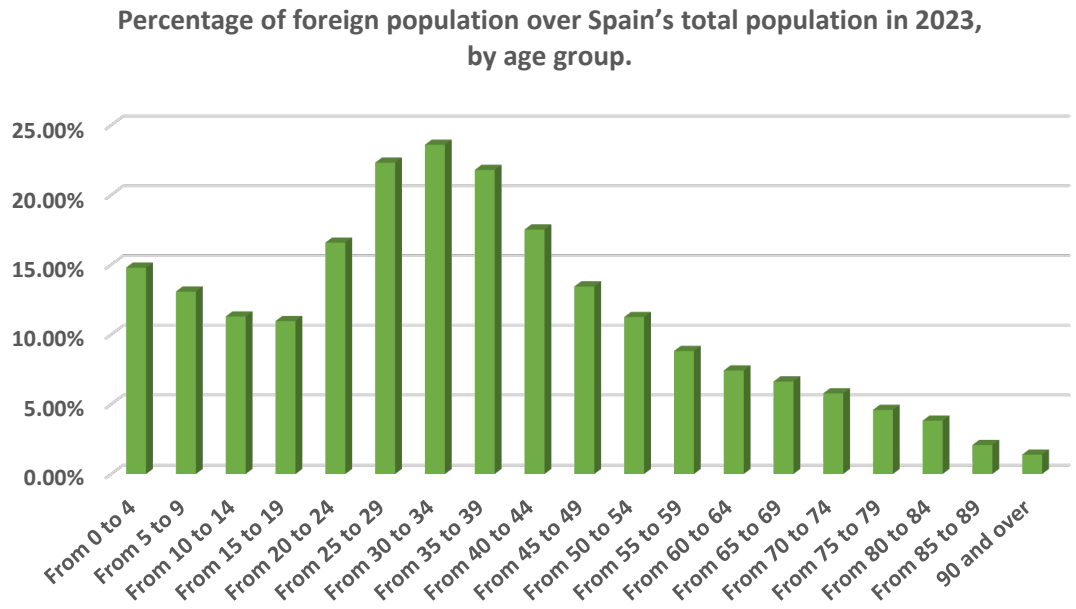

Figure 4: Percentage of foreign population over the Spanish population at 1 January 2023. Source: Prepared by the authors based on the INE's Continuous Population Statistics.

2.3 The services and support of Social Services.

The system of social services provision to people in vulnerable situations is **one of the basic pillars of social protection** in our country, along with the pension system and the health system. The aim of this system is to avoid people facing barriers that prevent them from exercising their

[3] *Social vulnerability in the context of the depopulated Spain. The difficulties of living in the depopulated Spain. https://www2.cruzroja.es/web/ahora/-/informe-espana-despoblada#:~:text=Cruz%20Roja%20acaba%20de%20publicar%20un%20informe%20sobre,a%20causa%20de%20la%20pandemia%20de%20la%20COVID-19..*

rights or enjoying a full life in the community, avoiding or reducing situations of social exclusion or neglect.

The provision of social services in Spain responds to a **decentralised policy**, with the vast majority of competences in this area being transferred to the autonomous communities and cities, as established in the Spanish Constitution. As a consequence of this distribution of powers, the autonomous communities have been passing their own social services laws, and the autonomous cities their own regulations, to implement a public social services system that integrates resources, actions, benefits and facilities directed at the social care of citizens, while the General State Administration (hereinafter, AGE) guarantees a minimum content of shared rights for all citizens everywhere on Spanish State territory.

Social Services are structured into basic and specialised, depending on the level and actions taken. **Basic Social Services** are the first level of care and are directed at the entire population regardless of their social or demographic characteristics, and their actions are therefore universal, in response to any demand or need of the population. Their scope of action is circumscribed to a territory, to facilitate proximity and access for citizens, and the basic portfolio of services attempts to respond to four main sets of needs: information and guidance, support for the co-living unit and home help, social integration and prevention, alternative accommodation and promotion of solidarity and social cooperation.

Specialised Social Services constitute the System's secondary level and are aimed at people and groups requiring specific attention. This specialised services system includes, among others, specific care for people with disabilities and for people in dependency situations, who are the target groups of long-term care (hereinafter, LTC).

The specific regulations governing **disability** in Spain are found in *Royal Legislative Decree 1/2013, of 29 November, approving the Consolidated Text of the General Law on the Rights of Persons with Disabilities and their Social Inclusion*. For the purposes of this law, disability is defined as "a situation resulting from the interaction between persons with foreseeably permanent impairments and any barriers that limit or prevent their full and effective participation in society on equal terms with others". Article 50 of this Law states that "People with disabilities and their families have the **right to social services** for family support, prevention of impairments and intensification of disabilities, promotion of personal autonomy, information and guidance, care at home and in residences, support in their environment, residential services, cultural and sporting activities, leisure and free time activities (...), likewise, legislation of the autonomous communities may provide **services and financial benefits** for people with disabilities and their families who are in situations of need and lack the essential resources to cover such need"[4]. A special system of benefits has been implemented for this group, regulated by Royal Decree 383/1984 of 1 February.

According to Royal Decree 888/2022, of October 18, establishing the procedure for recognition, declaration and qualification of the degree of disability, people with a physical, mental, intellectual disability, developmental or sensory disorder, rare disease or other can apply

[4] Royal Legislative Decree 1/2013, of 29 November, approving the Consolidated Text of the General Law on the Rights of People with Disabilities and their Social Inclusion.
https://www.boe.es/eli/es/rdlg/2013/11/29/1/con.

for **recognition of the degree of disability**.[5] After the applicant has been assessed by an interdisciplinary team, a decision is issued, if appropriate, recognising the degree of disability, expressed as a percentage. Recognition of a disability grade of equal to or more than 33% entitles the person in this situation to access the different benefits, allowances and services recognised throughout Spain.

At the same time, the reference legislation governing the **System for Autonomy and Care for Dependency** (hereinafter, SAAD) is *Law 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care for people in situations of dependency*. For the purposes of this Law, **dependency** is understood as "the permanent state of persons who, for reasons derived from age, illness or disability, and linked to the lack or loss of physical, mental, intellectual or sensory autonomy, require the care of another person or persons or significant assistance to carry out basic activities of daily living or, in the case of persons with intellectual disabilities or mental illness, other support for their personal autonomy"[6.] .

The system is based on and financed across **three levels of protection**: 1) A *minimum level of protection*, fully paid for by the AGE, according to the number of dependent persons receiving an effective benefit; 2) An *agreed level of protection*, based on collaboration agreements between the AGE and the autonomous communities; and 3) An *additional level of protection*, whose implementation is optional for the autonomous communities and financed exclusively by the latter.

As described later in this document, the **SAAD benefits catalogue** includes services such as dependency prevention, promotion of autonomy, telecare, day and night centres or residential care, as well as financial benefits linked to services, for care in the family environment or personal assistance.

2.4 Financial situation of older people and people with disabilities in Spain.

Pensions are the **main source of income for the majority of older people.** As set out in Annex 2 of the **Social Protection Committee Annual Report 2023**, their amount has been increased. Indeed, in 2023, the average retirement pension in Spain reached 1,375 euros per month. This average pension amount of the system is distributed differently according to the age group in question, as the average pension decreases as pensioner age increases, standing below this average for retired people currently aged 75 plus.

According to the *Living Conditions Survey (hereinafter, LCS)*, published by the INE in 2023, with income data for 2022, the **average income** of people aged 65 and over stood at 16,185 euros per person, 15% above the national average income of 14,082 euros. If we look at the indicator of

[5] Royal Decree 888/2022, of 18 October, establishing the procedure for recognition, declaration, and qualification of the degree of disability, https://www.boe.es/eli/es/rd/2022/10/18/888
[6] Law 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care for people in situations of dependency. https://www.boe.es/eli/es/rd/2023/07/18/675.

severe material and social deprivation, we see that, for people aged 65 and over, the indicator is 3.4 percentage points below the national indicator (5.6% for people aged 65 plus compared to 9% in the case of the general population). This improvement in the situation of the over-64s in terms of severe material and social deprivation has occurred gradually, as in 2018 the difference between the national total and peopled aged over-64 was only 0.6 percentage points.

Even so, 18.3% of people aged 65 and over are still below the poverty threshold, which according to the 2023 LCS was 10,989.5 euros for a single person household. This difference in the poverty rate presents a significant gender gap, as it stands at 15.8% for men compared to 20.3% for women below the poverty line.

On a separate note, in the case of **people with disabilities of working age**, 1,941,900 in 2022, the unemployment rate is 21.4%, 8.6 points higher than that of the population without disabilities. The proportion of the active population between 16 and 64 years of age is 35.3%, 42.7% points below the population without disabilities[7]. In terms of salary, the INE states that in 2021 the average gross annual salary of employees with disabilities was 21,544 euros, 17.2% lower than the average for people without disabilities. In addition, there is a clear gender effect, as the salary was 10.3% lower for women[8].

In Spain, people with disabilities are entitled to receive different benefits, such as the Minimum Income Guarantee Allowance (SGIM), the Third Person Assistance Allowance (SATP), the Mobility Allowance and Compensation for Transport Costs (SMGT) or the Health Care and Pharmaceutical Benefit (ASPF), and, in addition, to receive a non-contributory disability pension.

In the case of the SGIM and SATP allowances, their amounts have not changed in recent years, remaining constant for the people to whom they were granted at 149.86 euros per month for the former and 58.45 euros per month for the latter, given that they were replaced by the non-contributory disability pension. In the case of the SMGT allowance, its amount has been increased over time, established for 2023 at 78.20 euros per month. In 2023, a total of 8,098 beneficiaries received these allowances: 2,884 beneficiaries of the SGIM, 280 of the SATP, 769 users of the SMGT and 4,609 of the ASPF.

At the same time, the non-contributory disability pension is designed to ensure that all citizens in situations of disability and need receive a financial benefit, free medical-pharmaceutical assistance and complementary social services, even if they have never made contributions or have contributed insufficiently to be entitled to a contributory pension. Beneficiaries can be Spanish citizens and nationals of other countries with legal residence in Spain who meet the following requirements:

- Are aged eighteen or older and under sixty-five on the date of application.
- Reside in Spain and have done so for a period of five years, two of which must be consecutive and immediately prior to the date of application.

[7] Data of the National Statistics Institute of Spain (Instituto Nacional de Estadística - INE). Employment of persons with disabilities 2022. https://www.ine.es/prensa/epd_2022.pdf

[8] Data of the National Statistics Institute of Spain (Instituto Nacional de Estadística - INE). The salary of people with disabilities. 2021. https://www.ine.es/prensa/spd_2021.pdf

- Are affected by a degree of disability equal to or greater than 65%.
- Lack sufficient income: in general, the entitlement arises when the annual personal income, for 2024, is less than €7,250.60 per year. The income limit, in the case of living with family members, varies depending on the household's size and total income.

In 2023, the non-contributory disability pension benefitted 173,263 people in Spain, with a monthly amount of 529.20 euros. At the same time, a proportion of those receiving non-contributory retirement pensions are those over the age of 65 who are receiving disability pensions, representing a further 54,756 people.

Following this summary description of the demographic situation and living conditions of older people and people with disabilities in our country, we proceed to briefly evaluate the different aspects related to Spain's long-term care system, organised according to the European Commission's Recommendations, highlighting implemented good practices and the challenges we face.

3 Diagnosis of needs and remaining challenges

3.1 BLOCK 1. Adequacy, availability and quality of care

3.1.1 Adequate care: timely, comprehensive and affordable

The Council of the European Union recommends that Member States ensure the adequacy of social protection for long-term care, in particular by ensuring that all people with long-term care needs have access to long-term care that is

a) ***timely**, allowing people in need of long-term care to receive the necessary care as soon as, and for as long as, needed;*

b) ***comprehensive**, i.e. covering all long-term care needs, arising from mental and/or physical decline in functional ability identified through an assessment based on clear and objective eligibility criteria, and in coordination with other support and welfare services;*

c) ***affordable**, enabling people in need of long-term care to maintain a decent standard of living and protecting them from poverty and social exclusion due to their long-term care needs as well as ensuring their dignity.*

3.1.1.1 Timely care thanks to the SAAD

Care protection in Spain

In Spain, long-term care is a **subjective right** based on the **principles of universality, equity and accessibility**, by virtue of *Law 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care for people in situations of dependency* (hereinafter, Law 39/2006), which develops a **model of comprehensive care** for citizens to promote autonomy and care for dependent persons from a **social and community-based approach**.

This law is a milestone in the development of the welfare state in Spain and a step forward in the social protection of dependent persons, guaranteeing **equal access** for all persons in need of long-term care to a set of comprehensive public benefits integrated in the **SAAD** network, with the collaboration and participation of all Public Administrations.

The quality of the SAAD throughout the country is guaranteed by common criteria established by the **Territorial Council of Social Services and the SAAD** (hereinafter, the Territorial Council), which was set up under the same Law and brings together the Central Government and the autonomous communities. The agreements of this Territorial Council include: the

intergovernmental cooperation framework, intensity of services, conditions and amounts of financial benefits, criteria for copayment by beneficiaries, or scale for the recognition of dependency.

The General State Administration is responsible also for the **SAAD Information System (SISAAD)**, created also by order of Law 39/2006, to guarantee the availability of SAAD-related information and reciprocal communication between the public administrations, in addition to compatibility and coordination between the different systems.

SAAD benefits and services

The SAAD benefits, as set out in Law 39/2006, are **mixed** in nature, offering both services and financial benefits, intended, on the one hand, to promote personal autonomy and, on the other, to meet the needs of people with difficulties to carry out the basic activities of daily living.

The ultimate aim of these benefits and services is to achieve a better **quality of life** and **personal autonomy**, within a framework of effective equal opportunities, in accordance with the following **objectives**:

- Facilitating the person's autonomous existence in their usual environment, for as long as desired and possible, and
- Providing dignified treatment in all areas of personal, family and social life, facilitating the person's active incorporation in community life.

The **services** the SAAD catalogue includes are:

- **Services for the prevention** of dependency situations and for the promotion of personal autonomy.
- **Telecare** Service (TA).
- **Home Help** Service (SAD):
    - Domestic care.
    - Personal care.
- **Day and Night Centre** Service:
    - Day centre for older people.
    - Day centre for people under 65 years of age.
    - Day Centre for specialised care.
    - Night Centre.
- **Residential Care** Service:
    - Residence for older people in dependent situations.
    - Care centre for people in dependent situations, according to the different types of disability.

The Catalogue's **services** are of **a priority nature** and are provided by the respective autonomous communities through the public offer of the Social Services Network by duly accredited public or private services and centres.

In cases where care cannot be provided through one of these services, it is possible to apply for one of the **financial benefits** set out in the law:

- **Service-linked financial benefit (PEVS)**: this personal benefit, linked to the purchase of a service, is recognised when it is not possible to access a public or subsidised care service, according to the beneficiary's degree of dependency and financial capacity.
- **Financial benefit for care in the family environment and support for non-professional carers (PECEF)**: this benefit can be accessed when the beneficiary is being cared for by their family environment and under certain conditions established by the Territorial Council.
- **Financial benefit for personal assistance (PEAP)**: whose objective is to contribute to the hiring of personal assistance, for a number of hours, that facilitates the beneficiary's access to education and work, and to more autonomy in the exercise of the basic activities of daily life.

By the end of 2023, the SAAD was providing **services and economic benefits** to a total of **1,387,863 people**. The services most frequently provided are: telecare, serving 427,677 people, and the home help service, enjoyed by 343,152 people. The most frequently delivered financial benefit is the one linked to care in the family environment, with 558,234 people receiving this benefit at the end of 2023 (see figure 5).

Classification of the situation of dependency

After applying for the recognition of dependency, the person's situation and needs are assessed and they are assigned a determined *degree of dependency* based on the intensity of the support they require to carry out the basic activities of daily living.

Law 39/2006 establishes the following degrees:

a) **Grade I. Moderate dependency:** when the person needs help to perform several basic activities of daily living at least once a day, or requires intermittent or limited support for their personal autonomy.

b) **Grade II. Severe dependency:** when the person needs help to perform several basic activities of daily living two or three times a day, but does not want the permanent support of a carer or, has extensive support requirements for their personal autonomy.

c) **Grade III. Major dependency:** when the person needs help to carry out several basic activities of daily living several times a day and, due to total loss of physical, mental, intellectual or sensory autonomy, requires the indispensable and continuous support of another person, or has generalised support requirements for their personal autonomy.

Accordingly, beneficiaries' **priority of access** to services is determined by the degree of dependency assigned and, to the same extent, by the financial capacity of the applicant. If a lack of network capacity or implementation means dependent persons are unable to access its services due to application of the aforementioned priority system, they will be entitled to the indicated financial benefit.

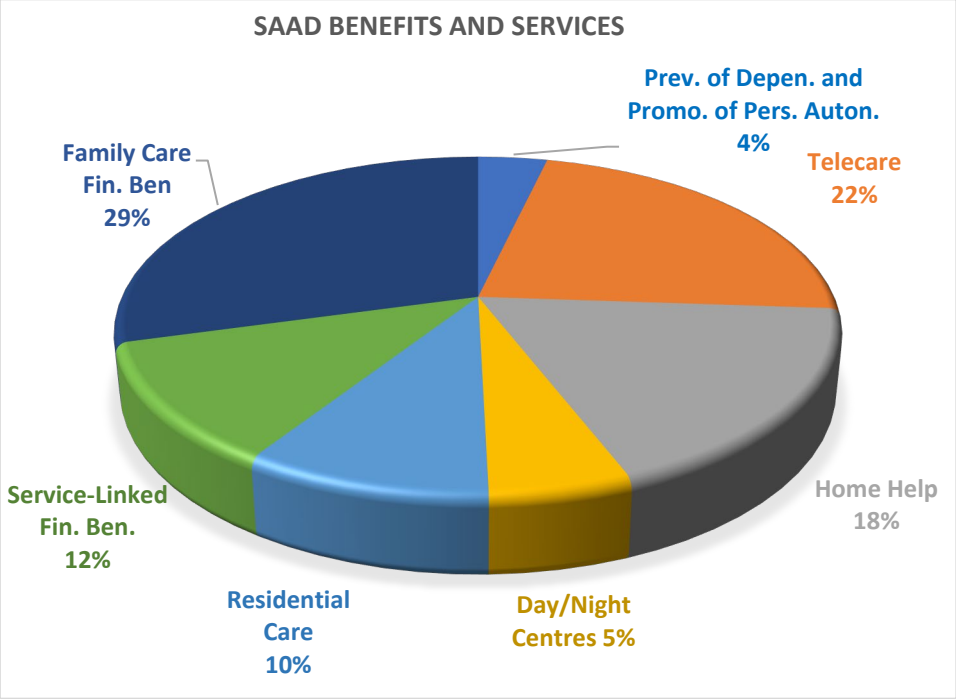

Figure 5: SAAD services and benefits distribution.
Source: Data from SAAD statistics reports of the Imserso at 31 December 2023.

Caring for people when they need it

The Spanish system **guarantees the allocation of care** to dependent persons for **as long as required**, as there is no time limit for enjoyment of a benefit once it has been recognised.

According to the Law, the **maximum period for recognising such benefit or support** is six months. At the end of 2020, a total of 1,084,209 people were receiving care and benefits, with 311,445 on the waiting list, and an average number of days to process a file of 457 days. With the firm objective of improving access to and quality of the SAAD, in 2021 the Ministry of Social Rights, Consumer Affairs and 2030 Agenda approved the *2021/2023 Shock Plan of the System for Autonomy and Care for Dependency (hereinafter, the SAAD Shock Plan)*, which contemplated measures such as reducing waiting lists or increasing services and benefits (see figure 6). Thanks to these measures and the considerable investment made, by the end of 2023 the **waiting time** between the application for dependency and its resolution was **shortened** to 324 days, by 133 days compared to the 2020 data.

Figure 6: Seven areas for improvement included in the 2021-2023 Dependency Shock Plan

At the same time, from the end of 2020 to the end of 2023, the **number of people assisted rose sharply** from 1,084,209 to 1,387,863, increasing by 28.01% (303,654 more people assisted), in many cases each person receiving more than one benefit (see figure 7). The number of benefits and services **also rose** significantly, by more than 33.95%, **from** 1,427,207 at the end of 2020 to 1,906,051 at the end of 2023. In terms of **the type of services**, residential care or day/night centres have grown less in proportion, by 16% and 18% respectively, compared to home help (35%) or telecare (68%). Table 1 shows a comparison of the distribution of benefits and amounts of the system's different services and benefits between 2020 and 2023.

Despite this significant improvement, further work is still needed to reduce waiting list times by **simplifying the set of assessment and personalisation procedures** in various ways, among them by simplifying the financial capacity assessment by rethinking copayment and the resources to be considered, and transforming the Individual Care Plan, described later, into a more easily modifiable instrument (SAAD Evaluation Report, 2022).

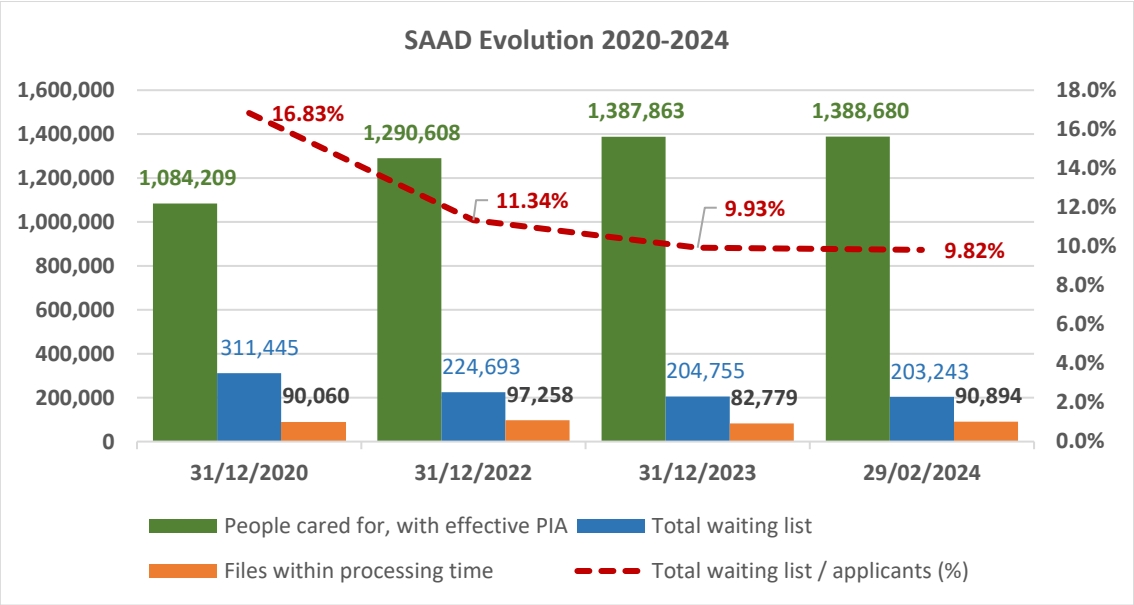

Figure 7: Waiting list reduction between 2020 and 2024.
Source: Report of the SAAD at 29 February 2024 on evolution of the SAAD's main management indicators.

3.1.1.2 Personalised assessment for comprehensive care

As mentioned above, recognition of the situation of dependency and assignment of the corresponding services or benefits is carried out following a **comprehensive assessment** of the applicant, which takes into account their capacities, need for support or supervision to perform the basic activities of daily living, health reports, barriers of the environment where they live, prescribed technical aids, orthoses and prostheses, as well as their preferences and wishes regarding the type of care and place where they wish to receive such care.

This assessment is made by the **assessment bodies** established by the **autonomous communities**, which will be public and whose composition and actions will be agreed by the Territorial Council. These assessment bodies will apply a **common scale,** also agreed by the Territorial Council and regulated by Royal Decree 174/2011, of 11 February. This regulation approves two scales: one for assessing the degrees and levels of dependency of over 3-year-olds (BVD) and a specific scale for assessing children under age 3 (EVE). In both cases, objective criteria are established that determine the person's ability to perform basic activities of daily living by themselves, as well as the need for support and supervision to perform them of persons with an intellectual disability or mental illness.

Distribution of benefits at the national level				
	31/12/2020	**31/12/2023**	**Difference**	**% Difference**
Persons receiving care or benefits	1,084,209	1,387,863	303,654	28.01
Average number of benefits per beneficiary	1.27	1.35	0.08	6.34
Total benefits	**1,427,207**	**1,906,051**	**478,844**	**33.55**
Services and benefits				
Dep. and Promo. Preven. Personal Assistance	61,411	69,697	8,286	13.49
Telecare	254,644	427,677	173,033	67.95
Home Help	253,202	343,152	89,950	35.52
Day/Night Centres	88,465	104,917	16,452	18.6
Residential Care	156,437	181,817	25,380	16.22
Financial benefits (FB)				
Service-Linked FB (PEV)	154,547	210,403	55,856	36.14
PEV Linked to the P.A.P.D Service.*	*11,820*	*22,322*	*10,502*	*88.85*
PEV Linked to the Telecare Service	*293*	*197*	*-96*	*-32.76*
PEV Linked to the Home Help Service	*46,805*	*67,194*	*20,389*	*43.56*
PEV Linked to the Day/Night Centre Service	*24,374*	*27,295*	*2,921*	*11.98*
PEV Linked to the Residential Care Service	*71,239*	*93,395*	*22,156*	*31.1*
PEV Linked to an unidentified service	*16*	*0*	*-16*	*-100*
Family Care FB	450,517	558,234	107,717	23.91
Personal Assistance FB	7,984	10,154	2,170	27.18

** Promotion of Autonomy and Prevention of Dependency*

Table 1: SAAD services and benefits distribution (2020 and 2023)

Following this assessment, a resolution is issued establishing the recognised degree of dependency and an **Individual Care Programme (PIA)**, which determines the intervention modalities that are most appropriate for the person's needs, out of the services and financial benefits contemplated in the resolution recognising the degree, with the participation, prior

consultation and choice of the beneficiary and, where appropriate, family member, from among the proposed alternatives, such that **personalised and comprehensive care** is provided, in accordance with the preferences and choices of the person requiring such care. The PIA may be revised in the following cases: at the request of the interested parties or their legal representatives; ex officio, with the periodicity provided for in the regulations of each autonomous community; or on the occasion of a change of residence to another autonomous community. In any case, the PIA may be reviewed whenever there is an improvement or worsening of the dependency situation or if it is considered that there is an error in the diagnosis or in the application of the scale. Similarly, the benefits recognised in the PIA can be revised to better adapt to the person's needs at any given time.

The **components of the assessment and PIA proposed** may vary according to the autonomous communities and depending on the individual needs of the beneficiary, but will generally include:

1. Assessment of the social-health situation: evaluating the person's physical and psychological state of health, and their social and family environment. Aspects considered include autonomy, functional capacities, and medical and therapeutic care needs, among others.
2. Determination of care needs: identifying the specific care needs of the dependent person, such as basic and instrumental activities of daily living, medical care, rehabilitation therapies, and psychological support, among others.
3. Establishment of individual objectives: defining the objectives to be achieved according to detected needs, prioritising improvement of the person's quality of life and autonomy inasmuch as possible.
4. Proposal of interventions and resources: identifying the concrete actions to be carried out to cover identified needs, along with the resources and support available to the person in question.
5. Monitoring and evaluation: establishing mechanisms to monitor the progress of the care plan, adjust it as necessary and evaluate its effectiveness in terms of improving the beneficiary's quality of life and well-being.

3.1.1.3 Affordable care to preserve dignity and prevent social exclusion.

The SAAD has **funding** to ensure compliance with the obligations incumbent on the competent Public Administrations, determined annually in the relevant budgets.

As explained earlier, there are three different **levels of protection**: minimum, agreed and additional. The **AGE assumes the full cost of the minimum level of protection** guaranteed for each beneficiary of the system according to their degree of dependency. This amount will be assigned to the autonomous communities for management according to the number of beneficiaries residing in their territory, their degrees of dependency and recognised benefits.

Pursuant to Law 39/2006, **funding of the agreed level** is based on the **annual or multi-annual agreements** signed in the **Framework of Interadministrative Cooperation** between the AGE and each administration of the autonomous communities, determining in these agreements the obligations assumed by each party to fund the services and benefits of the System. The agreements' distribution criteria will take into account the dependent population, its

geographical dispersion, insularity, returned emigrants and other factors. The Law establishes that the contribution of the autonomous community, for each year, will be at least equal to that of the AGE.

The third level of funding would correspond to the **additional level**, referring to the investment autonomous communities can make at their discretion.

Finally, the Law provides that **beneficiaries will also contribute financially to the services, progressively based on their economic capacity,** considering the type of service provided and its cost. Similarly, economic capacity will be considered when determining financial benefit amounts. In all events, the Law notes that **no citizen will be left uncovered by the System due to their lack of financial resources**.

Further to this contribution made by users to financing the SAAD's services and benefits in the form of copayments, it must be noted that the public system is sometimes insufficient to absorb all of the demand for services, so that, in some cases, dependent persons must opt for **private models of service provision**. Owing to their cost, these private models are beyond the reach of certain sectors depending on their revenue and income.

According to the SAAD Evaluation Report prepared in 2022[9], 80% of people with dependency living in private households had to complement the services and benefits of the SAAD with informal care or privately contracted services. Royal Decree 675/2023 of 18 July (BOE 171) modifying the intensities of the home help service, the maximum amounts of financial benefits (PEVS, PEAP and PECEF) and incorporating financial benefit minimum amounts, attempted to mitigate this situation.

Despite these improvements and the progressive nature of copayment, the reality is that the costs associated with LTC can exceed the financial capacity of especially lower or average-income families. Therefore, access to quality services can be limited by the financial capacity of the person requiring the service, giving rise to inequalities in access to care.

Again, due to the distribution of powers in the sphere of social services, where each autonomous community can legislate to improve the services and benefits offered by the System, there is **diversity in the copayment model** between the different autonomous communities, meaning that we cannot speak of a single model or provide integrated data at a national level. Thus, territorial differences are detected in all phases of the copayment determination procedure, from the consideration of groups exempt from payment, inclusion or not of the value of assets to determine financial capacity, different income brackets and percentages for determining the quota, application of deductions and rebates in some autonomous communities, among other differences. Consequently, people having the same income and assets can pay different copay rates depending on the autonomous community where they live, generating a problem of equal treatment of these people under the same social protection system. Indeed, the 2022 evaluation of the SAAD as a whole, found a wide variation in the contributions made by beneficiaries, ranging from 15% to 33% of the total amount, excluding services exempted from payment, based on the place of residence.

[9] Evaluation report of the System for Autonomy and Care for Dependency (SAAD). https://www.mdsocialesa2030.gob.es/derechos-sociales/inclusion/docs/estudio_evaluacion_saad_completo.pdf.

Range of average user contribution to the actual price of the service in the autonomous communities

Benefit	Min.	Max.
Telecare	0%	93.1%
Home help service	0%	44.9%
Day centres	0%	84.6%
Residential centres	28%	59.5%

Table 2. Proportion of average payments by beneficiaries. Maximum and minimum values of the autonomous communities.

However, a more detailed analysis of some of the figures reveals a much higher variability at the end of 2022. For example, telecare, home help or day centre services in some autonomous communities are exempt from copayment, whereas in others copayment for these services can be as high as 93.1% for telecare, 44.9% for home help and 84.6% for day centres. Where residential centres are concerned, users in all of the autonomous communities must contribute financially to the cost of the service, although the proportion ranges from 28% to 59.5%[10] (see table 2).

3.1.2 Adaptation to each person's needs

It is recommended that Member States increase the offer of long-term care services, while providing a balanced mix of long-term care options and in all care settings to cater for different long-term care needs and supporting the freedom of choice of people in need of care, including by:

a) *developing and/or improving **home care** and **community-based care;***
b) *closing territorial gaps in availability of and access to long-term care, in particular in rural and depopulating areas;*
c) *rolling-out **accessible innovative technology** and **digital solutions** in the provision of care services, including to support independent living; at the same time addressing problems that digitalisation may pose;*
d) *ensuring that **long-term care services and facilities are accessible** to persons with specific needs and disabilities, respecting the equal right of all persons with disabilities to live independently in the community, with choices equal to others;*
e) *ensuring that long-term care services are well **coordinated** with prevention, healthy and active ageing, and healthcare services, and that they support autonomy and independent living, restoring physical or mental conditions insofar as possible, or preventing their deterioration.*

[10] SAAD statistics of the Imserso at 31 December 2023. System for autonomy and care for dependency. https://imserso.es/documents/20123/6338181/inf_ssppmmesp2022.pdf/a104a186-d570-e87b-28ac-aae620658b0f

3.1.2.1 Community-based care

Most older people in dependent situations express their desire to stay in their own homes for as long as possible and in the communities or neighbourhoods where they live receiving the support they need there (Ilinca et al, 2022). For this to be possible, local health and social teams need to be reinforced and adequately coordinated, and to have suitable options to cover these people's needs and provide the necessary support.

In Spain, **the family** often assumes the care for dependent persons, devoting a large number of hours to care to the detriment of their own leisure time or time spent on their work and professional development. According to the SAAD Evaluation Report, 46.1% of live-in carers in Spain spend **more than 10 hours a day on care**. Moreover, 51.8% of main carers have been providing this care for more than eight years, implying a very high direct and indirect cost. In contrast, 44% of hired carers spend less than two hours a day in the home of the SAD user. As a result, public social services and privatised care become residual resources compared to the care provided by the family.

To support these carer families, Law 39/2006 provides for a **financial benefit for care in the family environment and support for non-professional caregivers**, for those cases in which the person in a situation of dependency is being cared for by their family environment, this being the System's most commonly provided benefit, accounting for 29% of the total benefits and services of the SAAD in 2023 (Imserso SAAD Statistics Report, 2023).

At the same time, family care is often complemented with other types of care or services provided by contracted personnel.

The Survey on Disability, Personal Autonomy and Dependency Situations (hereafter, the EDAD Survey) carried out in 2020 indicates that 22.9% of dependent persons receive **assistance from various providers**, with domestic service being the main channel of privatisation.

This survey indicates that 28.3% of carers who do not live in the same household as the dependent person are paid workers, of whom 11.8% are the main carers. This process confirms that **families adopt a multi-care strategy** trying to combine different resources and assistance to enable the culturally-predominant and preferred aspiration of most people to grow old at home.

Services and resources for community living

As explained, the SAAD is responsible for preventing and managing situations of dependency and promoting personal autonomy through the coordination of social services and health services, and for offering different services and benefits to people in dependent situations allowing for personalised and comprehensive care.

To offer **adequate care to older people** living in our country, Social Services have different service categories aimed at this population group, three of which focus on facilitating older people's permanence in their environment and one on providing residential resources. These categories, which we describe below, are: home care services, social participation services, day or night care services, and residential services.

The main objective of ***Home Care Services*** is for people in situations of dependency to remain at home for as long as possible and, thus, to avoid uprooting them from their environment. This type of assistance includes the telecare service and the home help service, which in turn includes domestic care and personal care.

The **telecare service**, included in the SAAD, is the one with the highest number of users, accounting for 22% of the total number of SAAD services and benefits in 2023 (Imserso Statistics Report, 2023). This service is described in more detail in later sections.

The SAAD catalogue also includes the **home help service**, which represents 18% of the System's total services and benefits (Imserso SAAD Statistics Report, 2023). This service is key to care and, in combination with telecare, plays an important role in encouraging people to stay at home. For this reason, the 2022 SAAD Evaluation Report called for extending the intensity of its working hours, improving the professionalization and professional accreditation of its staff, and improving social-health coordination.
In this regard, the Agreement on common criteria for the accreditation and quality of the centres and services of the SAAD (hereinafter, Accreditation and Quality Agreement), established a series of requirements to be met by companies providing this service to ensure its quality, specifying its extension, training of personnel providing this care, working conditions or way in which to organise the service, so as to guarantee a dignified treatment and exercise of the rights of the person receiving this care. At the same time, Royal Decree 675/2023 increased the intensity of the service.

Social Participation Services: There are 3,739 Centres for Older People in Spain. [11] These are community facilities designed to provide a variety of services and activities for older people residing in a specific area of a district or municipality. They are designed with a broader approach than day centres. They offer a wide range of activities to promote physical, emotional and social well-being, including exercise, workshops, cultural and educational activities, leisure activities, etc. They also serve as a meeting place for networking and community participation, as they are strongly linked to neighbourhoods and generate a sense of belonging and community.

Day Care Services: also included in the SAAD catalogue, Day Care Centres are daytime care services that offer comprehensive care to people in a situation of dependency, with the aim of improving or maintaining the best possible level of personal autonomy and supporting families or carers. In particular, and as specified in Law 39/2006, they cover, from a biopsychosocial approach, the needs of advice, prevention, rehabilitation, guidance for the promotion of autonomy, habilitation or assistance and personal care. Its services include personalised nursing services, physiotherapy, occupational therapy and cognitive stimulation activities. They also provide food and basic healthcare services. Numerous recreational and social activities take place; they also provide support for carers. These centres are run by public, private or non-profit organisations. At 31 December 2022, the offer was of 105,447 places distributed over 3,545 centres, implying a coverage ratio of 1.09 (No. of places/Total number of people aged 65 plus*100). Of the 66,421 users, 68.7% are women and 66.5% are over the age of 80.

[11] Social services for older people in Spain.
https://intranet.dimserso.int/web/imserso/elimserso/documentacion/estadisticas/servicios-sociales-dirigidos-a-personas-mayores-en-espana-diciembre-2022.

Residential services. Residential Centres are the most widely used, accounting for 97.7% of places, whereas Housing for Older People only accounts for 2.3%. Where houses and apartments are concerned, according to 2022 data, they are barely established in Spain. According to data from the report "Social Services for Older People in Spain" published by the Imserso, at 31 December 2022, the number of places for older people in houses was 9,372, compared to almost **381,514** places in residential care[12,13.]

Residential centres offer accommodation, food and care on a permanent or temporary basis to people who need it. There are **6,831** residential centres in Spain, offering 381,514 places for older people and 45,120 places for people with disabilities.

Of the total 6,831 centres, **5,188** are specialised for older people, **1,455** are for people with disabilities, and **188** are open to any type of profile.
In the **residential centres for older people**, the profile of the user is female in **68.7% of cases** and male in 31.3%. Regarding age, on a national level it is observed that **74.5% of residents are aged 80 or over,** 21.4% are between 65 and 79 years old and 4.2% are under 65 years old.

In the case of **centres for people with disabilities**, the system's 1,455 centres have the capacity to offer **49,435 places**. The gender distribution in this case is much more balanced, with women accounting for 41.6% and men for the remaining 58.4%. Regarding age, on a national level it is observed that **84.9% of residents are under 65 years of age**, 11,6% are aged between 65 and 79 and only the remaining 3.5% are aged 80 plus.

Approximately **9.5%** of the benefits of the system for autonomy and care for dependency are residential services, attending to about **181,817** people. A further 93,395 people receive a financial benefit associated with payment of residential centres by beneficiaries who for various reasons have not been able to access a residential place.

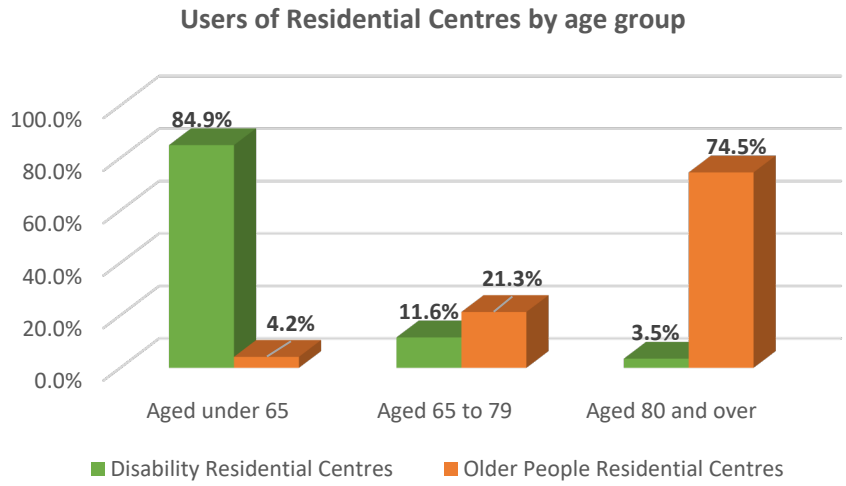

Figure 8: Age distribution of people living in residential centres for older people and for people with disabilities.
Source: Census of social services residential centres in Spain. Imserso 2024.

[12] Evaluation report of the System for Autonomy and Care for Dependency (SAAD). https://www.mdsocialesa2030.gob.es/derechos-sociales/inclusion/docs/estudio_evaluacion_saad_completo.pdf.
[13] Census of Social Services Residential Centres in Spain. https://imserso.es/el-imserso/documentacion/estadisticas/censo-de-centros-residenciales-en-espana.

According to the Spain 2021 Report of the Universidad Pontificia de Comillas, on the impact that COVID-19 has had on long-term care, the pandemic has made us aware of the weaknesses of the residential system and the lack of capacity to exercise human rights that users have. The report states that, in general, Spanish nursing homes offer very uniform care with few options for people to choose and decide on a day-to-day basis when they need help from professionals (time to get up, go to bed, where and with whom to eat or spend the day), with activities that are often childish and with little meaning for people, with double rooms (sometimes even with more capacity), with constant change of professionals who rotate between the different floors, common spaces where residents are kept lined up... Situations that violate the most elementary ethical principles, such as **personal dignity**, understood as conscious and responsible **self-determination** of one's own life, which the institutionalization of care often does not allow, **autonomy in the choice** of a model of life that allows one to decide where and how to receive care, or **equity**, which pursues the recognition of specific rights for specific groups with the aim of achieving material equality.

Less than 4% of people over 65 years of age live in a residential centre, if we refer to the population of any age, less than 1% live in nursing homes. But the decision to live in a residential centre should not entail giving up being included in the community, nor loss of rights, nor should it necessarily imply institutionalisation and the depersonalisation of care. To improve living conditions in residential centres, the Accreditation and Quality Agreement mentioned earlier was approved, containing guidelines to be followed for certain aspects relating to centres' location, services and infrastructure. One of the basic elements for residents to stay in touch with society is the centre's location in relation to the urban centres where they are based. In Spain, according to the Census of residential services centres carried out by Imserso in 2023, **78.3%** of residential centres **are located within the urban area**, allowing for the permeability of these institutions with communities, shops, streets and squares, and other social resources, and for the interaction of residents.

Another important element is the **size of the facilities**, as personalised care is easier in more home-like settings with smaller numbers of residents. In Spain, 46.2% of centres for older people have 50 places or less and only 9.3% have more than 150 places, the average being 73.5 places. The size of disability-specific centres is considerably smaller, with a national average of 34 places per centre. In this case, 85.7% of the centres have 50 places or less. Residences can provide a favourable environment to expand the network of social relationships that are sometimes difficult to achieve in a single-person housing environment and with difficulties in accessing cultural or community activities. According to the Report Census of Residential Centers of social services in Spain, published by Imserso, the percentage of single-type rooms in centers for the older people in 2022 was 48%, decreasing this percentage to 40% in the case of centers for people with disabilities. This means that more than half of the people living in centres live in their rooms with other people, who are often not linked by any type of relationship or previous relationship.

3.1.2.2 Quality care irrespective of territorial differences

Rural areas, especially the most depopulated ones, have certain characteristics that make it more complex to provide care and support. These include a significant ageing population, limited social and healthcare resources and great difficulty finding professionals to provide such care.

Other factors present in rural or depopulated areas include limited access to transport; the digital divide, accentuated by the lack of connectivity; the inaccessibility of housing and the built-up environment; the limited presence of associations; the lower density of social relations and the lack of opportunities to participate in inclusive cultural and leisure activities.

All this increases the burden on informal caregivers, who are often other older people, mostly women, caring for husbands, fathers or children with disabilities.

To try to **alleviate the shortage of professionals** in rural insular settings and in small rural municipalities, an attempt has been made to make the requirements that are demanded from companies and workers wishing to provide services in this area more flexible, articulating a way of incorporating personnel and training them on the job. Thus, when there is no one with the required training available to provide direct care and the lack of job seekers in the area is accredited, people who do not have the required professional qualifications may be hired until their positions can be filled by qualified professionals or until they acquire the corresponding qualification.

Persons hired in these circumstances will be entitled to receive training for their qualification immediately upon their incorporation, free of charge, and may use up to 20% of their working day for such training.

In terms of the **available resources**, data has already been provided earlier in this report on day, night, residential and social participation centres. Furthermore, in Spain, **access to public health care is guaranteed throughout the country,** and although there are municipalities with a highly dispersed population, access is provided through primary care centres or local clinics. **Pharmacies** are another very important resource due to their role in detecting and supporting situations of dependency. In Spain, there is an extensive network of 22,220 community pharmacies that are closely linked to neighbourhoods and villages and can detect situations of vulnerability.

Particularly relevant in this context is the **European social services innovation project** "*Integrated social and Health care in the home at Rural Scale - RuralCare*", which consists of the design, testing and evaluation of an innovative systemic approach to the provision of integrated long-term care, tailored to people living in rural areas according to their individual values, wishes and preferences[14].

The model developed by *Rural Care* moves away from the concept of the residential model as the primary solution for people's care needs, including in cases where the user requires high-intensity care. RuralCare develops an alternative model that understands that people who have any need for professional support, preferably older people, people with disabilities or chronic illnesses, complex situations included, can remain at home carrying out their daily activities of social participation, healthcare and, in general, all those activities that help them to maintain

[14] European innovation project in social services. RuralCare. https://ruralcare.eu/es/.

their lifestyle, providing them with the necessary support to develop their life project, according to their wishes and desires.

The project's final evaluation demonstrated that Rural Care is a care model for people in need of professional care that delivers results, is tailored to people's needs and wishes, guarantees freedom of choice, is accessible, affordable and offers better value for money than the residential model[15]. The average cost of care per person per month in Rural Care - excluding medical care - is € 681.94 whereas the average cost in residential care is € 1,392.87, which is almost twice as much.

3.1.2.3 Digital solutions to facilitate autonomy and independent living

In Spain, one of the most widely used services is telecare, which 427,677 people had access to by the end of 2023. This service is based on the use of communication technologies to establish permanent contact between the user and a specialised care centre. The basic features of the service are:

Immediate response in an emergency situation: people have a device installed in the form of a pendant or bracelet that connects them immediately in case of emergency to a specialised centre that will activate an emergency response to any situation that could arise, physical discomfort, falls, situations of risk, etc.

Continuous and personalised attention: the person can communicate with the telecare staff to request information or advice according to their needs.

Emotional and social support: specialised staff can provide emotional support and support also in situations of loneliness or distress. In addition to calls from the user, service staff periodically call the person to establish communication and detect possible situations that require support or constitute a potential risk.

Coordination with other services: this service is usually coordinated with social services personnel, medical personnel and emergency services.

Advanced telecare exists in some regions, which includes, in addition to the basic telecare services required by the user, complementary technological support in the home, such as remote monitoring, detection of risks or altered habits, and also outside of the home, such as mobile telecare with geolocation. It also provides interconnection with information services and reference professionals of the health and social systems, developing processes and action protocols based on the detected care need.

In addition to basic and advanced telecare, there are numerous digital and technological solutions available to support and care for dependent persons.

Also, through the Imserso, the Ministry of Social Rights, Consumer Affairs and 2030 Agenda, has a **State Reference Centre dedicated to Personal Autonomy and Technical Aids**, whose objective, among others, is to contribute to making the rights of older people and people with disabilities

[15] RuralCare project Final Evaluation Report. https://ruralcare.eu/wp-content/uploads/2024/01/Informe_Final_Evalucion-Rural-Care_VF.pdf).

effective, through comprehensive accessibility, assistive products and technologies, and design conceived for everyone.

Similarly, this time through the Royal Board of Trustees on Disability, a public centre is created to research and promote **cognitive accessibility** in the public administrations and, through the Disability Directorate General, the **Telephone Intermediation Centre** (CIT) is operating with the aim of facilitating communication between people who are deaf, or have hearing and/or speech impairments and are users of text telephones, mobile phones, fax, e-mail or videoconferencing, with hearing people and with services that use conventional telephones.

3.1.2.4 Accessible care to ensure a level playing field

Universal accessibility involves designing and developing environments, products, goods and services that can be used by everyone safely, autonomously and on equal terms. Until now, the different actions carried out in the field of accessibility focused on facilitating accessibility for the individual person. However, the concept of universal accessibility extends a little further, aiming to ensure that the person can decide and achieve the goal they pursue when using the surroundings, service or product, not focusing exclusively on specific elements, but addressing the accessibility chain as a whole.

Accessibility thus becomes the right that facilitates the development of a dignified human life, such that without access to the good or service, the right to enjoy it would be unfulfilled.

Among the ten lever policies contained in the Recovery, Transformation and Resilience Plan, lever VIII, called "New care economy and employment policies" covers component 22, Shock Plan for the care economy and strengthening of equality and inclusion policies, whose main objective is to modernise and reinforce all social services, paying special attention to the LTC model, by promoting innovation and a Person-Centred Care model. This generic objective includes improving social services through innovation and new technologies and **promoting universal accessibility** in all areas.

Additionally, amendment of the Accreditation and Quality Agreement of Centres and Services of the SAAD, already mentioned in this document, sought, among other objectives, to improve the accessibility of residential centres by bringing them into line with accessibility regulations.

The agreement also states that users will have access to their individual care plan in an accessible format that guarantees their understanding of and participation in the plan. In relation to home help, it states that care tasks and functions will adapt to the characteristics of the home, helping to make it an accessible environment that facilitates the participation of the person and development of care functions in an appropriate manner, both for the care workers and for the person in a situation of dependency and for the people with whom they live.

Finally, Royal Decree 193/2023, of 21 March, regulates the basic conditions of accessibility and non-discrimination of people with disabilities for access to and use of goods and services available to the public and establishes a series of positive action measures and other complementary supports aimed at making up for the initial disadvantages that people with disabilities generally experience.

Specifically, in relation to social, assistance and care products and services for children and older people, it states that facilities dedicated to these types of services will have the necessary

mechanical and electronic elements, assistive products and technologies, as well as sufficiently and adequately trained support staff so that people with disabilities can access such products and services on equal terms with others and receive equal and appropriate care.

At the same time, it also states that the public administrations, in the sphere of their respective competences, may establish provisions, criteria or practices that are more favourable to persons with disabilities and their families in relation to access to and use of these products and services, such as quotas or specific shifts reserved on the grounds of disability, preference criteria on the grounds of disability, aid and subsidies that mitigate the cost for the person or family, greater intensity of care and others of similar significance.

3.1.2.5 Coordination between social and health actors for independent living

Comprehensive social and health care is necessary for all dependent persons, especially for those with advanced diseases, dementia, behavioural problems, mental illness, specific medical needs, in palliative care, etc. who also present social needs.

For this reason, as early as 2011, 63 measures were proposed to **boost social and healthcare coordination in Spain**, working on the autonomy of persons cared for and of carers, including proposals for technological innovation.

In 2022, the Territorial Council, through the agreement signed with the autonomous communities regarding the common criteria for the accreditation and quality of centres and services of the SAAD, in its article thirteen, stated that health care, which is the responsibility of the National Health System, will in all cases guarantee the same level of access to the portfolio of services for dependent people as for the rest of the population, regardless of whether they reside in private or collective homes.

The competent administrations will establish permanent instruments for social and healthcare coordination in each autonomous community and city so as to guarantee the necessary cooperation between the social and healthcare spheres to respond comprehensively, in coordination and efficiently to the care needs of dependent persons.

Likewise, the administrations responsible for social services and health in the different territorial areas will promote the exchange of information and interoperability between the health system and the social system.

Regarding the **users of residential centres**, the Agreement establishes the following:

- For the purposes of the health system's structure of services, the residential centre will be considered the usual place of residence of the persons in care.
- The necessary measures will be articulated so that both the social and health systems exchange information and have shared access to the medical history, the exchange of social information, access to electronic prescriptions, the management of complementary tests, inter-consultation, coordination and review of cases, as well as to the use of teleconsultation, sending and receipt of medical analyses, the implementation of technology that automates processes, and to the register of advance directives of the autonomous community or city.

- Public health care will be provided from the primary health care facilities, through specialised and hospital care and with the collaboration of the healthcare professionals who may be providing services in the actual residential centres.

- The autonomous administrations or competent administration, where appropriate, will ensure that each accredited residential centre has a **functional coordination plan,** which will be drawn up jointly with the competent public health system corresponding to the zone or area where the centre is located, both for the primary care level and for outpatient and inpatient care.

- Residential care centres with more than 30 accredited places must have professionals who carry out the functions of coordination and liaison with the public health system and supervision of care guidelines. When the centre has more than 75 places, the functions described above must be carried out by healthcare personnel as defined in articles 2 and 3 of Law 44/2003, of 21 November, on the organisation of the health professions. In the case of residential centres for people with disabilities who do not require specialised health care, this role will not be required.

- For publicly owned residential centres, such healthcare personnel may be statutory personnel belonging to the corresponding health system if this is provided for in the autonomous community's sphere of competence.

- To meet the healthcare requirements derived from the type of population living in residential centres, it will be important to provide sufficient space and resources to offer such care in a framework that ensures personal dignity and respect.

- Regarding users of the other services contained in article 15 of LAW 39/2006 (telecare, home help, day centres, promotion of autonomy, etc.), coordination channels will also be ensured between social services and the primary healthcare services to guarantee that personal care and support plans have a comprehensive approach.

The above will be proposed by the Territorial Council to the Plenary of the Interterritorial Council of the National Health System for the purposes of agreeing on and promoting this coordinated care.

3.1.3 Quality care

It is recommended that Member States ensure that high-quality criteria and standards are established for all long-term care settings, tailored to their characteristics and to apply them to all long-term care providers irrespective of their legal status. To that effect, Member States are invited to ensure a national quality framework for long-term care in accordance with the quality principles set out in the Annex and to include in it an appropriate quality assurance mechanism that:

*a) ensures compliance with q**uality criteria and standards** across all long-term care settings and providers in collaboration with long-term care providers and people receiving long-term care;*

*b) provides **incentives to** and enhances the capacity of long-term care **providers** to go beyond the minimum quality standards and to improve quality continuously;*

c) *allocates **resources for quality assurance** at national, regional and local levels and encourages long-term care providers to have financial resources for quality management;*

d) *ensures, where relevant, that requirements regarding the quality of long-term care are integrated in **public procurement**;*

e) ***promotes autonomy,** independent living, and inclusion in the community in all long-term care settings;*

f) *ensures **protection against abuse**, harassment, neglect and all forms of violence for all persons in need of care and all carers.*

3.1.3.1 Compliance with quality criteria and standards

The quality and efficacy of the SAAD is regulated by Title II of Law 39/2006, which sets out measures to ensure the quality of the system, training in dependency for professionals and carers, the information system, and action against fraud.

Within the framework of competences assumed by each public administration in terms of developing the content of the Dependency Law, the **power to evaluate** (and eventually sanction) corresponds to the autonomous communities, which have the authority to periodically evaluate the functioning of the system in their respective territories, and to inspect and, where appropriate, sanction breaches of requirements and quality standards of the centres and services and with respect to the rights of beneficiaries.

Consequently, the autonomous communities have exercised the power to inspect and sanction, albeit unevenly, and there is a widespread consensus regarding the need to reorient and reinforce the agencies and procedures established for inspection of the services.

However, Spain has not developed mechanisms of care regulation, accreditation, inspection, certification, standardisation and evaluation sufficiently to advance towards quality care. The **quality management model** applied in our country is still mostly oriented towards fulfilling functional, material and personnel requirements, and to a lesser extent towards evaluating care outcomes in terms of quality of life. However, it is noteworthy that in recent years, approaches more oriented towards the personalisation of care are being developed in the regulations, accreditation and assessment of outcomes.

In order to **improve the quality control system** and orient it to care outcomes in the lives of such care receivers, in June 2022, the Territorial Council approved the aforementioned Accreditation and Quality Agreement. This Agreement establishes that accredited centres and services will be subject to appropriate inspection, control and monitoring to ensure continued compliance with the requirements that led to accreditation. To this end, the competent administrations will have adequately equipped public inspection services. At the same time, the competent administrations will establish annual inspection plans of the centres and services and will make them public, periodically and accessibly reporting on the inspections carried out, specifying, among other data, the inspected centre or service's identification, its ownership and management, date of and reason for the inspection, result of the inspection and, where appropriate, measures taken.

To implement this control and monitoring system, the same Agreement provides for the creation of a technical presentation on the evaluation and quality of the SAAD to prepare a proposal for a common system of quality assessment of SAAD services and benefits, referring especially to their outcomes and impacts on people, and more especially on their dignity and quality of life.

3.1.3.2 Incentives for quality assurance and fulfilment of targets

As explained above, the **Accreditation and Quality Agreement of 2022** aims to establish **common criteria to improve the quality of the SAAD** beyond the minimum standards established in the previous Agreement of 2008, which had informed the legislation and regulations of the autonomous communities and cities up to that point. In this way, an attempt is made to adapt the System's services to the current reality, so that **the rights of users are guaranteed and** care is offered that places the **needs, preferences and desires** of people in situations of dependency at the centre, from a **proximity and community-based approach**. This Agreement also underlines the importance of **quality employment**, based on the conviction that dignifying and improving the conditions of carers will have a direct impact on the quality of care provided.

The **new care model** proposed by the Accreditation and Quality Agreement for all centres and services of the SAAD is based on the following **guiding principles**:

- Dignity and respect,
- Personalisation and person-centred care,
- Participation, control and choices
- Right to health and personal well-being,
- Proximity and community connections.

The **accreditation requirements** proposed by the Agreement for the different centres and services of the SAAD are based on these principles, with a timetable for their gradual adaptation in the **transition to this new model of care**. As these requirements are phased in, the public administrations will adjust the funding of the SAAD and the price of the agreed services.

In particular, Law 39/2006 provides that the Framework of Interadministrative Cooperation agreed between the AGE and the autonomous communities, in the Territorial Council, will orient the **agreed level of funding** towards **guaranteeing the common criteria for the accreditation and quality of the centres and services of the SAAD**. Accordingly, the corresponding **agreements** between the AGE and the autonomous communities for the distribution of funding of the agreed level of protection will take into account various criteria set out in the SAAD Shock Plan, such as reducing waiting lists and improving administrative flexibility, increasing the intensities of the services and benefits, and also improving the quality of the services and the working conditions of persons employed in the SAAD. As part of improving the quality of the services, consideration will be made for the different means and resources committed by the Autonomous Communities for the **promotion and encouragement of the adaptation of their centres and services to the accreditation and quality criteria**. In this way, the State encourages the efforts and commitments of the autonomous communities for the different centres and services located in their territories to foster continuous improvement in the quality of the provided care.

At the same time, in recent years, the different **inspection bodies of the autonomous communities** have demonstrated an increased concern for **boosting the quality of the system**, so as to not only evaluate and control the basic aspects of inspected centres' operations, but also pay attention to staff qualifications, quality plans, the personalisation of care or

implementation of procedures guaranteeing users' dignity and rights. An example of the latter would be the inspection work carried out since 2022 on the abusive or inappropriate use of physical and chemical restraints in residences and centres for older people and people with disabilities, based on Instruction 1/2022 of the Public Prosecutor's Office in this regard.

3.1.3.3 Funding geared towards meeting quality criteria

As previously explained, the funding system established in Law 39/2006 is based on the existence of **three levels of protection**. Accordingly, first there is a minimum level of protection, to be paid in full by the AGE according to the number of dependent persons receiving an effective benefit. In second place, there is an agreed level of protection, based on conclusion of the corresponding collaboration agreements between the AGE and the autonomous communities. The AGE's funding of this protection level is based on the annual distribution of determined amounts among the autonomous communities according to a series of predefined variables and criteria. Finally, there is an additional level of protection, which the autonomous communities can choose to implement, funded exclusively by them.

Since the Dependency Law came into effect, various **exceptional financial allocations** have been made to fund actions related to the care of dependent persons and promotion of the SAAD. Among the latest actions, the SAAD Shock Plan, of 15 January 2021, which made it possible to add 600 million euros from the General State Budget to the dependency care budget for 2021. This budget was increased in 2022 by a further additional 600 million euros. The anticipated total investment in the SAAD Shock Plan is 3.6 billion until 2023 and transfer to the autonomous communities is strongly linked to fulfilment of the objectives set out in the Plan.

At the same time, since 2019, the AGE has resumed funding for the **signing of a special Social Security System agreement** by non-professional carers of people in dependent situations who meet the requirements specified for this purpose. Through this funding, the AGE covers the relevant contributions, so that the non-professional carer can sign the aforementioned agreement without incurring any expense.

As a result of signing this special agreement, the non-professional carer is considered to have paid contributions during the period they remain outside of the labour market due to providing care in the family environment for the purposes of accrual when the time comes to claiming contributory benefits from the Social Security system (retirement, disability, death and survivors' pensions).

This measure has a marked impact on women, as the data regarding the signing of this type of special agreement shows that the vast majority of signees are women (about 88%). This derives from the traditional pattern in our society of the burden of care almost always falling on women, making it difficult for them to develop a professional career, and consequently impossible to generate sufficient periods of social security contributions to earn future contributory benefits of the Social Security system.

According to the information published by the Imserso[16], **expenditure on dependency benefits** in 2021 reached 9,704 million euros. This amount increased by 5.66% in 2022, the last available year of certified expenditure, reaching 10,253 million euros that year. This amount means that, in 2022, the expenditure per beneficiary was 7,806 euros per year, added to the rebate of the

[16] Report on the evolution of dependency funding. Year 2021 — Year 2022. https://imserso.es/en/autonomia-personal-dependencia/sistema-autonomia-atencion-dependencia-saad/financiacion-saad

Social Security contribution for just over 69,602 family carers in 2022, which currently, in 2024, benefits more than eighty thousand non-professional carers.

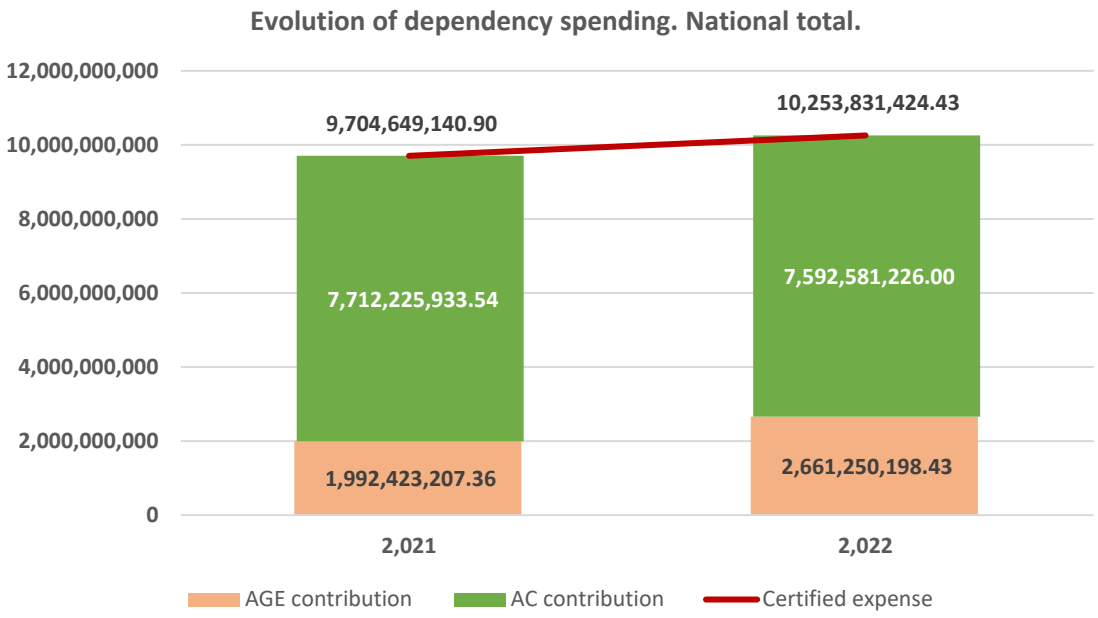

Figure 9: Evolution of dependency spending.

3.1.3.4 Quality criteria integrated in public procurement

All of the criteria set out in the Accreditation and Quality Agreement apply to all of the services that each person's individual care programme (PIA) may contain, whether publicly or privately owned, and whether provided directly by the public sector or through subsidised services, including services provided through a linked financial benefit directed at the dependent person.

The Territorial Council, through the Accreditation and Quality Agreement, requires from service provider entities or companies affiliated to the service provision wishing to be accredited and to contract with the administration, in relation to their staff in positions of direct care and coordination, to comply with the following:

- The centres and services of the SAAD will guarantee that 80% of all employment contracts are **permanent contracts**, unless there is a justified and accredited reason due to staffing shortage.
- The percentage of contracts of first-level direct care staff of SAAD centres and services with **ordinary working hours** (full-time) must be at least 66% of the total number of hours contracted by the entity. This percentage will be 50% in the case of the home help service.
- Compliance with the legal obligation to **reserve employment for people with disabilities,** established in the consolidated text of the General Law on the Rights of People with Disabilities and their Social Inclusion, approved by Royal Legislative Decree 1/2013, of 29 November.

In any case, the stipulations of the Collective Bargaining Agreement applicable in each territory must be fulfilled.

3.1.3.5 Community inclusion in all care settings

Proximity and community connections are one of the principles of the Accreditation and Quality Agreement. Community, understood as the setting or environment in which we live (neighbourhoods, towns and cities), is the scene of each person's life. Services and centres should be designed to help and facilitate people staying in and keeping connected to the places and people that are meaningful to them. Proximity of centres and services to urban environments and social activity is key to promoting an active life in the community. It will therefore be a priority to know the environment and identify the meaningful life opportunities it offers to people in a situation of dependency, also as a key strategy to avoid situations of isolation and undesirable loneliness. This dimension also includes aspects related to family and close friends' role and participation in the person's life and in the improvement of the centres and services.

Likewise, the entire Agreement refers to personalisation and person-centred care as a central dimension for moving towards a new model of care and support. **Personalisation,** understood as people's right to choose and control the way in which their care is planned and delivered, is based on what is important to each person and on a vision of the person according to their individual strengths, capabilities and needs. It implies that the individual's will and preferences guide the support relationship and are prioritised over organisational needs. Person-centred care represents a new relationship between people, professionals and the community. It is a positive shift in power and decision-making that allows users to have a voice, to be heard and connected to each other and their communities.

3.1.3.6 Protection against abuse and all forms of violence

All care relationships require an **ethical approach** that protects and enhances the dignity of people in all areas of their lives and throughout their life cycle. Therefore, work is based on the premise that every individual deserves to be treated with respect and consideration at all times, ensuring good treatment is received by persons requiring care and support and also their relatives or support staff.

Dignified treatment implies promoting settings that dignify people's lives and ensure the exercise of their rights, in terms of equal opportunities, equal treatment, freedom of choice, self-determination, control over their own lives and respect for their privacy and intimacy. Likewise, support should be provided without discrimination on grounds of sex, racial or ethnic origin, religion or beliefs, disability, age, or sexual orientation and identity. This principle also includes all aspects related to reducing restrictions and eliminating restraints.

Therefore, accredited centres undertake to provide **restraint-free care**, establishing that all persons cared for within the scope of the SAAD have the right to receive care free of restraints, whether physical, mechanical, chemical or pharmacological, and also free of coercion. Recognition of the person's **dignity** and **promotion of their autonomy** must be the backbone of care and support for all people.

3.1.4 Challenges related to the adequacy, availability and quality of care

The analysis of factors related to the adequacy, personalisation and affordability of LTC in Spain has identified several **challenges for the SAAD**:

First, to provide quality services and support requires **expanding coverage and improving access** to these services. In this sense, changes in the dependency care system should be oriented towards a broader and more flexible catalogue with a less welfare-based approach aimed more at activating the person by promoting their personal autonomy.

The diversity of standards of the different autonomous communities also needs to be addressed to **ensure fairness** between territories. Regulatory improvement should also focus on reducing bureaucracy, which would also result in reducing waiting times, ensuring timely care when needed.

A swift, flexible response with the necessary services adapted to care requirements has a direct impact on preventing institutionalisation. To achieve this, **home and residential care** must be improved. This includes expanding, diversifying and making the services offered in the home more flexible, as well as favouring supported housing alternatives and reorienting the residential model.

The importance of ensuring **the quality** of services throughout the country is also highlighted, which implies improving monitoring systems and implementing procedures to systematically assess the quality of services provided and make the necessary adjustments and improvements.

All of the **common criteria approved in the June 2022 Agreement of the Territorial Council,** designed to improve the quality of the centres and services of the SAAD are in-keeping with the **Recommendations of the Council of Europe**. The goals related to quality of the services, which emphasise collaboration between providers and the active participation of care recipients, in addition to development of a system that promotes person-centred care, prioritising a rights-based approach, placing dignity above all other values, promoting autonomy, independent living and inclusion in the community, and guaranteeing the protection of both cared-for persons and carers, at the same time as ensuring economic and human resources, represent the path that the different levels of Spain's public administrations have already started to travel. The challenge now lies in fully realising these goals, with decisive progress and the highest quality possible.

3.2 BLOCK 2. Carers

3.2.1 Quality employment and fair working conditions

It is recommended that Member States support quality employment and fair working conditions in long-term care by

a) *promoting national **social dialogue** and **collective bargaining** in long-term care, including supporting the development of attractive wages, adequate working arrangements and non-discrimination in the sector, while respecting the autonomy of social partners;*

b) *without prejudice to Union law on **occupational health and safety** and while ensuring its effective application, promoting the highest standards in occupational health and safety, including protection from harassment, abuse and all forms of violence, for all long-term care workers;*

c) *addressing the challenges of **vulnerable groups** of workers, such as domestic long-term care workers, live-in care workers and migrant care workers, including by providing for effective regulation and professionalisation of such care work.*

3.2.1.1 Improving working conditions, social dialogue and collective bargaining

The professional care economy sector has experienced **remarkable growth in recent years**, far outpacing the rate of expansion of the Spanish economy as a whole. According to the study "Evaluation Report on the System for Autonomy and Care for Dependency (SAAD)", by Rodríguez Cabrero et al. (2021), it is estimated that the number of people working in care for dependency has increased gradually from 273,150 in 2008 to 452,026 in 2021, with 374,170 being the average number of people employed in the sector during the period 2009-2021 and registering a greater job creation dynamic than the Spanish economy as a whole.

This increase in the number of jobs responds to larger cohorts entering the age bracket in which support starts to be needed, and also to budget increases aimed at increasing the intensities of support for dependent persons, especially in the provision of home help.

Component 22 of the Recovery, Transformation and Resilience Plan, aimed at implementing a *Shock Plan for the care economy and strengthening of inclusion policies*, becomes one of the necessary levers for increasing the system's capacity to **create quality jobs**, jobs that cannot be relocated and are essential for increasing the well-being of the population.

In terms of working conditions, **permanent contracts** account for 58.86% of the total, and in terms of working hours, full-time contracts account for 58.98%. However, there is a relatively higher share of part-time casual contracts, suggesting a certain precariousness in working conditions.

Looking ahead, the **demand for care professionals is projected to increase significantly**, with the number of jobs in this sector estimated to rise to 648,000 by 2040. This increase is evidence of the growing importance of this area in Spain's economy, with 212,000 additional jobs expected

between 2022 and 2040. This number of jobs seems insufficient to support the projected increase of 1.5 million more people aged 80 and over between now and 2040, according to INE projections.

Added to the challenge of a shortage of professionals, other challenges persist related to working conditions. The **unemployment rate** in this field reached 10.3% in 2021, and there is **considerable precariousness**, with 18.0% of workers in the sector working fewer hours than desired and a temporary employment rate of 29.5%.

According to the annual wage structure survey, the **average annual earnings** per worker in the health and care services sector stood at 17,435.22 euros in 2021, 32.7% lower than the average earnings for all occupations in the country. Precariousness in the sector is also more acute depending on the sex of the worker, with significant gender pay gaps persisting, with men earning 30% more than women in this sector over the same period. This disparity significantly exceeds the **gender pay gap** in other sectors, which stands at about 22.5% in the economy as a whole, underlining the precariousness and wage discrimination faced by women in the dependency field compared to the economy as a whole.

According to Demá and Estébanez (2022) in "The working conditions of the auxiliary staff of the home help service", the main problem revealed by the data is the **precariousness** faced by this staff, noting a high percentage of part-time work and work of a highly temporary nature. It also notes that a significant part of the workforce is employed part-time, with the added difficulty this entails in terms of hours and the associated limitation of making this work compatible with other jobs and/or reconciling it with their personal and family lives.
This picture underlines the need to address quality and fairness in the working conditions of care professionals, especially in the context of a sector in continuous growth and transformation.

Collective bargaining and agreements

In Spain, the working conditions of care sector professionals are regulated by the **different existing collective agreements**.

Workers employed in publicly managed centres are governed by the *Fourth Single Agreement for the workforce of the General State Administration* if attached to centres managed by the AGE, or by the different collective agreements for the workforce of the different autonomous administrations, when the centres are managed by these administrations. Meanwhile, professionals who work in privately managed centres are governed by the corresponding collective agreements signed between the sector's employers and the workers' union representatives. It should be noted that there are considerable **differences between the wage and working conditions of workers in the public and private sectors**, which are better in the case of the former. There are also inequalities between the collective agreements signed by the different administrations of the autonomous communities.

People who need long-term care belong mainly to two groups: older people and people with disabilities. With respect to the first group, 22.7% of care centres for older people are publicly-owned compared to 77.3% privately owned. With respect to people with disabilities, 20% of care centres for this group are publicly-owned compared to 80% privately owned. As inferred from this data, **the vast majority of professionals in the care sector work in privately managed centres** and are therefore governed by the collective agreements that regulate this type of

centre: one for private centres caring for people in dependent situations and another for those caring for people with disabilities.

On 9 June 2023, the Official State Gazette published the Resolution of 30 May 2023, of the Directorate General for Employment, registering and publishing the **VIII State framework agreement on care services for dependent persons and developing the promotion of personal autonomy.** Its scope of application extends to companies and establishments carrying out their activities in the sector of care for dependent people and/or the promotion of personal autonomy, comprising residential homes for older people, day centres, night centres, sheltered housing, home help service and telecare, regardless of their name and with the sole exception of those companies managed and owned by the public administration.

This agreement's validity extends to 2023, 2024 and 2025, improving the salary conditions of the sector's professionals with respective increases of 4%, 2.5% and 2.5%, with a salary updating clause that applies if the sum of the real annual CPI for the month of December in each of the cited years is higher than the agreed salary increases, with a ceiling of up to 3%. Likewise, in relation to working hours, reductions of 8 hours are agreed from the annual working time calculation in 2024 and of 12 hours from the annual working time calculation in 2025. In relation to work-life balance, the possibility is implemented of enjoying the 4 personal days included in the agreement throughout the year.

Finally, compensation in situations of temporary incapacity due to professional contingencies is improved by compensating up to 100% of the salary from the 22nd day of incapacity until the 90th day; once this period has elapsed, the compensation is reduced to 95% of the salary up to 120 days of incapacity and, after 120 days, the salary compensation is of 90% up to 180 days of temporary incapacity.

This means that, for specific first-level care staff, gross annual salaries have evolved, in the case of the geriatric nursing assistant category, from 13,958 euros per year in 2019 to 15,456 euros in 2023 or, depending on the CPI, to a minimum of 16,240 euros in 2025; and in the case of a home help assistant from 13,776 euros per year in 2019 to 15,260 euros/year in 2023 or to a minimum, depending on the CPI, of 16,030 euros in 2025.

These wage increases are in line with the interprofessional minimum wage (IMW) increases in Spain over the years, with a very small difference between the IMW in 2023, which stood at 1,080 euros/month, and the 1,104 euros/month of a geriatric nursing assistant's wage or 1,090 euros/month in the case of a home help assistant.

On a separate note, with respect to professionals in the disability sector, on 4 July 2019, the Resolution of 27 June 2019 of the Directorate General for Employment was published in the Official State Gazette, registering and publishing the **XV General Collective Agreement on care centres and services for people with disabilities**. This agreement covers the professionals of privately-owned care centres caring for children and adults with disabilities, mental illness or brain damage in different centres (specialised care and rehabilitation centres, day centres, family respite centres and services, occupational centres, work integration centres, sheltered housing, residences, foundations and other institutions, etc.).

This agreement, valid from 2019 to 2021, is in a situation of extreme activity ever since employers and unions failed to reach a consensus after negotiations began to replace it on 10 March 2021 through constitution of the mandatory Negotiating Commission. Pending a definitive global agreement, on 8 January 2024, the Resolution of 25 December 2023, of the

Directorate General for Employment was published in the Official State Gazette, registering and publishing the **Partial agreement on economic matters of the XV General Collective Agreement on care centres and services for people with disabilities**. This Resolution published an update of the salary tables for the years 2022 and 2023 corresponding to teaching staff and the staff of educational centres for people with disabilities. Wage conditions have improved, such that the salary corresponding to the professional categories of educational technical assistant - special education teacher and carer increased from € 990 in 2019 to € 1,080.84 in 2023, like the IMW.

The **gender gap in the distribution of care work** is another major problem in the job market. The social security affiliation data set out in the Social Services Employment Report published by the Imserso[17], reveals that in the first quarter of 2024 there were 644,635 active workers in the activity branches corresponding to "assistance in residential establishments" (54.5%), and to "social services activities excluding accommodation" (45.5%). The prevalence of women in the care sector is obvious from the fact that 16.6% of active workers are men compared to the 83.4% of active workers who are women. We would have to add to the latter workers assigned to the special agreement of non-professional carers of people in situations of dependency, who amounted to 80,321 people in the same period. Most employment relationships are established through permanent contracts, which represent 66.2% of all social services contracts, compared to 17.3% represented by temporary contracts, with contracts for discontinuous permanent staff being in the minority at 3.1% of the total, as well as those of indefinite duration, with 12.5%.

3.2.1.2 Actions against all forms of discrimination and abuse

In 2007 Spain approved *Organic Law 3/2007 for the effective equality of women and men*[18], establishing important measures for the **promotion of equal treatment and opportunities** in various areas, with the aim of ensuring that this equality is genuinely achieved in society and is not limited to a formal recognition before the law. Among its main contributions are measures to: **combat all forms of discrimination** on grounds of sex, sexual harassment or harassment on grounds of sex, eliminating social stereotypes and obstacles that prevent the true promotion of equality between women and men and preventing discriminatory behaviour by implementing active policies in this regard and procedural guarantees of protection, to achieve equality in the workplace and to promote the reconciliation of personal and working life, promoting co-responsibility between women and men and equal access to goods and services, to reduce the wage gap between women and men, to encourage the inclusion of women in management and positions of responsibility, to make gender-based violence visible, promoting policies to combat it, or to guarantee equal opportunities for women and men in access to education and training and in professional promotion. Additionally, *basic instruments* are created, such as the Strategic Plan for Equal Opportunities, an Interministerial Commission for Equality, compulsory reporting on gender impact, or the obligation of companies with more than 250 employees to have equality plans. This law has been a **pioneer in the legislative development of gender equality rights** in Spain.

[17] Quarterly Social Services Employment Report, First Quarter 2024, https://imserso.es/el-imserso/documentacion/estadisticas/informe-trimestral-empleo-servicios-sociales
[18] Organic Law 3/2007, of 22 March, for effective equality between women and men. https://www.boe.es/eli/es/lo/2007/03/22/3/con

Various amendments have been made to Organic Law 3/2007 in recent years, which demonstrate **Spain's commitment to continue advancing towards full equality between women and men and the fight against inequalities in working conditions**. Of particular note is *Royal Decree-Law 6/2019*[19], extending the obligation to **draw up equality plans to companies with 50 or more employees**, establishing measures to promote a **work-life balance** and parental **co-responsibility** for care, and introducing the **concept of "work of equal value",** establishing the obligation of equal pay for work of equal value without discrimination on the grounds of sex.

Additionally, the presence of other laws, such as Law 31/1995 on **occupational risk prevention**[20] and Comprehensive Law 15/2022, of July 12, for **equal treatment and non-discrimination** [21], reflects the commitment to **creating safe and violence-free work environments**. The Occupational Risk Prevention Law establishes measures to protect the health and safety of workers in the workplace by identifying and managing occupational risks, thus helping to ensure safe and healthy working conditions for all employees. Together, these laws contribute to promoting gender equality and safety at work, fostering healthier, more equitable and respectful work environments. By providing a solid legal framework for the protection of workers' rights, these regulations reinforce the importance of creating organisational cultures that reject violence, harassment and discrimination in all its forms.

3.2.1.3 Particular attention to workers from vulnerable groups

The employment landscape in the social services sector presents even greater challenges when we focus on certain groups that perform care tasks and who present greater vulnerability, such as people who work in the domestic environment and/or who are migrants.

According to statistics regarding affiliation to the general social security system of the Ministry of Inclusion, Social Security and Migration, at the end of 2023, migrants represented 45.4% of domestic workers, more than 95% of whom were women. At the same time, according to the Report on employment in the social services sector, published by Imserso, in the first quarter of 2024, Spanish nationals affiliated to the Social Services increased by 6.2% year-on-year, and represented 90.7% of the total number of people affiliated to the Social Services. In the same line, foreign affiliates increased to a greater extent, by 16.7% compared to the first quarter of 2023, and represented 9.3% of the total number of affiliates of the Social Services. Of the total number of people, 47.4% are women and 52.6% are men.

This **disparity between the data for people working in social services in general and those working in domestic care** underlines the need for inclusive policies and programmes that address the barriers and inequalities faced by migrant workers in the sector.

With regard to **domestic workers**, this employment relationship includes “services or activities provided for the family home, which may cover any type of domestic work, in addition to

[19] Royal Decree-Law 6/2019, of 1 March, on urgent measures to guarantee equal treatment and opportunities between women and men in employment and occupation.
https://www.boe.es/eli/es/rdl/2019/03/01/6/con
[20] Law 31/1995, of 8 November, on Occupational Risk Prevention.
https://www.boe.es/eli/es/l/1995/11/08/31/con.
[21] Comprehensive Law 15/2022, of 12 July, for equal treatment and non-discrimination.
https://www.boe.es/eli/es/l/2022/07/12/15/con

management or care of the household as a whole or in parts, care or attention for family members or persons forming part of the domestic or family environment, and other jobs that are carried out as part of the overall domestic tasks, such as daycare, gardening, driving vehicles and other similar" (art. 1 of Royal Decree 1620/2011). Due to this wide range of tasks, people who work in domestic service often care for dependent people, despite not having the appropriate training and skills to provide adequate care to these people.

This sector has a **high prevalence of women and is extremely precarious**. Of the total number of people affiliated to the Special System for Domestic Employees and Social Security, 371,537 in April 2024, more than 43% are foreign, and of this figure, 94% are women. Historically, these workers have suffered clearly disadvantageous and discriminatory working conditions compared to those of other employed workers. In recent years, different legislative initiatives have been adopted to try to equalize their working conditions. *Law 27/2011, of 1 August, on the updating, adaptation and modernisation of the Social Security system*[22], *established a progressive equalization of the contribution system for domestic workers. Additionally, Royal Decree 1620/2011, of 14 November, regulating the special relationship that characterises service within the family household*[23], *and Royal Decree-Law 29/2012, of 28 December, on the improvement of management and social protection in the Special System for Domestic Employees and other economic and social measures*[24], advance towards the **gradual improvement and** protection of domestic workers. This regulation ensures that the Interprofessional Minimum Wage is the minimum floor to be received in cash, and does not allow this amount received to be reduced by salary in kind for maintenance or accommodation. If there is compensation in kind, it may not exceed 30% of the total salary payment. Additionally, it sets the maximum working week at 40 hours. However, despite these significant improvements, important discriminatory differences with respect to other workers still persist, such as exclusion from the unemployment benefit.

Spain's ratification of *Conventions 189 and 190 of the International Labour Organization (hereinafter, ILO)* has been crucial to **equalise the rights of women workers**, and these regulations have been transposed into our legal system through *Royal Decree-Law 16/2022, of 6 September, for the improvement of working conditions and Social Security of domestic workers*[25] *revising determined aspects of our country's social-labour regulations in order to achieve equal conditions, eliminating unjustified and differential treatment that generates a specific disadvantage, and ensuring a coherent and complete legal system for this group.*

In short, domestic workers, especially in the case of live-in domestic workers who care for older people, have been subject to a **greater risk of situations of violence and unfair and discriminatory treatment**, aggravated by situations of isolation. [26]

Both domestic workers and care workers in the domestic environment face **physical health risks** due to the requirements of the job. According to Demá and Estébanez (2022) in "The working

[22] Law 27/2011, of 1 August, on the updating, adaptation and modernisation of the Social Security system. https://www.boe.es/eli/es/l/2011/08/01/27

[23] Royal Decree 1620/2011, of 14 November, regulating the special relationship that characterises service within the family household. https://www.boe.es/eli/es/rd/2011/11/14/1620.

[24] Royal Decree-Law 29/2012, of 28 December, on the improvement of management and social protection in the Special System for Domestic Employees and other economic and social measures. https://www.boe.es/diario_boe/txt.php?id=BOE-A-2012-15764

[25] Royal Decree-Law 16/2022, of 6 September, for the improvement of working conditions and Social Security of domestic workers. https://www.boe.es/eli/es/rdl/2022/09/06/16/con

[26] Casanova Martín, (2023). https://laborum.es/revsegsoc/

conditions of the auxiliary staff of the home help service", more than half of the illnesses and injuries of auxiliary home care personnel are musculoskeletal, presumably caused by handling and moving people with reduced mobility.

In assessing the risks assumed by this group, we must take into account that they work in private homes, which do not have occupational risk prevention plans. The risks assumed are of various types, from risks related to travelling between the different locations where they provide their services or the precariousness of working conditions, to risks related to psychological, verbal and/or sexual violence, caused mainly by the asymmetrical relationship established in this type of employment between employee and employer, which can give rise to behaviour that seeks to demonstrate the employee's subordinated position with respect to the employer generating a strong sense of insecurity in the employee.

In relation to the **violent behaviours or risks** experienced by these workers, a recent study highlights manifestations of this violence as follows: constant reproval of work carried out; intimidation and threats about keeping the job, especially in the case of migrant workers; personal insults; racist and classist verbal abuse in the case of migrant workers; surveillance of private life; constant suspicion; control over the use of time and space in the home; violation of their privacy; even not eating the same food as the family, or not having hot water for showers can be considered violence. Situations of sexual violence are also reported, which include "non-consensual touching, comments with sexual connotations and even propositions to have sexual relations in exchange for money[27]", the aggressor in these situations always being the man, whether he is the employer, the care recipient or another member of the family environment [28].

Other risks faced by this group relate directly to **working conditions**, such as wage insecurity, violation of basic labour rights such as holiday entitlement, personal days, the right to a work-life balance, informality and impermanence.

In short, the different conditions and risks faced by domestic workers make them a vulnerable professional sector requiring specific measures to be adopted to improve their working conditions and prevent situations of abuse and even violence. Although improvements have been achieved, progress must continue to be made in the regulation, protection and professionalisation of this group.

[27] Paniagua De La Iglesia, 2022. In hostile territory: a qualitative approach to experiences of violence among migrant domestic workers.
[28] Acosta-Uribe, 2022. Occupational psychological harassment among domestic workers. https://revista.unsis.edu.mx/index.php/saludyadmon/

3.2.2 Professionalisation of care and training:

It is recommended that Member States, in collaboration, where relevant, with social partners, long-term care providers and other stakeholders, improve the professionalisation of care and address skills needs and worker shortages in long- term care, in particular by:

a) *designing and improving the **initial and continuous education and training** to equip current and future long-term care workers with the necessary skills and competences, including digital ones;*

b) *building **career pathways** in the long-term care sector, including through upskilling, reskilling, skills validation, and information and guidance services;*

c) *establishing pathways to a **regular employment status** for undeclared long-term care workers;*

d) *exploring **legal migration** pathways for long-term care workers;*

e) *strengthening professional standards, **offering attractive professional status** and career prospects and adequate social protection to long-term care workers, including to those with low or no qualifications;*

f) *implementing measures to tackle **gender stereotypes** and gender segregation and to make the long-term care profession attractive to both men and women.*

3.2.2.1 Improving initial education and training

Component 22 of the Recovery, Transformation and Resilience Plan, aimed at implementing a Shock Plan for the care economy and strengthening inclusion policies, becomes one of the necessary levers for increasing the system's capacity to train staff and create quality jobs, as jobs that are not relocatable and are essential for increasing the well-being of the population. Additionally, because the care sector in Spain relies heavily on non-professional carers, a strong investment in training is required to increase their qualifications and professionalisation, contributing to improving their working conditions and reducing precariousness and the informal economy.

The Spanish education system offers different options for training in LTC-related professions, through different levels of vocational training and degree qualifications, accreditations of professional competence or certificates of professionalism.

In the case of **Vocational Training,** the **range of training on offer** includes sequentially from micro-credentials (partial accreditation of competence, certificate of competence and professional certificates) to modular training cycles of a basic, intermediate and higher level. Among the **skills** that can be acquired through vocational training in the education system, comprised in the professional families of Socio-Cultural and Community and Health Services, we find, in relation to health, the auxiliary health care skill, while in the socio-cultural field there is a more extensive offer, from jobs related to cleaning intervention spaces or domestic service on

the first level, to skills in social-health care for dependent and/or disabled people both at home and in institutions or home telecare managers on the second level. The third level of competence would include the acquisition of multiple qualifications, for example competences in the education of social and personal autonomy skills, competences in the labour integration of people with disabilities, in promotion and socio-educational intervention with people with disabilities, etc.

The National **Catalogue** of Professional Qualifications lists the different qualifications, structured in 5 levels of professional qualification (Royal Decree 1128/2003, of 5 September, Annex II)[29]. These levels respond to the professional competence required by the activities to be developed according to criteria of knowledge, initiative, autonomy, responsibility and complexity, among others. Vocational training covers levels 1, 2 and 3 of competence, leaving levels 4 and 5 for university studies (degrees or equivalent and higher).

At the same time, the system provides for a **skills assessment and accreditation** procedure directed at recognising, evaluating, and accrediting professional skills acquired through work experience or other non-official or informal channels. This procedure requires work experience of at least 3 years or a minimum of 300 hours of training to obtain official recognition of professional competences. This helps to increase the chances of finding employment, accessing better working conditions and continuing training at different levels based on the accredited skills. This procedure is regulated in Title VI (Articles 90 to 93) of Organic Law 3/2022, of 31 March, on the organisation and integration of Vocational Training and in Title VI (Articles 175 to 188) of Royal Decree 659/2023, of 18 July, developing the organisation of the Vocational Training System.

3.2.2.2 Career pathways and continuous training

Currently, the initial training of care professionals in Spain varies according to the specific area of work. Three main pathways can be distinguished:

1. University degree: in areas such as Social Work, Psychology, Nursing, Occupational Therapy, and Social Education, among others. These degree programmes usually last 4 years and provide comprehensive training in the field of care. They can be accessed from an advanced vocational training level without requiring a university entrance exam or from the Baccalaureate level.

2. Vocational training: there is intermediate and advanced vocational training in relation to care, as Care Technician for People in Situations of Dependency or Auxiliary Nursing Care Technician at the intermediate level, among others. These programmes tend to offer more practical and specific training for direct care work with people. Passing an intermediate vocational training level gives access to an advanced level, such as the Higher Technician in Social Integration or in Communicative Mediation, qualifying the person to attend to the deaf community or to assist deaf-blind people.

3. Professional skill certificates: these are official qualifications that accredit professional skills in different areas of work. In the field of care, there are professional skill certificates in social-

[29] Royal Decree 1128/2003, of 5 September, regulating the National Catalogue of Professional Qualifications. https://www.boe.es/eli/es/rd/2003/09/05/1128/con.

health care for people at home, social-health care for dependent people in institutions and management of telecare calls, among others.

Access to entry-level training is not only limited to those who have completed basic vocational training or compulsory secondary education, but is also possible through specific entrance examinations. In addition, there is the possibility of validating part of the training obtained through professional skill certificates with the Technician qualification. It is important to note that educational progression allows access from entry level to advanced level qualifications.

On 15 January 2021, the plenary session of the Territorial Council approved the SAAD Shock Plan, containing twelve points for improving the system, one of which referred to the need to address "the amendments to the 2008 Agreement on Accreditation of Centres and Services of the SAAD required to strengthen the quality of the services".

Thus, on 26 July 2021, the plenary session of the Territorial Council approved the basic Agreement and roadmap for the **modification of the common accreditation criteria to guarantee the quality of centres and services of the SAAD.** It recognised the need to revise and reformulate the agreement in force since 2008 towards a new text. The points this new text was to address included in all events: determining the professional figures and profiles for provision of the support, their qualification, framework and functions; and establishing the procedure for accrediting support staff, along with the appropriate training plans. These were to include a **programme to train staff in the person-centred care model** in residential and home-based services.

Following this mandate from the Territorial Council, in 2022 the above-mentioned Accreditation and Quality Agreement was approved. This new agreement incorporates a full section dedicated to quality employment, including:

- the necessary professional qualifications, skills and competences;
- the continuous training of care personnel that all service providers must afford their staff;
- common recruitment criteria for both direct care staff and coordination personnel of the service providers or companies assigned to provide the service;
- the framework for producing and promoting qualified personnel for the care sector;
- the occupational health of care staff to be monitored in centres and services

3.2.2.3 Regularisation of undeclared workers

According to the Report on the Integration of the foreign population in the Spanish labour market, prepared by Ramón Mahía Casado and Eva Medina Moral, and promoted by OBERAXE of the Ministry of Inclusion, Social Security and Migration, estimates of informal work (without affiliation) in domestic work activities reveal that about 30% of employed people could be working irregularly.

At the same time, for workers who cannot be considered family carers and who carry out these tasks, often as domestic staff and who do not wish to register due to the loss of other benefits they receive from the protection system, compatibility has been enabled between being employed and receiving benefits such as the minimum income or the active insertion income, in

the case of part-time employment, although the amount of the latter would decrease according to the income received.

Finally, **eight migrant regularisations** have been carried out in Spain, with more than one million people having benefited from the conditions of regularisation, the last one having taken place in 2005. The regularisation process involves granting work and residence permits to irregular migrants who have been living in Spain for some time and who do not have the required documentation for being in the country.

Currently, thanks to a Popular Legislative Initiative, the Congress has given the go-ahead to considering an extraordinary regularisation of more than half a million migrants in Spain.

According to social security affiliation data, the activity with the highest proportion of non-EU foreign affiliates is that of domestic workers, with more than a third of non-EU foreigners, more than 90% of whom are women. This group is often responsible for caring for older people.

If this regulatory process occurs, it would mean the achievement of fundamental rights for these workers, both in terms of social protection through unemployment benefits or pension entitlements, and in terms of employment through the employer's compliance with legislation regarding wages, working hours, etc.

3.2.2.4 Legal migration pathways for foreign workers

The Eurofund report (2020) *Long-term care workforce: Employment and working conditions*, points out that the LTC sector in the EU employs an increasing proportion of workers, while at the same time experiencing growing staff shortages. The workforce is predominantly female, with a relatively large and growing proportion of professionals aged 50 and over and a large presence of migrants. In addition, undeclared work in the sector has to be considered, which in Spain reaches figures approaching 32% of total employment in personal household services in 2019 (Mercader Uguina et al., 2020).

At present in Spain, despite the need to find people for care work, there are no specific mechanisms in place to attract personnel from third countries to migrate legally to our country. However, there are various methods for regularising people who are already in Spain working irregularly. These include the temporary residence permit for social integration which is a permit granted to foreign citizens who are in the country and meet the conditions of “arraigo social” (social integration). This temporary residence permit is granted to foreigners who have been in Spain for a minimum of three years, have a work contract, family ties in Spain or are socially integrated.

3.2.2.5 Social protection and professional career

There are specific regulations governing the employment relationship of workers in the domestic care sector. As mentioned previously, regardless of their affiliation to social security, the reality is that this group often assumes the tasks of caring for the house and also caring for members of the family unit and in particular older people or people in situations of dependency. Moreover, this activity is provided under particular conditions that are different from other work

environments because it takes place in a personal environment, linked to personal intimacy and based on a special relationship of trust, which is not essential in other environments and which can make workers much more vulnerable to family decisions. Royal Decree 1620/2011, regulating the special relationship that characterises service within the family household, seeks to dignify the working conditions of people who provide services in the family household, by:

- establishing more and better rights for workers, applying, insofar as feasible, the general regulations set out in the Workers' Statute and complementary legislation;
- introducing greater employment stability through abolition of the non-causal temporary annual contract and application of the rules of the Workers' Statute on temporary contracts; and
- introducing mechanisms to strengthen transparency to avoid discrimination in access to employment and information on working conditions.

Spain's ratification of ILO Conventions 189 and 190 and their subsequent transposition into our legal system through *Royal Decree-Law 16/2022 for the improvement of the working conditions and Social Security of domestic workers,* has represented a great advance in the regulation of the working conditions of these workers and their alignment with other employed professionals. The improvements achieved refer both to the social protection of this sector and to working conditions, responding to a historic demand of this group.

3.2.2.6 Gender stereotypes in a female-dominated sector

The family-based nature of LTC in Spain makes wives and daughters the main caregivers. According to the 2020 EDAD survey of the INE, almost half of people aged six and over with disabilities reported receiving personal care or assistance[30]. 24.6% received this care solely from people resident in their home, 12.1% from non-residents and in 13% of the cases care was provided by both. 63.7% of these carers were women, with the most frequent profiles being women aged between 45 and 64 years old (41.0% of cases) and men in the same age group (20.7%). In relation to intensity, 49.7% of people receiving care reported being cared for eight or more hours a day.

Among those aged 6-44 who received care, the main caregiver was a parent in 69.8% of cases (10.5% the father and 59.3% the mother). For 48.1% of people aged 45-79 the main carer was the spouse or partner. Meanwhile, for 59.1% of people aged 80 and over, the main carer was their offspring (18% a son and 41.1% a daughter).

The assumption of care by women continues to be a social reality, despite the progressive incorporation of men into these roles. Women's role as family carer is also reflected in the labour market. As indicated throughout the text, according to the Labour Force Survey, if we take into account activities related to care in residential establishments, social services activities without accommodation and activities of households as employers of domestic staff, in 2023 we find

[30] In this survey, disability is defined as any major limitation to carrying out the usual activities of daily living that has lasted or is expected to last more than 1 year and is due to illness(es) or health problem(s), as estimated by the subject themselves. In this sense, a person is considered to have a disability, even if the limitation is overcome with the use of external technical aids or with the help or supervision of another person.

that, on average, 1,367,000 people were active, of which between 82% and 84% were women in the first two branches of activity, rising to 88% for jobs related to domestic services.

Care-related sectors account for 7.8% of employed women in Spain, with no other activity showing this level of female concentration. Even when caring becomes salaried work, it incorporates cultural elements associated with its low social value and, therefore, also experiences remarkable precariousness and invisibility[31].

Gender inequalities in unpaid care work have an impact on women's ability to take up paid work, on the quality of jobs to be filled, and therefore on achieving gender equality. To achieve this equality, the burden of unpaid care must be redistributed between the sexes, awarding social and economic recognition to work in the sector.

3.2.3 Identification and support of non-professional carers

It is recommended that Member States establish clear procedures to identify informal carers and support them in their caregiving activities by:

a) *facilitating their **cooperation with long-term care workers;***

b) *supporting their access to the **necessary training**, including on occupational health and safety, counselling, healthcare, psychological support and respite care, as well as supporting them in balancing work and care responsibilities;*

c) *providing them with **access to social protection and/or to adequate financial support,** while making sure that such support measures do not deter labour market participation.*

3.2.3.1 Care: a shared commitment between professionals and families

The care model in Spain has traditionally been based on a family model, where women have assumed the role of providing the necessary support and care for dependent members of the family in their close environment. This model, which assigned the state a subsidiary role, leaving the burden of care on families, began to evolve towards a more professional model with Law 39/2006.

The care sector in Spain relies to a large extent on non-professional carers, with an estimated 70% of dependent persons being cared for exclusively by a family member or close friend, with women being the main carers, whether they are partners, daughters or mothers[32].

[31] Evaluation report of the System for Autonomy and Care for Dependency (SAAD). https://www.mdsocialesa2030.gob.es/derechos-sociales/inclusion/docs/estudio_evaluacion_saad_completo.pdf.

[32] State strategy for a new community-based care model: a process of deinstitutionalisation 2024-2030 https://estrategiadesinstitucionalizacion.gob.es/.

Among non-professional carers, those who are in the close environment of the dependent person, unless they are pensioners or self-employed workers, when designated as carers in the PIA, can benefit from a special agreement (Royal Decree 615/2007) which regulates the Social Security of carers of dependent persons. The agreement's protective action relates to their retirement, possible permanent disability and vocational training, and the cost is assumed by the AGE since 2019. If the dependency of the person being cared for is grade I or II, the agreement can be signed while the carer reduces their working hours in their usual job, under certain conditions. When caring for a person with grade III dependency, it is considered incompatible with another job, although the interested party may choose to maintain the level of their contribution basis provided that they assume the increased contribution cost.

In the first quarter of 2024, according to data published by the Imserso based on data of the General Treasury of the Social Security, a total of 80,321 people were covered by the special agreement for non-professional carers of dependent persons. Of this group, 12% are men, while 88% are women, reflecting a clear gender predominance in this area. Furthermore, it is noted that most carers are under 50 years of age, indicating not only a high involvement of younger age groups in non-professional care, but also implications for their work performance. It is worth considering, nonetheless, whether people affiliated to this agreement are representative of all caregivers or whether there are people who are unaware of this possibility or do not meet the criteria to qualify as beneficiaries.

Informal care, especially in the family setting, represents a significant part of the Spanish care system. 57% of people over 65 in need of care are cared for in a purely informal setting, 26% receive mixed care, 8% receive formal care at home and another 8% receive the care they need in residential care homes. In fact, the theoretical economic value of informal care in Spain is estimated to be much higher than current public spending on LTC.

It seems therefore that the number of agreements signed with the social security is not high considering the high percentage of care that is provided by family members. According to the SAAD Evaluation Report, the low percentage of agreements with the Social Security is due, according to Montserrat (2021), to various reasons: One of them would be that most caregivers are spouses who are also usually older people and pensioners receiving a public pension for retirement or widowhood, who would therefore no longer contribute to a future retirement pension. In the case of daughters who are in employment, it is difficult to imagine that they would give up their jobs in order to be indirect beneficiaries of a financial benefit for care in the family environment whose maximum amount is 315.90 euros per month for a grade II dependency level. In short, only family members who are inactive or unemployed and under pensionable age are eligible for the special agreement with the Social Security system for family carers.

In Spain, more than half of informal carers spend 10 or more hours per week on care work. However, this dedication places a disproportionate burden on women, since, according to the report *Long-term care report,* prepared by the European Commission in 2021[33], more than 30% of women who care informally do so for more than 40 hours a week, a much higher proportion than that of men, underlining gender inequalities in the distribution of care responsibilities.

[33] Long-term Care Report. Trends, challenges and opportunities in an ageing society. (vol 2). https://op.europa.eu/en/publication-detail/-/publication/b39728e3-cd83-11eb-ac72-01aa75ed71a1

Cooperation between informal caregivers and LTC professionals is essential to provide comprehensive and high-quality care to dependent people in Spain. Coordination between the different actors of the care system is necessary, promoting the integration of information technologies and the creation of support networks.

The Tertiary Sector complements existing public and private services in the provision of care. In Spain there are almost 28,000 social organisations where more than 500,000 people are estimated to work, of which approximately 77% are women. More than one million volunteers also collaborate in tertiary sector organisations.

In some cases, informal carers' in-depth knowledge of the cared-for person is recognised and valued, but in others, professionals do not always consider their views.

Collaboration between informal and professional caregiver groups and organisations is significantly strengthened by the Accreditation and Quality Agreement of centres and services of the SAAD, which has already been mentioned in this document. As part of the personalisation of care, it incorporates the consideration of family members and significant others of the person receiving care, favouring their participation both when the cared-for person is in a residential centre and when they attend a day centre or receive home help.

In the first case, and provided the resident considers it appropriate, the family or persons close to the resident will be introduced to the professional contact person and reference to facilitate the adaptation process and will be invited to participate in the design of the personal care and support plan. In addition, each centre will have bodies for the direct participation of residents, which may include family members and close persons if the resident considers it appropriate. In the case of day centres, participation in the personal care and support plan may include persons of the user's choice, as in the case of the home help service.

3.2.3.2 Support for non-professional carers: training, health and work-life balance

Persons covered by the non-professional carers' agreement can participate in the offer of the vocational training subsystem for employment in the same way as other unemployed and employed workers. Moreover, anyone, whether or not they provide care, can take regulated studies, as there is a wide range of courses on offer in the different autonomous communities, not only in the morning or afternoon, but also through distance learning, and in the case of vocational training, in the dual system. Some strategies, such as the Strategy on Neurodegenerative Diseases, include in their objectives the provision of support for caregivers, reporting and training on the disease and its care. The mutual support of associations of relatives of people with health conditions or disabilities should also be acknowledged within the non-formal training accessed by carers.

In relation to counselling, the public social services systems of the different autonomous communities have a common catalogue of essential services and benefits, including information and guidance or counselling. In some cases, as well as in person, it can take place online or by telephone, with or without an appointment. They are open to the population that needs them.

In Spain, health care, which includes psychological care, is provided to everyone, whether or not they work. In some regions there are positive action measures for carers. Regarding the organisation of respite services, they take the form of stays, occasional support or temporary

accompaniment, both from the public administrations and from the tertiary sector. In Spain, there are day and night centres that can be a fundamental resource for the respite of informal carers.

In terms of reconciling work and care responsibilities, in addition to the aforementioned family care benefits and agreement with the Social Security, there are other benefits and resources in the work setting that help to reconcile work and care. These include, for example, paid leave of five days for serious accident or illness, hospitalisation or surgery without hospitalisation requiring home rest of the spouse, unmarried partner or relatives up to the second degree of consanguinity or affinity, as well as adaptations of the duration and distribution of the working day to care for dependent cohabitants or disabled persons. There are also tax deductions in some regions for people who care for a person aged over 65 or with a disability.

3.2.3.3 Social protection and economic support

Concerning financial support for informal carers, Royal Decree 675/2023 establishes maximum financial amounts to be received as the financial benefit for care in the family environment, according to the degree of dependency of the cared-for person. Thus, up to 455.40 euros per month corresponds to care for a person with grade III dependency, 315.90 euros for grade II and 180 euros for grade I. The social protection provided for in the aforementioned special agreement for non-professional carers makes it possible to participate in the job market when caring for a person with dependency grades I or II, under certain conditions. The possibility of accrediting professional skills in the field of care to obtain all or part of a vocational training qualification makes it easier for care experience to lead to employment in the care sector, favouring the labour participation of informal carers.

3.2.4 Challenges related to professional and non-professional carers

The LTC sector faces significant challenges affecting both professional and non-professional carers, and involving both professional and personal aspects. The new care model aims for all people, regardless of their support and care needs, to be able to pursue their life projects in their communities. And this principle should also apply to caregivers, whether professionally, through jobs that allow them to live without having to face precarious professional and economic situations, or personally, through being able to balance caring for their family member or loved one with their professional growth without having to give up large areas of their personal lives during the period in which the care is provided.

Among the challenges facing the system in relation to the professional care sector, the first we would highlight is the current **staff shortage**, which will become more acute in coming years unless it is systematically addressed.

At the root of this staff shortage we can identify factors constituting challenges in themselves, which need to be addressed directly. One of them is **improving working conditions and job quality** to attract and retain talent in this essential sector, which often faces low wages and unstable situations.

It is crucial to optimise the available **work capacity** through better training and improved training processes. The shortage of qualified staff is a significant challenge that requires the implementation of measures that foster staff **training** and preparation, along with effective strategies to improve the long-term satisfaction of qualified professionals. This may include continuous education programmes, professional development opportunities and improvements in wages and working conditions. In addition to training, there is a need to address the **simplification of accreditation procedures** for working in the care sector which could facilitate access to employment and attract more skilled workers.

In addition, it is critical to **make the importance of domestic work visible** as an important sector that frequently provides support in housework and care for dependent family members. These workers often face precarious situations due to the special nature of their work, added to the fact that many of them are migrant workers, placing them in a situation of potential vulnerability that needs to be addressed.

Another key factor is to **improve the recognition and appreciation of care professionals**, by improving their image both among the general population and among potential users and their families, as currently the work they do, which is key for society and the quality of life and protection of highly vulnerable people, does not correspond at all to the limited social recognition afforded to the sector. Greater professional recognition will increase job satisfaction and attract more talented individuals to this area.

We also need to move towards **gender equality** in the care sector, both by extending protection to women, who are the main source of care and assistance, and by encouraging male involvement in LTC. This would diversify the workforce and promote a fairer distribution of responsibilities, thus strengthening people's rights to be cared for.

It is also crucial to provide **support to informal carers**, who take on a responsibility with often critical consequences in their professional and personal lives. Exhaustion linked to long periods of care has very important consequences for the caregiver's health and can lead to a burnout resulting from the impossibility to provide care any longer, which in turn leads to the institutionalisation of the person in need of care. Therefore, effort in the quality of care must be rewarded with care for caregivers. Providing them with systematic support is essential to enable them to provide care in a dignified manner without compromising their own dignity and health. This involves providing **resources, counselling and respite services** to ease the emotional and physical burden of long-term care. Also, to ensure quality care, it is important to provide resources to develop the **skills and knowledge** required to provide quality care and meet daily challenges, while ensuring **self-care**.

In conclusion**,** addressing these challenges is important to improve working conditions and job quality in the LTC sector. Doing so will not only ensure quality care for the dependent person, but also promote the well-being and job satisfaction of personnel, caregivers and especially informal carers involved in this important work.

3.3 BLOCK 3. Governance, monitoring and reporting

It is recommended that Member States ensure sound policy governance in long-term care, including an effective coordination mechanism to design, deploy and monitor policy actions and investments in that area, in particular by:

a) *having in place a **long-term care coordinator** or another appropriate coordination mechanism, in accordance with national circumstances, supporting the implementation of this Recommendation at national level;*

b) ***involving relevant stakeholders**, for example, social partners, civil society organisations, social economy actors, vocational training and education institutions, care recipients and other stakeholders, at national, regional and local levels in the preparation, implementation, monitoring and evaluation of long-term care policies, and improving the consistency of long-term care policies with other relevant policies, including policies in the area of healthcare, employment, education and training, broader social protection and social inclusion, gender equality, rights of persons with disabilities and children's rights;*

c) *ensuring a **national framework for data collection and evaluation**, underpinned by relevant indicators, where relevant and possible sex and age-disaggregated, collection of evidence, including on gaps in long-term care provision;*

d) ***gathering lessons learned, successful practices and feedback** on long-term care policies and practices, including from care receivers, care givers and other stakeholders, in order to inform policy design;*

e) *developing a **mechanism for forecasting long-term care needs** at national, regional and local levels and integrating it into the planning of long-term care provision;*

f) *strengthening **contingency planning** and capacity to ensure continuity of long-term care provision when confronted with unforeseen circumstances and emergencies;*

g) *taking measures to **raise awareness, encourage and facilitate** the take-up of available long-term care services and support by people in need of long-term care, their families, long-term care workers and informal carers, including at regional and local levels;*

3.3.1 Good governance and coordination mechanisms

3.3.1.1 Coordinating the process to drive change

At the request of the European Union Commissioner for Jobs and Social Rights, on 27 March 2023, the Minister of the then Ministry of Social Rights and 2030 Agenda appointed a National Coordinator to implement the Council's LTC recommendations, situating responsibility in the head of the Directorate General of the Institute for Older People and Social Services, of the Secretariat of State for Social Rights.

3.3.1.2 The key role of all stakeholders

As explained above, **the provision of social services in Spain is decentralised**. Thus, exclusive competence in this area is transferred to the autonomous communities and cities and there is no state framework defining social services at national level. The local administration exercises wide-ranging competences, making harmonisation essential between the local corporations, on which primary social care depends, and the autonomous communities, responsible for specialised social care. The participation of the tertiary sector and private initiative in the provision of these services is also relevant, although responsibility for the organisation, planning and management of the system always lies with the public administration. Due to the involvement of different public administrations and entities, it is therefore **a complex system that requires adequate collaboration and governance for it to function**.

Despite the decentralisation of social services, **there are various state-level laws that regulate basic conditions** that guarantee the equality of all Spaniards in the exercise of their rights and duties and that serve as a guide for the legislators of the autonomous communities, such as the aforementioned *Law 39/2006*, which recognised the subjective right of access to the SAAD and a catalogue of services and benefits for all dependent persons, with the collaboration and participation of all public administrations and with full respect for their competences. The explanatory memorandum to the Law already stated the necessary commitment and joint action by all public powers and institutions for the System to function correctly, and therefore the necessary **measures** were adopted to **ensure this coordination and cooperation** with the autonomous communities.

These measures included the creation of the **Territorial Council of Social Services and the SAAD**, attached to the Ministry of Social Rights, Consumer Affairs and 2030 Agenda, constituted by said Ministry's Minister, who chairs it, and by the heads of the competent Councils for social services and dependency in each of the autonomous communities, with one of them holding the vice-presidency. The Territorial Council is responsible for achieving maximum coherence in the determination and application of the various social policies implemented by the AGE and the autonomous communities, through the exchange of points of view and the joint examination of the problems that may arise and the actions planned to tackle and solve them.

Its **functions** include agreeing on the **Framework of Interadministrative Cooperation** for implementation of Law 39/2006 by means of the corresponding agreements between the AGE and each of the autonomous communities, determining the obligations assumed by each party

for financing the system's services and benefits according to distribution criteria designed to secure a commitment to various measures aimed at improving the services offered by the SAAD. This Council is also responsible for: the agreement regarding the intensity of services, conditions and amounts of financial benefits, criteria for copayment by beneficiaries, or design of the scale for the recognition of dependency. The Territorial Council also agreed in 2021 to implement a Shock Plan with various measures to improve the SAAD, which will be described in the policy response, given its importance for improving the accessibility and quality of the System.

Law 39/2006 also establishes various **advisory bodies for institutional participation in the SAAD**, responsible for informing, advising and formulating proposals on matters of special interest for the System's functioning:

- The **SAAD Advisory Committee**: a tripartite collegiate body whose purpose is to ensure the permanent participation and collaboration of government, trade union and employer organisations in the SAAD. It acts in Plenary and in the Standing Committee. Its functions include: advising on matters related to the catalogue of services and benefit contents, compliance with the rights and duties of users, development and implementation of services and programmes, coordination and cooperation between public administrations, financing and budget execution, assessment, quality, the information system and regulatory development.

- The **State Council for Older People**: created in 1994 and regulated by Royal Decree 117/2005, of 4 February (BOE of 5 February 2005; correction of errors on 11 March 2005), is an inter-ministerial collegiate body, of an advisory and consultative nature to the AGE, attached to the Ministry of Social Rights, Consumer Affairs and 2030 Agenda, which guarantees the participation and collaboration of older people in the definition, application and monitoring of care, social inclusion and quality of life policies aimed at this sector of the population in the field of competences attributed to the AGE. Its general functions are: to channel the initiatives and demands of older people towards the AGE and to advise and inform on the consultations formulated by the Ministerial Departments and Institutions on matters affecting the conditions and quality of life of the older adult population.

- The **National Council on Disability**: created in 2004 and attached to the Ministry of Social Rights, Consumer Affairs and 2030 Agenda, comprising organisations representing people with disabilities and their families and the AGE. The purpose of this Council is to ensure that people with disabilities and their families can participate in the creation and planning of public policies that affect them.

- The **State Council of Non-Governmental Organisations of Social Action**: created in 1999, is a collegiate, inter-institutional and consultative body, conceived as a forum for meeting, dialogue, participation and advice on public policies of social services. Its main purpose is to promote the participation and collaboration of the associative movement in the development of social action policies within the scope of competences attributed to the Ministry of Social Rights, Consumer Affairs and 2030 Agenda.

This **collaboration and consensus** between the various stakeholders have also been sought in the drafting of the *Accreditation and Quality Agreement*, agreed by the Territorial Council with the aim of establishing **common criteria for accreditation to ensure the quality of centres and**

services of the SAAD. Accordingly, its drafting takes into account the contributions made at the Social Dialogue Round Table, in addition to those made by civil society organisations, scientific societies and professional bodies, in a **participatory process** promoted by the Secretariat of State for Social Rights.

This **participatory process** has also played a fundamental role in developing the *State Strategy for a New Community-Based Care Model: a process of deinstitutionalisation (2024-2030),* promoted by the Ministry of Social Rights, Consumer Affairs and 2030 Agenda. This Strategy is a commitment to transforming the support and care system so that everyone can pursue their chosen life projects and be fully included in society, contributing to their communities and enjoying their fundamental rights. It is the result of an **important process of reflection, dialogue, participation and consensus**, in which approximately 12,332 people took part. Different methods of participation have been used and consultations have been made with different departments of the AGE, the autonomous communities, local authorities, tertiary sector organisations, national and international experts and citizens in general, paying special attention to the participation and opinion of experts through experience.

This document for *Implementation of the European Care Strategy*, following the path of the State Strategy for a new care model, has also opted for a **participatory method** involving the main ministerial departments with competences in the field of LTC and carers and the councils of the autonomous communities, in the design and implementation of policies aimed at older people and people with disabilities who require support and care.

3.3.1.3 A shared information system and evidence-based policies

Information and monitoring of long-term care in Spain is articulated by the **SAAD Information System (SISAAD)**, for which the central government is responsible. The SISAAD is regulated by Order SSI/2371/2013, of 17 December, with the aim of ensuring better availability of information and reciprocal communication between public administrations. It also seeks to facilitate the compatibility and exchange of information for better management, exploitation and transparency of the data it contains.

The regulations include the minimum data to be shared by the autonomous communities, and the Law also specifies the analyses to be conducted and statistics to be prepared using all of the system's information, in the interest of the central and regional administrations, and of the commitments derived from international supranational organisations.

The SISAAD is available to all the autonomous communities so that they can, if they wish, manage their files and generate the statistics of the dependency care system. Regardless of whether or not the autonomous communities manage their files through the SISAAD, they are all obliged to report certain consolidation and control data at different stages of the file.

The SISAAD has important **quantitative and qualitative benefits**. Among the former, we would highlight: the capacity to manage and process thousands of files online; a single global management system for the entire process of recognition of dependency status; centralised management of the Network of Services throughout the country; immediate availability of management reports based on geographical distribution; monitoring of information through

online and automatic processes, using consolidated and updated information; and the reduction of paper use in processing applications.

Similarly, we must highlight some of the qualitative benefits derived from using the shared information system, such as: it offers a robust solution that guarantees stability in its use and management; it helps to anticipate organisational and management problems in general; it reduces costs by making a single application available to all autonomous communities; it facilitates management control and operational efficiency by using consolidated information; it offers process homogeneity, by facilitating management language between the autonomous communities, and the exchange of information between and within each autonomous community; plus it is available in all the official languages of Spain.

The Imserso **publishes monthly national data and data broken down** by autonomous communities showing the evolution of the SAAD[34].

Monitoring and evaluation of Spain's response to the EU Council's recommendation on access to high-quality and affordable LTC presented here will be based on data of the SAAD, but additionally will be linked to the monitoring and evaluation process of the *State Strategy for a new community-based care model,* due to the nature and purpose of the two processes, which share many of the same measures and objectives. Monitoring of the Strategy foresees annual progress reports that set out the information provided by the public administrations regarding the level of implementation of the different measures contained in their Operational Plan. An evaluation process for the Strategy has also been designed, which includes two mid-term evaluations, in 2026 and 2028, and a final evaluation in 2030.

3.3.1.4 Gathering lessons learned and successful practices

To enrich the design of Spain's care policy, **20 projects** of civil society organisations with extensive experience in tackling complex social challenges were funded, with the aim of **achieving the deinstitutionalisation of various groups through social innovation processes**. The purpose was to identify successful experiences that could later be scaled up and serve as evidence for designing broader actions aimed at deinstitutionalisation and improving care.

In all of them, the goal to pursue was a transition from an "institutionalised" care model to another one based on a human rights framework, from a community development approach and centred on each person's life project. These projects were funded under component 22 of the "Shock Plan for the care economy and strengthening of inclusion policies" forming part of the Spanish Government's Recovery, Transformation and Resilience Plan[35].

[34] *A detailed description of the SAAD information system and access to all the statistics can be found at: https://imserso.es/autonomia-personal-dependencia/sistema-autonomia-atencion-dependencia-saad/el-saad/sistema-informacion-sistema-autonomia-atencion-dependencia-sisaad*

[35] Recovery, transformation and resilience plan, lever VIII, referred to as "New care economy and employment policies" Component 22, Shock Plan for the care economy and strengthening of equality and inclusion policies. https://planderecuperacion.gob.es/politicas-y-componentes.

Accompanying the projects and also as part of the Strategy, the **VIDAS Platform**[36] was developed, constituting an innovation ecosystem with members of pilot projects and other social actors to share a collective learning process for the creation of a new model of care and services integrated in the community and centred on the person.

3.3.1.5 Forecasting of care needs integrated into planning

To adequately forecast needs, it is **essential to have information tools** that provide us with data regarding both possible recipients of care and the services and resources available, so we can guarantee coverage of the population's needs.

The information provided by the INE is crucially important in this respect, as it makes **population projections** that help to forecast the increase in Spain's older population in coming decades and, therefore, the approximate proportion of people who may require care and support in the future. Thanks to these projections, the administrations can plan actions and adopt measures that allow us to assess and design a response to face future challenges.

The *SAAD Information System*, as described above, is also very useful in providing **detailed data on all the services and benefits of the System** provided by the autonomous communities. In addition to the reports produced by each autonomous community, the Imserso is responsible for aggregating all the national data and producing periodic and evolution reports that monitor the System's functioning. All this data is publicly accessible and the reports are available on the Imserso website.

On a separate note, it is worth mentioning the recent *Census of residential centres for older people and people with disabilities*, both public and private, which has made it possible to **assess the system's current capacity** and to establish a starting point on which to **base planning**, taking into account the care model we wish to implement and the country's population projections.

Other important developments on which to build in the future include that, from 2021 to 2023, Spain has participated in the *InCare Project*, funded by the European Commission's EaSI call, which addresses the **inclusive support of community-based long-term care services through participatory approaches**. As part of this project, a **predictive model with different scenarios of care needs** was developed[37]. More specifically, the main objectives of this work were to estimate the current costs of LTC in Spain, to project the future costs of care in 2036, based on projected demographic change, and to estimate the resources that would be needed. Providing better care and support based on policy scenarios developed through stakeholder engagement formed part of the project. This analysis was conducted from a social perspective, intended to include all costs of care, including those related to unpaid care provided by family and others, publicly funded care, and private spending on care services.

[36] VIDAS platform. https://plataformavidas.gob.es/

[37] Supporting Inclusive development of community-based long-term CARE services through multi-stakeholder participatory approaches (InCare) project. https://imserso.es/en/el-imserso/relaciones-internacionales/union-europea/actividades/programas-cofinanciados-union-europea/proyecto-incare#:~:text=El%20proyecto%20InCARE%20agrupa%20a%20instituciones%20p%

3.3.1.6 Contingency analysis to ensure continuity of care

In Spain, care for dependency and the promotion of autonomy is one of the pillars of the welfare state and enjoys a social and political consensus that ensures its continuity. However, there are social or economic circumstances that may compromise to some extent the provision of services with the necessary coverage and quality. The COVID-19 pandemic highlighted the need to establish systems to analyse contingencies and ensure continuity of care.

In November 2020, following the COVID-19 pandemic, a **group was formed within the Delegate Committee** of the Territorial Council of the SAAD to set up a common framework of work aimed at:

1- **Collecting evidence and lessons learned from** the different COVID-19 scenarios in residential care homes, providing us with different approaches to handling them.

2- **Compiling and analysing the contents of Contingency Plans** drawn up by the autonomous communities at the level of governance and by the residential centres regulated in article 10 of Royal Decree - Law 21/2020, of 9 June, at the level of direct preventive action.

3- Drafting **proposals for the minimum data structure** to be collected within the common tools for collecting information from residential centres, in such a way that they conform to minimum common parameters configured in accordance with international standards.

4- Finally, **compiling the methods of coordination** between the social services system and the health system in each autonomous region.

This group drew up a report establishing the need not only to have contingency plans for emergencies in all centres, but also the importance of everyone linked to the residential centre knowing and understanding the action protocols in case of different contingencies[38].

3.3.1.7 Raising social awareness regarding long-term care

In recent years, there is evidence of a **change in the way people with support needs are perceived socially** and, therefore, in the way LTC is conceived. The more institutional models, characterised by homogenised care, with rigid and restrictive routines centred on organisational needs, lack of control and choice, rupture with the person's life project and relational and community environment, and asymmetrical relationships between the persons cared-for and providing care, have proven to be highly reductionist and unsatisfactory. The need for a shift towards personalised models of care that focus on human rights, put people at the centre, respect their choices, will and preferences, and promote social participation and inclusion in the community has become even more evident during the COVID-19 pandemic, bringing to the surface the shortcomings of a system that is more service- and organisation-centred than people-centred.

[38] Final report of the working group COVID-19 and residences, 2022. https://imserso.es/en/el-imserso/mas-informacion/covid-19-servicios-sociales/informe-final-grupo-trabajo-covid-19-residencias

Aware that **a real transformation of the care system requires a real cultural change**, public administrations, along with different tertiary sector organisations and entities, have developed and continue to develop different awareness-raising initiatives aimed at both the general population and at everyone involved in LTC (users, family members, care professionals, organisations and entities, legislators, etc.).

The **change of outlook towards people with disabilities or with support needs** has motivated the adoption of different strategies and legislative initiatives, designed to ensure the full exercise of these people's rights and the removal of obstacles that prevent them from effectively participating in society. Through these awareness-raising activities, it is not only necessary for society as a whole and carers in particular to understand the effects that care systems with more restrictive and protectionist approaches can have on the personal development of these people and on the enjoyment of their rights and freedoms, but also for people with disabilities or in situations of dependency to become aware of these rights and of the different resources to which they are entitled to receive the care and support they need.

The *Accreditation and Quality Agreement* also reflects this necessary change of approach in the provision of care for dependent persons, linking the accreditation of centres and services of the SAAD to the adoption of the guiding principles of dignity and respect, personalisation and person-centred care, participation, control and choice, right to health and personal well-being, and proximity and community connections. At the same time, this Agreement emphasises the **necessary raising of awareness and training of all professionals** of these centres in person-centred support and care models, in interventions that promote the autonomy and well-being of users, and in professional practices based on ethics and rights.

Similarly, different social and health services develop **awareness-raising campaigns regarding the specific needs and dangers of stigmatising certain groups** of people in need of support and care, such as the group of people with intellectual disabilities, the group of people with neurodegenerative diseases or the group of people with mental illness.

Finally, we would point out the importance of other awareness-raising campaigns that **raise public awareness of realities** such as ageism or undesired loneliness, organised from different spheres, both professional and through platforms and social media, and aimed at different audiences (those affected, family members, professionals, society as a whole).

3.3.1.8 Ensuring adequate and sustainable funding for long-term care.

Article 32 of Law 39/2006 deals with the System's funding by the Public Administrations, stating in its first section that the financing of the System will be sufficient to guarantee compliance with the obligations corresponding to the competent public administrations and will be determined annually in the corresponding Budgets. As stated above, the AGE bears the full cost of the **minimum level** provided for in Article 9.

Additionally, Article 10 establishes that it is within the Territorial Council that the AGE and the autonomous communities agree on the Framework of Interadministrative Cooperation, to be developed through the corresponding agreements between the AGE and each autonomous community. Through these agreements, the AGE and the autonomous communities agree on the objectives, means and resources for application of the services and benefits, thereby establishing the so-called **agreed level** of funding. They also establish the criteria for determining

the intensity of protection of each of the services included in the catalogue, and the compatibility and incompatibility between them, as well as the funding corresponding to each Administration.

In addition to the two levels of funding described above, there is an **additional level** of protection, which is an optional contribution that the autonomous communities can make to improve the system in their territories. Finally, it should be noted that dependency is subject to resource conditions and that copayments can be made by users.

SAAD Funding

YEAR	Minimum level	Agreed level	(1) Additional Level + user copayments	Total
2007	82,563,029	224,608,989		307,172,018
2008	647,223,610	261,234,884		908,458,494
2009	1,214,159,534	306,961,650		1,521,121,184
2010	1,510,040,867	306,905,634		1,816,946,501
2011	1,284,421,236	306,903,064		1,591,324,300
2012	1,380,475,401	0	5,486,649,585	6,867,124,986
2013	1,216,380,619	0	5,592,028,771	6,808,409,389
2014	1,128,264,135	0	5,508,477,437	6,636,741,572
2015	1,193,202,662	0	5,960,016,121	7,153,218,783
2016	1,191,547,570	0	6,112,784,515	7,304,332,085
2017	1,228,347,476	0	6,341,976,341	7,570,323,817
2018	1,347,603,296	0	6,725,941,866	8,073,545,162
2019	1,382,221,711	0	7,224,503,080	8,606,724,791
2020	1,384,058,400	0	7,523,392,945	8,907,451,345
2021	1,685,478,862	306,961,650	7,712,206,608	9,704,647,120
2022	2,137,505,748	523,744,450	7,592,581,226	**10,253,831,424**
2023	2,442,565,600	849,823,590	Not available	

(1) Amounts according to AC certificates

Table 3. SAAD funding from 2007 to 2023

The AGE's **funding of the SAAD** has increased significantly in recent years. As can be seen in table 3 and figure 10, this contribution suffered an important blow following the economic crisis in 2011 and started to experience a sizeable increase in 2021. The funding provided by the autonomous communities has similarly experienced a significant increase. In the table shown below, it should be noted that the obligation to provide certified data on the total expenditure incurred by autonomous communities, including additional levels and copayments, is regulated in RD 1050/2013[39], meaning that prior to this date there is no available data.

[39] Royal Decree 1050/2013, of 27 December, regulating the minimum level of protection established in Law 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care for people in situations of dependency. https://www.boe.es/eli/es/rd/2013/12/27/1050/con

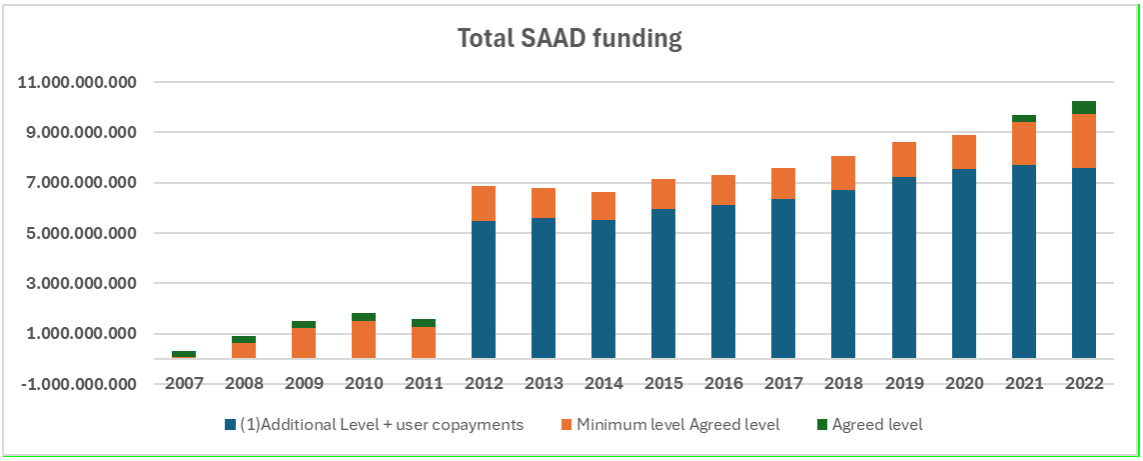

Figure 10: SAAD funding, disaggregated by minimum, agreed and additional level – copayments (2007-2022).

Long-term care has been a political and funding priority for the Spanish government for several years.

This priority intensified significantly due to the COVID-19 pandemic. The pandemic caused by the spread of the coronavirus led to a political, economic and social crisis that affected all spheres of activity on multiple levels: global, national and local. Indeed, the pandemic generated an economic shock marked by economic hibernation and the petrification of the social and productive fabric. The European Union responded swiftly to this situation by creating an unprecedented solidarity instrument, **the Next Generation Funds**, which led to Spain's approval of the "Recovery, Transformation and Resilience Plan" through the Agreement of the Council of Ministers of 27 April 2021 (PRTR)[40].

The PRTR had four cross-cutting themes: ecological transition, digital transformation, social and territorial cohesion and gender equality. These four axes were in turn concretised in ten policy levers and 30 components articulating the programme of 102 reforms and 110 investments.

More specifically, **component 22 of the PRTR** was named "Shock Plan for the care economy and strengthening of equality and inclusion policies", as part of lever policy eight "New care economy and employment policies". The main objective of this component is to modernise and strengthen social services as a whole, with special attention to the long-term care model, promoting innovation and a Person-Centred Care model.

[40] https://planderecuperacion.gob.es/

Funding of Investments and reforms of Component 22 and the project of Component 19 of the Recovery, Transformation and Resilience Plan, promoted by the Ministry of Social Rights.

Type	Concept	Euros
Reforms	Strengthening care for dependency and promoting the change in model for long-term care and support: Evaluation report of the System for Autonomy and Care for Dependency	114,818
Investments	1. Long-term care and support plan: deinstitutionalisation, equipment and technology. 2. Social Services Modernisation Plan: Technological transformation, innovation, training and reinforcement of child care 3. Spain: An Accessible Country Plan	2,083,900,000 875,100,000 181,438,480
	Digital Transformation of the Tertiary Sector for modernisation projects of the social services (2021 and 2022)	135,000,000
	New territorial projects to ensure universal accessibility to housing for older people, people with disabilities and/or people in situations of dependency	50,000,000
	Development of technological tools for social services management *Telematic tool for social services credit management* *Telematic tool for tertiary sector project analysis* *Telematic tool for actions related to children and adolescents* *Telematic tool of a State **Information** System for Social Services (SIESS)* *Telematic tool of an **Information** System for social services management (SIESS)*	2,921,600 *598,400* *475,200* *475,200* *668,800* *704,000*
Subsidies	Deinstitutionalisation pilot projects *"My home: A life in community"* *"Rumbo Project: Towards a model of inclusive and connected personal autonomy"* *"Housing Rights": The challenge of deinstitutionalising the care system for homelessness"* *"Specialised foster care pilot"* *"BIOCUIDADOS (BIOCARE): New models of care provided by the community, centred on the individual, in rural settings"* *"CRECE (GROW): promoting people's capacities, competencies and empowerment for the prevention of institutionalisation and deinstitutionalisation.*	106,941,127 *24.900,000* *10.600,000* *24.900,000* *14.200,000* *14.200,000* *18.600,000*
	Social innovation pilot projects Axis 1: Care for children at risk: Axis 2: Care for homeless people: Axis 3: Care for older people	49,570,530 *21,389,080* *12,104,173* *16,077,277*
TOTAL		**3,675,829,755**

Table 4: Funding investments and reforms of Component 22 of the Recovery, Transformation and Resilience Plan (PRTR)

Thus, the budget of the then Ministry of Social Rights and Agenda 2030 included from that moment onwards European funds for the "Care Economy" axis of the Recovery, Transformation and Resilience Plan, most to be implemented by the autonomous communities and local authorities, through investment projects among other categories of expenditure in the provision of new public facilities for long-term care based on a new architecture centred on the person and on care in community settings, and remodelling and adapting existing facilities.

Indeed, the Ministry with legally established competences in the field of Social Rights, currently the Ministry of Social Rights, Consumer Affairs and 2030 Agenda, is primarily responsible for **component 22 "Shock Plan for the Care Economy and Strengthening of Equality and Inclusion Policies".** From a financial point of view, Component 22 initially has a budget under the **Recovery and Resilience Mechanism** of EUR 3,891.85 million, of which 80 %, EUR 3,156.6 million, is managed from the aforementioned ministerial department as the decision-maker.

In order to manage the traceability of PRTR funds, these milestones and targets were organised into projects, following the methodology of the PRTR funds management system, called **CoFFEE**. The implementation of these projects is at an advanced stage and the Ministry is in the process of finalising the documentation and submitting the Summary Document of Compliance (DRC) and other documents required under the Operational Arrangements (OA) Verification Mechanism.

In autumn 2023 following the legislative elections, the coalition government between the parties PSOE and SUMAR reestablished the political commitment to long-term care as reflected in the document of the Coalition Government Agreement between PSOE and SUMAR, which establishes as a priority the strategic development of social rights, and among them, the protection of older people and the promotion of the System for Autonomy and Care for Dependency. Among the objectives of this agreement is **to continue on the path of increasing dependency funding until the** funding provided by the AGE reaches 50% of the total, while ensuring that the autonomous communities do not reduce their own investment.

3.3.2 Challenges related to governance of the care system

As mentioned in this document, the system of social services in Spain, which includes LTC, is decentralised and therefore falls under the competence of the autonomous communities. For its part, the State maintains certain competences, including those of coordination, generation of information and data systems, and the essential guarantee of fairness throughout the country. This makes the work of co-governance between the AGE and the Territorial Administrations a crucial process for the quality of services and for consistent and integrated progress throughout the country, while respecting territorial competences and particularities.

One of the current challenges for governance of the system is to design a **joint and coherent planning** with a shared and long-term strategic vision**,** fostering collaboration between the actors involved in Spain to guarantee the quality and sustainability of these services. This challenge is taken up by the Territorial Council which has to reach agreements to improve the system globally and in each of the territories.

A challenge for territorial fairness lies in the **diversity of models** among the 17 autonomous communities, given that ever since Law 39/2006, which establishes the minimum system of care and benefits, they have developed their own systems with certain differences. This can lead to a lack of equal access to services or benefits between people with the same needs and economic situation living in different regions. This co-governance is therefore key to ensure **balance and compliance between respect for the distribution of competences and the guarantee of fairness** throughout Spain, while ensuring that services are flexible, personalised, appropriate to the different characteristics of the territories, and in particular, rural populations.

One of the major challenges facing our societies, and certainly the care sector, is the significant ageing of the population. In our country this is coupled with one of the highest lifespans in the world, which, while a great success, also requires long-term planning to prepare the system for the needs of the decades ahead. To this end, a powerful **information system** is already available, but new uses need to be incorporated, to complement it with the exploitation of other available statistics, using not only past and current data analysis, but also developing predictive models that offer planning based on demographic forecasts, care needs, and possible scenarios of available economic resources and services.

In line with this point would be the need to systematically address **learning and knowledge management**, taking advantage of the great development in recent years of projects by public and private administrations and organisations of the tertiary sector. In Spain there is huge potential for social innovation and tackling complex issues such as LTC. Progress in the aggregation of information and knowledge will help to identify and scale up successful initiatives in other territories or to convert them into public policies.

And finally, it is necessary to successfully face one of the challenges that underlie the rest, which is **financial sustainability and increased resources,** essential to ensure that these services are available, accessible, community-based, appropriate for requirements, and guarantee top quality for everyone who needs them.

4 Stakeholder participation

In 2022, the State Secretariat for Social Rights of the Ministry of Social Rights, Consumer Affairs and 2030 Agenda initiated the process of drafting the ***State Strategy for a new model of community-based care: a process of deinstitutionalisation 2024-2030***. This strategy, in its vision and in its approach to action, is strongly aligned with the approach of both the European Care Strategy and the EU Council Recommendations.

The **State Strategy for a new community-based care model: a process of deinstitutionalisation 2024-2030**, is a commitment and central element of Component 22 in the Recovery, Transformation and Resilience Plan, aimed at modernising and strengthening social services and the LTC model. It is a commitment to transforming the support and care system so that everyone, especially those requiring greater support and care and/or in more complex situations, can develop their chosen life projects in the community, on an equal footing with other people, and are not forced to live according to a specific system[41].

This Strategy mainly targets people with support and care needs, especially **people with disabilities, older people in a situation of dependency, children and adolescents in the protection system, and young people who have been through the protection system and homeless people**.

The scope of this strategy required a design that would open and articulate a public and plural debate surrounding the issues it addresses, which is why the measures it proposes are the result of an ambitious process of reflection, dialogue, participation and consensus, in which a total of 12,332 people took part (43,800 participations). Different methods of participation have been used[42] and consultations have been made with the autonomous communities, different departments of the AGE, local authorities, tertiary sector organisations, national and international experts and citizens in general, paying special attention to the participation and opinion of experts through experience.

Development of the *State Strategy for a New Model of Community-Based Care: A Process of Deinstitutionalisation* (2024-2030) has been an exhaustive and participatory process that has received the valuable contribution of its **Advisory Council**. This consultative body, composed of professionals, experts, academics, and expert practitioners played a very important role by actively participating in various spaces and consultations. The heterogeneity of profiles within the Council, with representation from the four population groups targeted by the Strategy, ensured a comprehensive and balanced vision. Their contributions were fundamental to define the strategic framework and formulate the axes, lines of action and concrete measures, thus ensuring inclusion and representation of all the actors involved. The strength and legitimacy of the Strategy is underpinned by the commitment and diversity of perspectives provided by this Advisory Council.

[41] State strategy for a new community-based care model: a process of deinstitutionalisation 2024-2030 https://estrategiadesinstitucionalizacion.gob.es/.
[42] State strategy for a new community-based care model: a process of deinstitutionalisation 2024-2030 https://estrategiadesinstitucionalizacion.gob.es/conocimiento/anexos-al-diagnostico/.

To produce this document which responds to the recommendation of the Council of the European Union, a synergy of action has been established with the State Strategy for a new model of community-based care, since both seek to redesign the care policy in Spain.

To make the consultation process with Ministries and autonomous communities easier, and given that they had already proposed actions for the State Strategy for a new care model, a process of analysis took place, which managed to link the Strategy's lines with the Council's recommendations. On this basis, the proposals of the Ministries and autonomous communities linked to the Council's recommendations have been identified and sent for validation and proposal of additional actions.

5 Policy objectives and measures adopted or to be adopted

5.1 Policy response

5.1.1 Commitment to adequate, available and quality LTC

Spain is currently undergoing a profound analysis and transformation of its care model, as are all other countries of the European Union.

Spain's concern to respond to the challenge of a progressively ageing population and the increase in the number of dependent persons has been the driving force in recent decades for the adoption of different measures and regulations to ensure the full and effective exercise of the rights of these persons, regardless of their place of residence or purchasing power.

As described in the diagnosis section, since 2006, Spain has had **specific legislation**, such as *Law 39/2006*, which guarantees equal access for all persons in need of LTC to a set of comprehensive public benefits integrated in the network of the *SAAD*, with the cooperation and participation of all the public administrations, and whose quality throughout the country is guaranteed through common criteria established by the Territorial Council set up under the same Law. In this way, Spain was attempting to respond to the three criteria that in 2002 the European Union, under the Spanish presidency, identified as those that should govern the dependency policies of the Member States: universality, high quality and sustainability over time.

This law was a crucial regulatory breakthrough in the field of social rights, leading to a **mixed system of public protection** combining financial benefits and services, which has achieved very positive results for all people in need of LTC. However, its deployment has been limited by the budgetary restrictions caused by the economic crises of 2008 and 2011 and, as discussed in the diagnosis section, there are still important issues to be resolved, such as the promotion of autonomy, which has been less developed than the services aimed at situations of dependency, the reduction of waiting lists to achieve a more agile response, the reduction of user participation in the financing of services in order to improve their affordability, and the heterogeneity and flexibility of the services offered in order to adapt to the different needs, wishes and preferences of the people receiving care.

The health crisis caused by the coronavirus pandemic highlighted the enormous importance of care and the need, not only in our country, but also in all the countries that make up the European Union, for **profound changes in the LTC system**, which will enable progress to be made towards a person-centred model with a community and proximity-based approach.

This is set out in the European Commission's 2021 *European Pillar of Social Rights Action Plan*, whose postulates culminate in the publication in 2022 of the *European LTC Strategy*. It is also reflected in the *Spain 2050 Plan*: *Fundamentals and proposals for a long-term national strategy* of 2021 (4th front of the 5th challenge): "Preparing our welfare state for a longer-living society"), which proposes several measures aimed at improving the professionalisation and quality of LTC,

offering better care to carers, family members and professionals, promoting changes in the forms of care and promoting the generation of systematised knowledge related to LTC.

A strategic commitment at the national level

This **strategic approach of Spain**, with a state policy approach to prepare the social welfare system for the increase in life expectancy of the population, has been highlighted in the European region-wide Synthesis Report on the degree of compliance with the Madrid International Plan of Action on Ageing (MIPAA) and its Regional Implementation Strategy (RIS) in the period 2017-2022 (UNECE, 2022). Likewise, the issue of change in the model of LTC and deinstitutionalisation has been high on the political agenda throughout the Spanish Presidency of the European Union, exercised during the second half of 2023, leading to the approval of a document of conclusions of the Council of the European Union on the *Transition of care systems throughout life towards holistic, person-centred and community-based support models with a gender perspective*[43].

Spain's political commitment to building a new model of professional care is based on the following **essential elements**:

- Proximity care: caring for people in their home and family environments.
- Care centred on people, on protecting their dignity and supporting their life projects, which requires more flexible models that adapt to the needs, wishes and preferences of each person.
- Public leadership, with public administrations assuming responsibility for directing and guaranteeing the quality of care services, so that they are not solely subject to market criteria.
- Dignifying professional care work: this is a major challenge given that the greatest added value in services to people is provided by direct care staff, most of whom work in precarious and clearly improvable conditions.

The task is complex, but it is accompanied by an **unprecedented budgetary effort**.

In 2021, the Territorial Council approved, as part of the *SAAD Shock Plan*, an **increase in SAAD funding by the AGE**, with an increase of 600 million euros for 2021 and similar cumulative increases for the 2022 and 2023 budget years. Thus, in the period 2021-2023, funding has been increased by 1.8 billion euros, representing an increase of 130%. This has made it possible to reduce waiting lists, increase the amounts linked to the *minimum level* of protection and recover the so-called *agreed level* of funding, suspended since 2012, whose territorial distribution is carried out through the Framework of Interadministrative Cooperation and the signing of agreements with each Autonomous Community, in accordance with the fulfilment of criteria that aim to improve the SAAD by reducing waiting lists, improving the working and professional conditions of its workers and introducing improvements in services and benefits. This strong economic investment, together with the implementation of different improvement measures, has resulted in the number of people attended increasing by 28.01% in 2023, compared to 2020

[43] Conclusions on the transition of care systems throughout life towards holistic, person-centred and community-based support models with a gender perspective.
https://data.consilium.europa.eu/doc/document/ST-15421-2023-INIT/en/pdf

data, which translates into 303,654 more people attended by the System. In addition, the number of benefits and services has increased by 33.5% in the 2020-2023 period, with many people receiving more than one benefit or service.

Because of their relevance, the set of **specific measures for reducing the waiting list and simplifying administrative procedures** to enable a more agile response are specifically included in the *SAAD's Plan for the Reduction of the Waiting List*, approved in April 2021. As a result of these measures, the waiting time between the application for recognition of dependency status and its resolution has been shortened by 133 days by the end of 2023 compared to the end of 2022 and, overall, waiting lists have been reduced by 66%.

For the coming years, through the Government Agreement, the current coalition government has committed to **continue on the path of growing dependency funding**, aiming for the funding of the AGE to eventually reach 50% of the total, ensuring that the autonomous communities maintain their own investment, which is expected to continue contributing to the reduction of waiting lists and the improvement of services and benefits, such as telecare, home help, day centres and, in short, to reinforcing and consolidating innovation in public policies.

At the same time, **Spain has dedicated a specific component of the European *Next Generation* funds to LTC**, specifically to the axis "Care economy and strengthening of equality and inclusion policies" (Component 22 of the Recovery, Transformation and Resilience Plan), whose main objective is to modernise and strengthen all social services, with special attention to LTC, promoting innovation and a Person-Centred Care model. Within this framework, the first specific challenge addressed is to **strengthen dependency care policies and promote the change in the model of support and LTC**, by means of:

- Reducing barriers to participation to achieve real inclusion of all people in need of support.
- The adoption of measures that enable dependent persons to continue living at home, connected to their families, neighbours and usual community environments, with the care they require and which responds in a personalised manner to their needs and preferences, promoting dignified and fulfilling lives, as well as reducing and preventing institutionalisation and loss of autonomy. At the same time, facilities compatible with the Person-Centred Care model should be increased for those requiring out-of-home care, by funding new public facilities of a size and design appropriate to this model, or by remodelling existing ones.
- The transition from Institutional Care to Community Care, advancing the process of deinstitutionalisation and promoting the development of person-centred community services and support models within a rights-based framework.

To address all these proposals for reform and improvement of the SAAD, as envisaged in the aforementioned *SAAD Shock Plan*, 53.54% of the funds of Component 22 (2083.9 million euros) are earmarked for **investment in a "Plan for support and long-term care: deinstitutionalisation, equipment and technology (C22.I1)"**. This line of investment has taken the form of **six actions**:

- Carrying out a **comprehensive evaluation of the SAAD**, to better understand its reality and territorial differences and identify needs for improvement, the results of which were published in September 2022 and revealed the need to address certain reforms.

  One of the actions resulting from the conclusions and recommendations of this evaluation, intended to improve the benefits of the system and achieve more personalised care by making these benefits more flexible and combinable, was the **reform in 2023 of Royal Decree 1051/2013 regulating the benefits of the SAAD**

established in Law 39/2006 (Royal Decree 675/2023). This historic agreement, included as one of the points of the *SAAD Shock Plan*, has enabled both the intensity of hours of the home help service and the amounts of the economic benefits of the SAAD to reach historic highs, with an increase of 17.35% in the economic benefits for care in the family environment and 4.5% in service-linked benefits and financial benefits for Personal Assistance. Minimum amounts are also established for each grade and financial benefit, so as to ensure that these benefits are not excessively reduced when applying the reductions provided for in the regulations of each Autonomous Community. It also considers the provision of telecare as a complementary service to the rest of the benefits and modifies the requirements and conditions for access to the financial benefit for care in the family environment and support for non-professional carers, so that, on the one hand, the requirement of kinship and accreditation of previous care is eliminated and the emphasis is placed on the suitability, availability and viability of the non-professional carers, so that such care can be provided by other people in the dependent person's environment who meet these requirements, and, on the other hand, benefits for care in the family environment that include a domestic support service for the dependent person are now considered services, so that carers can receive relief.

With regard to the aforementioned **figure of the Personal Assistant**, its definition and the common framework of specific conditions for access have been established by the Territorial Council in its Agreement of 12 May 2023 (Resolution of 24 May 2023 of the Secretary of State for Social Rights), considering this figure as one of the services with the greatest impact on the personal autonomy and independent living projects of people with support needs, within the framework of the current redesign of the care model and our country's commitment to deinstitutionalisation.

Another consequence of the SAAD evaluation has been to highlight the need to **reform Law 39/2006**, with both the new coalition government's Government Agreement and the objectives and lines of action of the Imserso for 2024 including a firm commitment to carry out this review. The aim is to **bring the Law into** line with the International Convention on the **Rights of Persons with Disabilities** and to introduce **measures to ensure that benefits of the SAAD are tailored to the circumstances, preferences and wishes of each dependent person**, so that **person-centred care** is provided. Some of the possible measures being evaluated are: elimination of the system of incompatibilities of benefits and services, elimination of the exceptional nature of the financial benefit for care in the family environment and support for non-professional carers, inclusion of people in the relational environment as carers, recognition of the telecare service as a subjective right, development of services and benefits to encourage the person with support needs staying in their community environment, or promotion of assistive products for personal autonomy.

- Development of the **"State strategy for a new community-based care model: a process of deinstitutionalisation (2024-2030)",** a central element of component 22 and an important Spanish commitment, as a roadmap for achieving a profound transformation of the support and care system, so that everyone can develop their chosen life projects, be fully included in society, contributing to their communities, and enjoy their fundamental rights. This Strategy, with a cross-cutting and intersectional approach that has generated an unprecedented participatory process and social debate, is aimed

primarily at people with support needs (people with disabilities, dependent older people, children and adolescents in the protection system and homeless people), and also at their families and professional carers. The content of the Strategy is structured around five strategic axes (Prevention of institutionalisation dynamics; Self-determination, community development and cultural change; Transformation of care models; Development of support and services for the transition and consolidation of a good life in community; Enabling conditions for deinstitutionalisation), 16 objectives and 50 lines of action that guide its implementation.

In this way, the Strategy has a preventive orientation, which implies working, on the one hand, on universal and structural factors such as housing, accessibility, guaranteed income or health and, on the other hand, factors aimed at developing agile and flexible responses to support people at risk of initiating processes of institutionalisation.

The Strategy also proposes to promote self-determination of people receiving support, develop good inclusive communities, and cultural change in citizenship.

It also proposes to transform the current models of support and care, both in terms of the intervention methodology, which must be person-centred, and in the transformation of professional practice, by improving working conditions for those working in the sector, eliminating the gender gap, activating monitoring and quality and evaluation mechanisms, and strengthening social innovation processes.

Finally, the cornerstone of the Strategy is the development of supports and services for the transition and consolidation of a good life in the community, which implies promoting new services and supports so that people can live according to their will and preferences in the community, all accompanied by the strengthening of interinstitutional coordination and between the different agents providing services, both public and private, and the Social Action Tertiary Sector.

This Strategy was approved by the Council of Ministers on 11 June 2024 and has an initial allocation of €1,323,471,810, primarily sourced from European Structural and Investment Funds (European Social Fund Plus -ESF+) and the funds from the Recovery, Transformation and Resilience Plan. This amount will be supplementing during the implementation of the Estrategy through the Operational Plans.

To ensure full implementation of this Strategy leading to a real transformation of the care model, it will be accompanied by a **major budgetary and funding effort**, as well as a **transformation of working conditions in the sector**.

Also linked to this *State Strategy for a new community-based care model* and included as an activity to be carried out in Component 22, is the implementation of **awareness-raising and dissemination campaigns** in various media, designed to make the general population **aware of the importance of this change of model**, and to make dependent persons and their families more aware of their rights and of the alternatives to the institutional and welfare model. These campaigns should also help to **enhance the social value of care work**, which is so necessary for society.

- Funding of several **pilot projects in deinstitutionalisation and prevention of institutionalisation processes**, aimed at demonstrating how new policies work and using them as upscalable learning experiences that contribute to developing the *State Strategy for a new model of community-based care*.

In addition to these pilot projects, this investment has also included a **research study on deinstitutionalisation processes and the transition towards personalised and community-based support models in Spain (EDI Project)**, which examines risk factors, good practices, recommendations and also considers the ethical, legal and financial framework required for the sustainable development of this transition from welfare models to personalised and community-based models.

- Funding for the **construction and remodelling of** residential **facilities** adapted to the Person-Centred Care model, new day centres and technology at the service of LTC, through the introduction of domestic equipment that favours the promotion of personal autonomy, through the use of advanced telecare, and any other technological resource that allows support and care to be provided in connected homes and inclusive care environments, also in the rural setting. All of this through the distribution of funds among specific investment projects presented by the autonomous communities, ensuring that they contribute to these objectives and guaranteeing an appropriate territorial distribution that helps to meet the demographic challenge.

Also noteworthy among the investments included in Component 22 are those aimed at modernising social services (C22.I2) and improving accessibility from a comprehensive perspective (C22.I3).

Regarding the former, the **"Social Services Modernisation Plan: technological transformation, innovation, training and strengthening of childcare (C22.I2)",** with a budget of 875.1 million euros, considers the necessary technological transformation, innovation, improved training of professionals and strengthening of childcare. Of particular note are the actions aimed at:

- Implementing **comprehensive programmes for the introduction of new technologies** in social services attention, to improve both its efficiency (shorter waiting times) and quality (better results of social interventions).
- Developing and implementing **specific technological tools** for the improvement of information systems and management of social services.
- Funding **pilot projects** that promote the reorientation of public policies towards innovative models that implement **normalising and people-centred care models**, and also ensure the delivery of social services in areas of low density or demographic decline, where assistance and ensuring universal access is increasingly complex.

  The funding of these pilot projects along with those projects already mentioned in the *Long-term Care and Support Plan (C22.I1)* represents a **historic investment in social innovation in Spain**. A total of 20 projects have been funded, consolidated in the VIDAS Platform (Innovative Pathways for Deinstitutionalisation through Learning in Society), which is run in a collaborative and coordinated manner and generates spaces for innovation and research common to all 20 projects, to ensure shared learning and the transfer of lessons to new public policies throughout the process. This investment amounts to a total of 156 million euros and involves 137 tertiary sector organisations, as well as local and autonomous community administrations, and is providing solid evidence for the change in model, which will enable the development of alternative solutions to institutionalisation and promote deinstitutionalisation.
  Both these pilot projects and the EDI Project mentioned above have been and continue to be key to generating evidence that can be incorporated and tested in the design and

development of the State Strategy for a new model of community-based care: a process of deinstitutionalisation (2024-2030).

- Design and develop a **training programme** aimed at the technical staff of the Public System of Social Services and the staff involved in the change of the support and LTC model (residential services, home help, personal assistance and telecare), training them in the principles of this new model, in the ethical practice of care, dignifying and valuing these essential professions.
- Invest in various aspects that favour the **refurbishing the equipment of centres for children and adolescents to adapt them to the Person-Centred Care model** (first reception and assessment centres, macro-centres and flats for children formerly in care).

In relation to the **"II National Plan for Universal Accessibility. *Spain: An Accessible Country*** (**C22.I3)",** it has funding of 197.6 million euros, and is directed at improving accessibility from a comprehensive perspective, with investments related to adapting physical spaces, developing accessible materials, adapting digital environments and web pages, promoting research and technology along with measures to guarantee accessibility without gaps between urban and rural areas. This Plan addresses strategic issues that are designed to protect people who are in a particularly vulnerable situation and tackles different areas in line with the Spanish Disability Strategy, such as the reality of people with high support needs, the gender perspective, the different stages of life, with special interest in children and older people, and the specific needs of people living in rural areas. In this way, Spain fulfils the mandates of the International Convention on the Rights of Persons with Disabilities and becomes a **pioneering country in this area**, with the aim of creating a more social, inclusive and accessible Europe. Its actions include the creation in 2023 of the **Spanish Centre for Cognitive Accessibility**, whose objective is to promote and foster everything related to cognitive accessibility in Spain, to eliminate barriers that prevent the full participation of all people under equal conditions.

Another milestone of the *SAAD Shock Plan* was the approval in June 2022 of the **Agreement on Common Criteria for the Accreditation and Quality of the centres and services of the SAAD** (hereinafter the "Accreditation and Quality Agreement"), which replaces the previous agreement adopted in 2008 to adapt to the current situation and establish common minimum standards that not only guarantee the quality of services received by people in situations of dependency but also underpin the rights of users under Article 4 of LAW 39/2006. At the same time, this Agreement underscores the importance of quality employment, among other measures, by improving direct care staff ratios, establishing qualification requirements, developing training plans oriented towards care and support in the community based on people's rights, and improving the employment conditions and occupational health of care staff. Finally, it promotes the creation of a permanent technical presentation of the evaluation and quality of the SAAD, based more on the results for individuals than on procedures alone, and establishes the system of competences with the different Public Administrations and funding conditions.

In this way, in addition to accreditation criteria common to all services (guarantee of non-discriminated access to centres and services, care free of restraints and common minimum documentary requirements), specific requirements are established for the different services: residential care, day centres, home help and telecare service.

The guiding principles of the new care model established by this Agreement are: dignity and respect; personalisation and person-centred care; participation, control and choice; the right to health and personal well-being; and proximity and community connections.

For certain, this Agreement, outcome of a wide-ranging debate and contributions from all sectors involved in LTC and support from the worlds of both disability and older people, represents a **very important step in the design of the roadmap for an unquestionable process of transformation of the LTC model** that we have been facing for years in Spain and in most European countries. In this way, the path towards a model that recognises the uniqueness of each individual and places them at the centre of their care process is continued and promoted, outlining a very clear vision of what services and benefits should be like for people with support needs on a day-to-day basis, and moving towards a rights-based intervention model, of personalised support, free of restraints and coercion, with better home and proximity services, and with smaller scale residential centres with homely environments and, above all, with a model of equal relationship between people who need support and those who work to provide it. Not forgetting to improve quality employment in this sector, with higher ratios of direct care staff, better working conditions and more training and professional qualifications, in addition to greater social and health coordination, so that support and care have a truly holistic approach.

Regulatory change to advance rights

All the aforementioned transformative measures of *Component 22 "Shock Plan for the care economy and strengthening of inclusion policies",* combined with those established and derived from the *SAAD Shock Plan*, have meant and continue to constitute a **strong boost to the care economy** and demonstrate the **profound cultural change** that is taking place in our country in the way of conceiving LTC and of understanding and addressing disability, promoting the autonomy and self-determination of these people and avoiding situations of abuse. This **new rights-based, community-based approach** is reflected in the **reform and development of different regulations**, such as:

- **Law 8/2021, of 2 June, which reforms civil and procedural legislation to support persons with disabilities in the exercise of their legal capacity**: through this law, Spain eliminates historical discrimination towards persons with disabilities and brings its legal system into line with the International Convention on the Rights of Persons with Disabilities of New York of 13 December 2006 (ratified by our country in 2007). With its entry into force on 3 September 2021, it recognises that people with disabilities have legal capacity, on equal terms with other people, in all aspects of their lives and, therefore, the right to self-determination, providing them with the support they need to make decisions based on their will, wishes and preferences, which must prevail and direct the actions of the people who provide them with such support. Thus, "judicial incapacitation", which was previously adopted as a measure of protection for people with disabilities of different causes (intellectual disability, people with dementia or other neurodegenerative diseases, people with severe mental disorders), disappears from our legal system, and a new system is introduced based on respect for the rights, will and preferences of the person with disability, regulating support measures to guarantee them that are proportionate and adapted to the circumstances.

- **Instruction 1/2022, of 19 January, of the Public Prosecutor's Office, on the use of mechanical or pharmacological restraints in psychiatric or mental health units and**

residential and/or social-health centres for older people and/or people with disabilities: This is another milestone in the ethical practice of care and respect for the dignity and rights of people who require support, through which the Public Prosecutor's Office will ensure that the inappropriate or abusive use of physical and/or pharmacological restraints is avoided, limiting their use to exceptional situations, when no other method of prevention has worked or in cases of imminent and serious risk for the person or for third parties, and always under medical prescription. The Public Prosecutor's Office invites us to reflect on the use of restraint as the only way to achieve the objective of control, protection and safety of these people and promotes the search for alternatives that are more respectful of the dignity and uniqueness of each individual and their health.

This restraint-free care approach is also contained in the aforementioned *Accreditation and Quality Agreement* (28/06/2022), which establishes that all persons cared for under the SAAD are entitled to receive restraint-free care, in recognition of their dignity and promotion of their autonomy, and all residential care centres and day centres are urged to have an official commitment to care that is free of restraints and coercion and to offer their direct care staff the necessary training in this regard.

- **Spain's Disability Strategy 2022-2030 ensuring that persons with disabilities can access, exercise and enjoy their human rights** (approved by the Council of Ministers on 3 May 2022): conceived as an ambitious and enabling roadmap for the Spanish State to contribute, through its public administrations and authorities, to making the human rights of persons with disabilities and of their families effective, in accordance with the provisions of the United Nations International Convention on the Rights of Persons with Disabilities and the framework established by the European Union. In this way, inclusion, full participation and the rights of persons with disabilities become state policy translated into measures for the promotion of autonomy, independent living and rebuilding an inclusive society for everyone, eradicating all forms of discrimination on the grounds of disability. This strategy is the outcome of a broad participatory process and has a cross-sectoral approach, with a focus on providing solutions to challenges such as care for people with disabilities, living in rural or depopulated areas, people with high support needs or people with psychosocial disabilities. This Strategy sets out seven strategic challenges with specific objectives and operational plans in areas such as accessibility, culture, education, health and women and girls with disabilities. To achieve the Strategy's objectives, **funding for policies aimed at this end has been increased by 468%** over the last four years, amounting to a total of 293 million euros.

- **Royal Decree 888/2022, of 18 October, establishing the procedure for the recognition, declaration and qualification of the degree of disability**: This Royal Decree amends the 1999 Decree and implies the abandonment of the traditional merely biological approach prevailing until then, to adopt the biopsychosocial model of the International Classification of Functioning, Disability and Health (ICF), proposed by the International Convention on the Rights of Persons with Disabilities of 2006. Disability is thus approached from a human rights perspective, with a more global and holistic vision that takes into account the psychosocial problems and difficulties in participation that these people encounter, and not only their impairments. The person and their needs are placed at the centre of the process, procedures are streamlined and made more flexible

through the use of telematic means to ensure the universal accessibility of the whole process, an emergency procedure is established for people in vulnerable situations, the right of minors or people with a high degree of disability to be heard and to participate in the decision-making process is guaranteed, and the assessment is adapted to the new realities of people with disabilities. Regarding the scales used in this assessment, **Order DSA/934/2023, of 19 July, modifies the scales of RD 888/2022**, so that they correspond to those agreed by the Plenary of the Territorial Council, taking as a reference the aforementioned biopsychosocial model proposed by the ICF.

- **Reform of Article 49 of the Spanish Constitution, of 15 February 2024**, approved in an extraordinary plenary session of the Spanish Parliament on 25 January 2024 to bring it into line with social reality and with the New York Convention on the Rights of Persons with Disabilities (2006), ratified by Spain in 2007. This amendment is the first of a social nature in our Magna Carta and responds to a long-standing demand from groups of people with disabilities. It includes both the language used and its structure and content. Regarding language, the term "physically, sensory and mentally handicapped" is replaced by "persons with disabilities", in order to guarantee the inherent dignity of these people. The article's structure is also reformed in line with the multiplication of approaches to disability, reflecting in each of its four precepts a different dimension of the protection of persons with disabilities. Finally, the content of the article is modified to adapt it to current conceptions of the protection of persons with disabilities, abandoning the medical-rehabilitative conception of the original wording in favour of the human rights paradigm that emerged from the Convention. In this way, emphasis is placed on the rights and duties of persons with disabilities as free and equal citizens. It also establishes the objectives that should guide the positive action of the public authorities, such as full personal autonomy of these persons, respect for their freedom of choice and individual preferences, and their social inclusion. It includes the participation of this group's representative organisations to develop these public policies and expressly refers to specific attention to the needs of women and girls with disabilities due to their situation of special vulnerability. This amendment to the constitutional text is a sign and starting point of the transformative equality that guides our country's policies and a driving force for change and development of new measures and future legislative amendments in different areas.

- **Amendment of the General Law on the Rights of Persons with Disabilities**: the Ministry of Social Rights, Consumer Affairs and 2030 Agenda is committed to amending this law to guarantee the provision of support to persons with disabilities, promoting their autonomy and self-determination, and to adequately reflect the obligation of the public authorities to promote policies that guarantee the full personal autonomy and social inclusion of persons with disabilities in universally accessible environments.

Promoting well-being and inclusive societies

In this transition from institutional care to community and person-centred care, which underpins Spain's political commitment, **important efforts** are being made in our country **aimed at preventing dependency and promoting more inclusive, fair, safe, healthy and accessible physical and social environments and cities**, which facilitate the **effective participation** of all citizens, regardless of their age or disability, in the different areas of their lives (social, economic, cultural and leisure, political, etc.), which offer **spaces for empowerment** and prevent exclusion, and which **reduce the perception of loneliness**, including in rural or more isolated environments, where these problems may be exacerbated.

In this regard, it is worth noting the role played since 2011 by the Instituto de Mayores y Servicios Sociales (Imserso - Institute for Older Persons and Social Services), through its collaboration agreement with the World Health Organisation (WHO), in coordinating and promoting the **Network of Age-Friendly Cities and Communities in Spain**, disseminating, training and advising to facilitate the our country's city councils' adhesion to the Network and the exchange of knowledge and experiences in age-friendly processes. There are currently 255 local councils that are members of the network, working to **improve the accessibility and social participation** of older persons and to **facilitate healthy and active ageing**. An age-friendly city is one in which policies, services and structures related to the physical and social environment are designed and reorganised to support and enable older people to live in dignity, enjoy good health and quality of life, and continue to participate fully and actively in society. The WHO strongly encourages the growth and development of this Network within the framework of the Decade of Healthy Ageing (2021-2030) and the 2030 Agenda, because of its relevance in **overcoming ageism** and **improving the quality of life of older people**.

The Network of Age-Friendly Cities and Communities is strongly linked to this implementation of the European Care Strategy, the aforementioned State Strategy for a new community-based care model, and the **State Strategic Framework against Loneliness,** soon to be published by the Ministry of Social Rights, Consumer Affairs and 2030 Agenda. This framework, which will come to light in 2025, with a cross-cutting approach, aims to serve as a reference in tackling loneliness across all age groups, coordinating actions and promoting recognition of this social problem. It includes a preventive perspective and incorporates elements for early detection and to raise awareness of this issue among the whole of society, and to intervene from a community approach, based on the building and interrelation of support networks. The WHO considers loneliness to be one of the greatest threats to the deterioration of people's health and a determining factor that favours their entering situations of risk or dependency; hence the special interest of Spain's government to implement the necessary measures to prevent this problem and improve the well-being of people who feel lonely. The Strategic Framework envisages medium and long-term actions, linked to the 2030 Agenda for Sustainable Development and the WHO Decade for Healthy Ageing, with a time scope from 2025 to 2030. An **Operational Plan against Loneliness 2024-2026**, developed by Imserso, is also being designed, with concrete measures in the short and medium term.

At the same time, the Ministry of Health, in coordination with the Autonomous Communities, is also developing actions to identify older people, especially those living alone, with **mental health**

problems in order to address this reality in a comprehensive and multidisciplinary manner, as well as to **prevent suicidal behaviour**. These measures are included in the **Mental Health Action Plan 2022-2024**, which is articulated around 6 strategic lines to respond to the mental health problems of the population and, in particular, to address the impact that the pandemic has had on the mental health of the general population and on certain specific groups in particular, because they are in more vulnerable situations, such as older people, or because of their essential role in health care during the pandemic, such as health professionals. This Action Plan, in addition to the Mental Health Strategy in which it is framed, are an example of the **priority that our National Health System gives to mental health**.

Both the *Network of Age-Friendly Cities and Communities* and the *State Strategic Framework against Loneliness* play a key role in **promoting active and healthy ageing** and **preventing dependency**, and in **promoting the well-being** of all persons in need of support. **Other actions** in this regard include:

- Actions carried out within the framework of the **Prevention and Health Promotion Strategy of the Spanish National Health System (NHS)**: initiative developed within the framework of the implementation plan of the *Strategy for Addressing Chronicity in the NHS* for the progressive development of interventions aimed at gaining health and preventing illness, injury and disability. In the context of this Strategy, the Ministry of Health will coordinate, during the period 2024/2025 and with a budget of € 72,600, the **Stratification of the population of the National Health System project,** with a dual objective: to develop a population stratification tool at different levels, defined on the basis of social-health variables, and a risk prediction model for application to specific populations. This measure is expected to improve the identification of each patient's level of need and thus facilitate the provision of specific interventions appropriate to each need. The objectives of the *Prevention and Health Promotion Strategy of the NHS* include the promotion of active and healthy ageing in the population aged 50 plus or the prevention of functional deterioration and promotion of health and emotional well-being in the population aged 70 plus, enhancing the coordination of comprehensive interventions in the health, social services and community spheres.

  In line with these actions, the Ministry of Health also intends to **update the consensus document on the prevention of frailty in the older person**, which proposes actions for the prevention, early diagnosis and management of frailty in order to achieve a better quality of life for older people. At the same time, an investment of € 806,500 is planned for this year to implement **health promotion campaigns focused on vulnerable groups**, such as older people, with particular attention to undesired loneliness and to improving accessibility to the health system in the event of mental health problems.

  With the intention of **improving coordination**, the Ministry of Health is also studying the possibility of financing a project that would help to make progress on recording social and family context-related conditioning factors in the Digital Medical Record, so that people with health and social vulnerabilities can be identified in real time, and integrated management models, process optimisation and improved coordination can be implemented between levels of care, social and health care and social care.

- **Agreement of the Territorial Council establishing the road map for the improvement of early childhood intervention in Spain, based on a common framework of universality, public responsibility, equity, gratuity and quality** (Resolution of 28 June 2023 by the Secretariat of State for Social Rights). To guarantee this right to early childhood care, the Agreement establishes the creation of a universal, publicly responsible and free Early Childhood Care Network, which adapts to and respects the diverse realities and competencies of the territories, within a framework of dialogue and cooperation between the General State Administration and the autonomous communities. This Network will make linging easier based on common criteria, of the health, education, or social services systems, which must work in coordination and coordinate with the other professionals involved in the case, according to the needs that arise and in relation to the corresponding early childhood care teams.

- **Imserso's Healthy and Active Ageing Programmes**: such as the Social Tourism Programme (aimed at people over 55 to improve their quality of life by participating in trips and tourist activities and with a budget for the 2023/2024 season of € 71,689,730), the Social Thermalism Programme (aimed at older persons who require recuperative treatments in established thermal establishments and with a budget for the year 2024 of € 35,869,660) and the alternative programmes to institutionalisation, such as the Basic Home Telecare Programme and the Basic Home Help Programme (to promote autonomy and encourage residents of the Autonomous Cities of Ceuta and Melilla to remain in their own homes), whose competences have been delegated to these autonomous cities since 2018, but whose cost is fully financed by the Imserso, in accordance with the budget allocation established for each year (for the budget year 2023, the Imserso contributed a total amount of € 1,079,480 for home help and home telecare services in the City of Ceuta, with this amount being € 823,480 for payment of these services in the City of Melilla for the budget year 2024).

- **Promotion of tourism and thermalism activities for people with disabilities**, through the granting of subsidies, subject to the Imserso's general subsidy system, to non-governmental organisations in the disability sector operating in Spain (regulated in Order TAS/980/2007, of 2 April). The objective of the subsidies for tourism activities is the personal and social integration of people with disabilities, giving them the opportunity to participate in trips to get to know places other than their usual environment, to interact and live with other people, to access leisure, nature and cultural offers in the territory of the State. The programme also facilitates respite for family carers. Subsidies for thermalism actions are aimed at promoting the health of people with disabilities by offering them thermal treatments in spas. Subsidies for tourism and thermalism are awarded annually on a competitive basis, with a total of € 3,514,830 having been earmarked for the 2023 call for proposals.

- Cooperation with the **State Council of Older Persons**: a collegiate advisory and consultative body of the AGE, designed to institutionalise collaboration and participation of older persons in the definition, application and monitoring of care, social inclusion and quality of life policies aimed at this sector of the population within the sphere of competence of the AGE. In the development of its functions, it participates in the

preparation and development of services corresponding to dependency situations and the different state plans related to older people.

- **Network of Imserso Centres**: this network serves as the frame for the collaborative work carried out by the Ministry of Social Rights, Consumer Affairs and 2030 Agenda to promote innovation in social interventions for persons with disabilities and/or older persons. The Network includes different types of centres. **Care centres for people with physical disabilities**, which care for people with severe physical disabilities who require the help of others to carry out basic activities of daily living. **Recovery centres for people with physical disabilities**, which offer people of working age with physical and/or sensory disabilities all those measures that can facilitate their personal and professional recovery and their integration into the labour market. Finally, **state reference centres,** which are designed to innovate and improve the quality of the resources aimed at a specific sector of dependent persons. These state reference centres are part of the network of the SAAD and, in addition to offering in some cases highly specialised prevention and direct care programmes designed to develop innovative experiences or good practices in the implementation or improvement of care services for older people and/or people with disabilities at risk of or in a situation of dependency, they are also **specialised knowledge management centres**, for promoting, developing and disseminating data, information and knowledge on a given subject or sector of dependent persons. These centres have a responsibility as drivers of change through social innovation, research and management of the knowledge generated.

All the strategies, programmes and bodies described above reflect the **priority that the Spanish government gives to policies on ageing and dependency**, placing older people and people in need of support at the centre and developing different initiatives that continue to move towards the promotion of active and healthy ageing, the prevention of dependency and institutionalisation, the promotion of the effective participation of this group in society and the provision of quality LTC, with a rights-based, community and proximity-based approach.

The aforementioned *State Strategy for a new community-based care model: a process of deinstitutionalisation (2024-2030)* is a key piece in the effective transformation of our care system, relying on the collaboration of the different ministerial departments, Autonomous Communities and Local Administration to achieve the objective of people with support needs being able to continue living at home or "like at home". To this end, in addition to measures to improve the care offered in services and care centres for dependent persons, it is essential to **develop different care services and home and community support**. In this sense, the Ministry of Health plans for the period 2024/2025 to create a working group to develop recommendations for the improvement of Home Care in the National Health System, to develop community health lines of action within the framework of Primary and Community Care actions, and to promote specific intervention strategies aimed at people with chronic health conditions and limitations of activity, in especially complex situations, or suffering from multiple pathologies, with special attention for case management and home care.

Care in the face of the demographic challenge

The provision of care and resources to be able to continue living at home or "like at home" is highly dependent on territorial variables and, particularly, on rurality and the progressive

depopulation of large geographical areas. For this reason, another of this government's commitments is to provide Spain with a **State demographic policy**. To this end, as a result of the collaboration between the General, Autonomous and Local Administrations, a **National Strategy on the Demographic Challenge** was drawn up in 2019, of a global and cross-cutting nature, which allows a joint response to be designed for the future in order to alleviate the problems of progressive population ageing, territorial depopulation and the effects of the floating population. At the same time, this Strategy serves as a tool to guarantee equal rights and opportunities for women and men in Spain, with no differences based on age or place of residence.

In addition, a **Plan of Government Measures to Address the Demographic Challenge** has been launched with 130 measures (hereinafter, *Plan 130*), organised into 10 lines of action, which are aligned with the national strategic framework and with the Recovery, Transformation and Resilience Plan, to ensure the incorporation of small municipalities into a green, digital, gender-sensitive and inclusive recovery. **Axis 8, "Social welfare and the care economy"**, includes different measures aimed at guaranteeing the provision of basic services, such as health and social welfare services, in close proximity and in fair conditions, paying special attention to the needs arising from the increased ageing of the rural population and addressing social welfare from a rights-based approach, to facilitate social inclusion and the full development of personal and professional projects that guarantee the freedom of choice in the place of residence. Specifically, the three main measures in the area of the care economy relate to the *Long-Term Care and Support Plan*, the *Social Services Modernisation Plan* and the Plan *Spain*: *An Accessible Country*, which have already been mentioned. **Total investment** in relation to these measures amounted to **just over 1.7 billion euros**, representing 13% of *Plan 130* as a whole, with 95% of the expenditure mobilised having been territorialised for management by the Autonomous Community Administrations.

On a separate note, among the actions of the Ministry for Ecological Transition and the Demographic Challenge included in *Plan 130* and linked to the *National Strategy on the Demographic Challenge*, it is worth highlighting the **annual announcement of grants**, on a competitive basis, for local authorities, non-profit organisations and companies and entrepreneurs, for the development of **innovative** multi-sectoral **projects**, including the promotion of projects for the care and attention of people in rural and sparsely populated areas. Another of the actions consists of **transfers to the Autonomous Communities**, within the framework of the Sectoral Conference on the Demographic Challenge, of financial resources **for investment in territorial transformation projects** in areas with demographic challenges, also of a multi-sectoral nature, including projects in the areas of care, social services and accessibility.

With this *Plan 130*, which reflects the efforts made by all of the Ministerial Departments and which has mobilised an **investment of 13 billion euros** over the period 2021-2023, the Government has made its presence in the territory effective, **by placing the focus on rural areas and small municipalities**, guaranteeing both the development of specific measures and projects, and the definition of objective criteria in general calls for proposals that favour the promotion of actions in these areas, representing the **greatest effort made in Spain to address equal rights and opportunities in our small municipalities**.

The **Strategic Framework on the Demographic Challenge** is currently in the process of being **updated** by the Government's Delegate Commission for the Demographic Challenge, and proposals are currently being sought from the 18 ministries that make up this body. The aim is for LTC-related services to have a prominent presence in this new strategic scenario in the face

of the demographic challenge, insofar as they constitute one of the areas that most contributes to combating territorial gaps, both because of their close links with the ageing population, which is particularly relevant in rural areas, and also because of their great potential as a niche for new jobs related to home care and community-based care.

Care beyond our borders

Finally, we must mention the effort and concern to **attend also to the needs of the Spanish population living outside of the country**. In this regard, the Ministry of Inclusion, Social Security and Migration will be allocating **2.2 million euros in subsidies to the Programme for Dependent and Older Persons**, to carry out informative, social or assistance activities directed at day centres, residences for older people or other institutions that house older and/or dependent persons not belonging to the active population who have the status of **Spaniards abroad**, or are their spouses, and who lack sufficient means to subsist on their own. At the same time, this Ministry will also allocate **1.4 million euros to subsidies aimed at federations, associations or centres of Spaniards abroad** that have more than fifty members and that provide assistance to Spaniards abroad, and at entities whose purpose is to support and promote the social and cultural development of this population. Through these subsidies, the Ministry aims to contribute financially to the running costs of the federations, associations and centres of Spaniards abroad, and to the repair and maintenance costs of the centres and facilities of the entities based abroad whose purpose is to provide social, health and socio-cultural assistance for the Spanish population abroad.

5.1.2 Commitment to carers

5.1.2.1 Commitment to family carers

Support and social protection for family carers in the home

The adequacy and quality of care provision directly affects the daily lives of the people who receive care, but it also affects the quality of life of those who provide care, be they professionals or family members.

Aware of the desire of many dependent persons to be cared for by their relatives at home, Law 39/2006 already recognised a **financial benefit for care in the family environment and support for non-professional carers**. The aim of this amount was to contribute to the expenses derived from this home care, to favour the permanence of the person in their environment and to offer social protection to these carers and especially family carers, through the establishment of a **special agreement with the Social Security**, so that their contributions, corresponding to retirement, permanent disability and death and survival, derived from accident or illness, would be assumed by the State.

This financing of Social Security contributions, which had been interrupted in 2012 as a result of budgetary restrictions, resumed in 2019 (RD 6/2019), in response to the **value that the government attaches to the figure of the non-professional carer**, who in many cases is obliged to leave their job and, therefore, interrupt their social security contribution history, in order to

care for the person in a situation of dependency. This measure also contributes to **reducing gender inequality**, as most family carers are women.

Advancing on the path of support and protection for family carers, in 2023 (RD 675/2023) the **requirements and conditions for access to the *financial benefit for care in the family environment and support for non-professional carers*** are **made more flexible**, by removing the previous period of care provision required and extending the status of non-professional carer to any person in the relationship environment of the dependent person who, at the latter's proposal, is in a position to provide such care. Likewise, the **amounts** of these benefits **are increased by 17.65%** and **minimum amounts** are **established** to guarantee that they are not excessively reduced when applying the reductions provided for in the regulations of the Autonomous Communities.

At the same time, financial benefits awarded for care in the family environment where the dependent person has **formalised an employment contract with a third party** to **collaborate with the non-professional carer in the domestic tasks** of the dependent person so that **family carers can rely on this support for care duties**, are now **considered to be a service provision**.

Following the European Directives and aware of the need to **guarantee a work-life balance for these family carers**, Royal Decree-Law 5/2023 was passed, which fully transposes European Directive 2019/1158, and which provides for the amendment of different Spanish regulations and the adoption of different measures relating to the form, duration, distribution and organisation of working time, paid leave, absences from work for urgent family reasons or periods of leave for family care, among other issues. The exercise of these rights will take into account the promotion of co-responsibility for care between women and men, to avoid the perpetuation of gender roles and stereotypes.

As a continuation of these measures and with the aim of **further improving support for families** in Spain, the Government has presented a **draft Family Law**, which is currently in parliamentary procedure, thus also responding to one of the commitments made as part of the Recovery, Transformation and Resilience Plan (C22.R3). This law has three main objectives: to recognise the different family situations that exist in Spain, to improve the social protection of families and to guarantee the right to a work-life balance. In effect, this law will establish a framework so that the different administrations in our country can implement family support policies and also offer support to extend rights, both through parliamentary amendments and in the negotiation of the General State Budget. The **concrete measures** proposed will provided for a better work-life balance, while promoting co-responsibility in care, preventing people, particularly women, who continue to assume most care-related tasks, from being forced to abandon their jobs and professional careers to take on this work. Likewise, the right to support measures for the care and attention of older, disabled or dependent persons, within the framework of the SAAD, and to monitoring, support and respite services are also guaranteed.

Among the different family situations envisaged, the Law on Families proposes **measures to support families with specific needs**, including those with a family member with a disability or in a situation of dependency. Measures set out for this group include those aimed at promoting equal treatment and opportunities for these people in the access to public support, goods and services for family life and those aimed at guaranteeing the right of these families to access specific social and/or, where appropriate, financial support services and measures to alleviate the overburden and extra cost associated with attending to their needs. This broad catalogue of measures ranges from the sphere of employment and social protection (such as Social Security

contributions) to the sphere of social and health care (coordination systems, strengthening of services to provide better care for their needs and facilitate work-life balance, support for carers of older, dependent or disabled persons, respite measures, psychological support and comprehensive care for families caring for people with high support needs, etc.) or relating to the right to decent, adequate and universally accessible housing.

Encouraging family collaboration and participation in the services of the SAAD

The **needs of family members of dependent persons who use the services of the SAAD**, such as **residential centres** and **day centres**, are also a focus of our LTC policies. Accordingly, the *Accreditation and Quality Agreement* referred to earlier sets out what relations with users' family environment should be like and what type of support should be offered to them to respond adequately to their needs, based on the recognition of their important role in supporting users both emotionally and by collaborating in care. To this end, their participation will be promoted, whenever the user considers it appropriate, adequate channels of permanent communication will be implemented, interaction and contact will be facilitated and they will be offered the support and advice they may require for the care and support of their family member.

5.1.2.2 Commitment to professional carers and job quality in the care sector

Improving training and upskilling

For the change in the model of care and support to become a reality, **real cultural change** is required, involving a significant investment in the **training of professional carers across the sector**. Training in these new models of person-centred care, based on rights and in the community, in the ethical practice of care, or in aspects as specific as restraint-free care, which requires not only the gradual withdrawal of restraints, but also learning new strategies of respectful support for people. Quality and updated training, in line with current support paradigms, is also a way to **dignify and enhance the value of these** essential **professions**, making it a central issue for this government. Making work in the care economy, which is so essential to our society, **visible** and **valued**, and turning it **into an attractive career option** and, more especially, a **decent living option** for its workers, the majority of whom are women workers, is a concern and constitutes one of this government's priorities.

To this end, the *Accreditation and Quality Agreement* is already **committed to these new competencies and to continuous training**, based on the conviction that improving the skills and competencies of these professionals will improve the quality of life of the people receiving care and support. Along these lines, the Ministry of Education, Vocational Training and Sport has expressed its **commitment to review the competency standards of both vocational certificates and vocational training qualifications** so that they reflect this transformation of the care and support system and are oriented towards the promotion of autonomy and independent living in the community from a person-centred care approach.

Accordingly, in the quest for **quality in employment**, the Agreement includes the **professional qualifications, skills and competencies** that **first level direct care staff** (staff providing direct support to dependent persons, essential for providing support for their autonomy, participation and basic activities of daily living) and **second level** care personnel (staff with a university degree

or equivalent, or higher vocational training qualifications in the social-health branch) must possess.

Regarding the first group, the professional qualification needed to accredit their competencies is specified and the exceptional qualification procedure is also facilitated for those carers, geriatric nursing assistants, home help assistants and personal assistants who, while not having the required qualification, have the required work experience. At the same time, a provisional qualification process is envisaged for those workers who, despite not meeting the requirements for exceptional qualification, undertake to participate in the processes of assessment and accreditation of their experience or to carry out the training linked to the professional skill certificates or vocational training qualifications within the established period. In this way, it has been possible to **regularise the situation of a large number of workers** who, for various reasons, had worked in the LTC sector but did not have the required qualifications or experience. Among this group of professionals were those who had worked in these centres during the social and health emergency caused by the COVID-19 pandemic in order to deal with the serious problem of staff shortages during that period. All these measures contribute significantly to **ensuring job stability** and **professionalising the sector**, which **has an unquestionable impact on the quality of care offered**.

The Agreement also provides for the necessary preparation and development of **continuous training plans** for all SAAD centre workers, aimed at training in people's rights and in ethical professional practice.

Finally, the Agreement also addresses the **skills and training needs** that may arise in **rural municipalities**, offering accreditation pathways and specific training programmes to meet the challenges of these environments.

Also in relation to professional training and retraining, it should be noted that, as previously mentioned, **Component 22** of the *Recovery, Transformation and Resilience Plan* includes a significant **investment in this line of updating training content and in providing more people with access to quality training**. Likewise, **Component 20** of the PRTR *(Strategic Plan for Vocational Training*) dedicates one of the investments (C20.I1 "*Reskilling and Upskilling of the active population linked to professional qualifications*") to the maintenance and improvement of the professional competencies of the active population (population over 16 years of age, employed or unemployed). One of this investment's actions, with an amount of € 394,784,000, is aimed at training in those sectors which, as a result of the foreseeable evolution of economic and social conditions, will generate jobs in the future, which includes **training in the care of people**.

Improving working conditions

It is also a **priority for the Spanish government to fight against the precariousness of this sector**, which is female-dominated and has a high percentage of professionals from other countries, by **improving the working conditions and salaries of its workers and regularising** the situation of some of these people, mainly migrants in an irregular situation.

With this objective, the Ministry of Labour registered and published in 2023, after four years of negotiations between employers and trade unions, the *VIII State framework agreement on care services for dependent persons and developing the promotion of personal autonomy*, which

regulates the working conditions of the staff of residences for older people, day and night centres, sheltered housing, home help services and telecare services under private ownership or privately owned and publicly managed. This Agreement established a wage increase of 9% (with progressive wage increases of 4%, 2.5% and 2.5% for the years 2023, 2024 and 2025 respectively), which could reach 12% in application of the wage update clause that will operate at the end of the term of the agreement. This increase is based on the 2022 wage tables, which are consolidated in this agreement and represented an increase of 6.5%. In this way, **the salaries of professionals in the care sector will be able to experience a maximum total increase of up to 18.5%** between 2022 and 2025. Other main improvements introduced by this agreement are: **reduction of the annual working day** by 20 hours (8 hours of the annual working day will be reduced in 2024 and 12 hours in 2025), improvements in **compensation in situations of temporary incapacity** due to professional contingencies (with the inclusion of the supplement for incapacity to work due to occupational accident or occupational disease of up to 100%, 95% and 90% during the first 180 days of sick leave), the possibility of taking 4 personal days off work throughout the year to **improve work-life balance** and adaptation of the text to the labour reform to **incorporate all the new regulations on equality and work leave**. This agreement, signed in a complex socio-economic context and marked by the health crisis of the COVID-19 pandemic, has been described by both trade unions and employers as "historic", as it achieves **significant improvements in the working conditions** of these workers throughout Spain, **empowering them** as "first level" professionals, and **provides stability to the sector** in terms of wages and job improvements, representing an **important advance in rights**.

The progress achieved is only a first step in **this government's commitment to respond to the demands of this sector's workers** in relation to working conditions, remuneration, recognition and coverage of occupational illnesses, prevention of occupational hazards and addressing part-time contracts, which is a major detriment to the contributions and work-life balance of these professionals. In this regard, the Minister for Social Rights, Consumer Affairs and 2030 Agenda has expressed the intention to resume the social dialogue table between trade unions and employers in order to continue to make progress on dignifying this sector.

Along with these issues, we must not forget that, for the work of these professionals to be carried out properly, it is fundamental to **offer stability and adequate contracts**, and for the **number of workers** to be **correctly sized** to the demand for the work and the number of users cared for, according to their needs. The *Accreditation and Quality Agreement* established common criteria in this respect in 2022. Thus, **80% of contracts in the centres and services of the SAAD** are guaranteed to **be permanent** and **minimum percentages of full-time contracts** are established for first-level direct care staff in day centres and residential homes (66%) and in home help (50%). At the same time, **the ratios of direct care staff, both first and second level, are raised**, establishing minimum ratios to be met by all centres and services of the SAAD, which are specified in the aforementioned Agreement.

Regarding **care centres and services for people with disabilities**, employers and trade unions are currently in the process of negotiating the replacement of the *XV General Collective Agreement for care centres and services for people with disabilities*, which is in a flurry of activity, since its validity period concluded in 2021. As mentioned in the diagnosis, pending a definitive agreement on this agreement as a whole, a partial agreement was reached in 2023 to update the salary tables for 2022 and 2023 retroactively, implying an **improvement in the salary conditions of these professionals**.

All of these improvements in the conditions of workers who provide care and support to people with disabilities or in situations of dependency will also make it possible to **attract more qualified professionals** who currently choose to work in other sectors, thus contributing to **solving the shortage of workers in the sector**, which will undoubtedly become a more pressing reality in the coming years.

Facing the shortage of professionals challenge

To address the problem of the **shortage of professionals in the care sector**, the government has launched various initiatives aimed at **facilitating the work of migrant professionals by speeding up the processes of regularisation and validation of qualifications inasmuch as possible** and, in this way, **attracting foreign talent**. In this regard, the Ministry of Universities, in view of the shortage of certain professional profiles, including healthcare personnel, especially in the specialities of medicine and nursing, approved in 2022 (Royal Decree 889/2022) a **new strategy for the homologation and validation of qualifications** that **simplifies the process and speeds up procedures** by incorporating digital file processing technologies, designed to shorten resolution times to no more than six months. To overcome the bureaucratic obstacle and speed up these approval processes, the Government established with this Royal Decree the creation of a *Commission for Technical Analysis of Homologations and Declarations of Equivalence*, responsible for proposing resolutions, as well as adopting measures of a general nature. The electronic processing of files introduced by this Royal Decree has been a great step forward, **generating an increase in the number of applications received and speeding up the procedure for their resolution**.

Following the *Recommendation of the European Commission on the recognition of qualifications of third-country nationals* (Commission Recommendation (EU) 2023/2611), aimed at **further shortening these processing times** and, in this way, **more effectively addressing the shortage of professionals** in sectors such as health and LTC, in February 2024, a Resolution was published *(Resolution of 21 February 2024 of the General Secretariat of Universities*) which urges the processing through a specific and preferential route of those files corresponding to persons legally residing in Spain with a work permit, and to persons holding Spanish nationality or that of a Member State of the European Union, in order to **achieve the rapid incorporation** of these persons **into the labour market**.

Addressing the challenges of vulnerable workers

On a separate note, special attention deserves to be paid to **domestic workers and professional home carers**, who are historically invisible, undervalued and subject to very precarious and sometimes even unregulated working conditions, affecting mainly women, a high percentage of whom are migrants.

Royal Decree 1620/2011, regulating the special relationship that characterises service within the family household, provided a first **regulation of the employment relationship of all those workers who provide services in the family home**, including services related to domestic chores or the care and attention of family members. This Royal Decree, together with *Law 27/2011 on the updating, adaptation and modernisation of the Social Security system*, initiated the **progressive equalisation of employment and Social Security regulations for this group**, in order

to avoid situations of disadvantage compared to other professionals that could be discriminatory. Although these reforms made it compulsory for domestic workers to be registered with the social security by their employers and their working conditions were dignified by equalising certain rights, increasing job stability and introducing transparency mechanisms regarding working conditions, certain issues remained pending, such as the right to unemployment benefit.

In 2022, as a result of the **Spanish government**'s **commitment to the labour rights of this group**, mainly comprising women, our country ratified *ILO Convention 189,* taking a **definitive step forward in the fight against precariousness in this sector and in the equalisation of their labour and social protection rights** with all other employed workers. The implementation of this Convention seeks to prevent abuses, by regulating working conditions and guaranteeing social protection against unemployment or dismissal, among other improvements, which, taking into account the prevalence of women in this sector, is an **effective and essential step towards the achievement of gender equality in the world of work and in the effective exercise of equal rights and protection of women before the law**.

The transposition of this Convention into the Spanish legal framework led to the approval, in t*he same year, of Royal Decree-Law 16/2022 for the improvement of working conditions and Social Security of domestic workers.* This legislation amends various laws and regulations to **bring the working conditions of these employees into line with those of any other worker**, guaranteeing, among other improvements, the protection of their health and safety at work, protection against occupational illnesses, access to unemployment benefits, and the regulation of dismissal conditions, eliminating the figure of termination of the employment relationship due to discontinuance and guaranteeing compensation for this reason. In short, this is a **historic step forward** in the **recognition and equalisation of the rights** of these workers, which responds to a historical demand of these women in the **struggle for equality**.

Within this group, **migrant workers in an irregular situation** in our country who work caring for dependent persons in their homes are particularly socially and legally vulnerable.

With the intention of improving the migration model, favouring the incorporation of migrants into the labour market, reinforcing regular migration channels and improving the management system, so as to avoid prolonged periods of irregularity, a reform of the Foreigners' Regulation (*Royal Decree 629/2022*) was approved in 2022. This Royal Decree has helped to **improve the legal situation of many immigrants** and to **combat the scourge of the black economy**. The regulations have been improved to favour the permanence of foreign students, increasing their possibilities of working and thus attracting international talent; the figures of "arraigo" (social roots) and family regrouping have been updated and a new figure of "arraigo" (social roots) for training has been included for foreigners who have been in Spain for two years in an irregular situation, which grants them a residence permit for a period of 12 months if they undertake to carry out regulated training for employment. Measures are also adopted to reinforce regular migration by streamlining the requirements for self-employed workers from third countries to facilitate the entry of entrepreneurs, by improving recruitment procedures at origin through the automatic incorporation of occupations belonging to certain sectors into the Catalogue of Difficult-to-Fill Occupations and by improving the circular migration model, providing greater stability for workers and companies and reducing administrative burdens. Finally, improvements in administrative management are incorporated.

Despite the fact that the aforementioned measures have had very positive effects that have allowed us to improve our migration model and to incorporate a significant number of migrants

into the labour market, there are still aspects that need to be improved, such as reducing the types of permits currently in force, simplifying documentation and procedures or reinforcing the protection of migrants' rights. To meet these challenges, and to transpose the two European regulations in this area approved under the Spanish presidency ("*Single Permit Directive*", which will allow third-country nationals wishing to reside and work in a Member State to apply, by means of a single permit, for work and residence permits, and the "*Long-Term Residents Directive*", which improves the rights of long-term residents and their family members), the Minister for Inclusion, Social Security and Migration announced a **new amendment to the Regulation of the Law on Foreigners in 2024**.

Another step forward in the defence of migrants' rights and the fight against the black economy led the Spanish Parliament to approve by a majority vote in April this year, the popular legislative initiative for the **regularisation of immigrants**, which could benefit more than half a million migrants, more than half of whom are believed to be women, who currently reside in our country illegally and are therefore unable to access public services and find themselves unprotected in the labour market. This extraordinary regularisation will make it possible to give visibility to the entire migrant population residing in the country, compensate for inequalities they present as a starting point and, at the same time, guarantee labour rights in equal conditions, reducing situations of abuse and exploitation. In the coming months, this Draft Law will continue its parliamentary procedure.

Committed to gender equality and the protection of care professionals

Finally, and bearing in mind that the care sector has a **prevalence of women workers**, it is important to mention the different initiatives of the Spanish government to **guarantee full equality between women and men in the workplace**, placing our country at the forefront of Europe in this field, as well as to guarantee the **protection of workers against harassment and violence**.

In this sense, the diagnosis already described the historic progress made by *LO 3/2007 for the effective equality of women and men*. Spain's current political and legislative commitment continues to move towards **full equality between women and men** and to **fight against inequalities in working conditions**. Of particular note is *Royal Decree-Law 6/2019*, extending the obligation to draw up equality plans to companies with 50 or more employees, establishing measures to promote a work-life balance and parental co-responsibility for care and introducing the concept of "work of equal value", establishing the obligation of equal pay for work of equal value, without discrimination on the grounds of sex.

In this respect, *Royal Decree 902/2020 on equal pay for women and men* takes a step further by facilitating the **identification of wage discrimination through a set of transparency instruments**, such as a pay register with information disaggregated by sex, professional classification and type of remuneration, a company audit that includes job assessments and plans to correct inequalities, or a job evaluation system that respects the principle of equal pay for jobs of equal value. It also establishes a commitment to inter-ministerial collaboration and collaboration with the social partners to analyse the effectiveness of the fight against the pay gap and to adopt the appropriate measures.

With regard to **equality plans**, *Royal Decree 901/2020* stipulates that they must contain a diagnosis negotiated with the social partners, along with a drafting procedure through a

negotiating committee, a minimum content, which must include the pay audit established by RD 902/2020, and a validity. This Royal Decree also establishes that these plans must include all workers, from the selection process until leaving the job, and that they must be registered. These measures are intended to ensure that equality plans are not merely declarations of intent, based on the **conviction that there is a direct link between a company's equality policies and the effectiveness of the fight to eradicate the gender gap**, which is not only limited to the area of pay, but is also reflected in the precariousness of jobs and the difficulties in achieving a work-life balance. These problems can lead to situations of precariousness and to the economic dependency of women, which must be combated in order to avoid situations of vulnerability and eradicate gender-based violence.

On a separate note, with a view to **eradicating violence and harassment in the workplace**, *ILO Convention 190*, to which Spain acceded in June 2022, came into force in our country on 25 May 2023. This recognises **everyone's right to a work environment free of these unacceptable behaviours and practices**, which constitute a threat for equal opportunities, and it acknowledges how gender-based violence and harassment disproportionately affect women and girls, making it essential to have an inclusive and integrated gender-sensitive approach that addresses underlying causes and risk factors, such as gender stereotypes, multiple and intersectional forms of discrimination, and the abuse of gender-based power relations, to put an end to violence and harassment in the workplace. This Convention calls for the promotion of a general environment of zero tolerance towards violence and harassment, to facilitate the prevention of such behaviour and practices, by adopting appropriate measures for prevention and control, as well as support and redress for victims.

Article 11.3 of the **Draft Organic Law on the Right to Defence**, recently approved by the government, would guarantee, for example, staying in the job in the event of making a complaint against any form of sexual or labour harassment, since it provides that "workers have the right to compensation for the unfavourable consequences they may suffer due to any action leading to the exercise of their rights of defence". This Draft Organic Law is a pioneering regulation in Europe, designed to provide security both to citizens in the exercise of their right to defence and to legal professionals in the exercise of their work, establishing a system of guarantees and duties, notably the right to receive free legal aid for people in vulnerable situations or the right of citizens to be addressed by the Justice Administration in clear, simple and accessible language. This Draft Organic Law develops a fundamental right enshrined in Article 24 of the Spanish Constitution and guarantees the right to obtain the effective protection of the Judges and the Courts.

All the measures outlined exemplify **Spain's real and deep commitment to changing the LTC model**, with measures that address the main challenges in different spheres (adequacy, accessibility, and affordability of care, quality of care, support for family carers and quality of professional care work). These are not limited actions, as all these measures are articulated in **different strategies with a broad scope and on a large scale** which are already making a reality of improving and transforming the way in which care and support is conceived and provided, placing the focus on all those involved in such care (persons with disabilities or in situations of dependency, family carers and care professionals). **The guidelines are laid down in the State Strategy for a New Model of Community-Based Care: a Process of Deinstitutionalisation (2024-2030) and by this document implementing in Spain the European Care Strategy presented here, which, with the same action horizon, combine synergies and efforts to advance in this ambitious and much needed process that will improve the quality of life of people who need**

support and their caregivers and, ultimately, move towards a fairer, more inclusive and supportive society.

5.1.3 Governance and policy coordination to ensure progress on the change in model

As explained in the diagnosis section, Spain has a decentralised model, according to which competences in the area of social services are transferred to the autonomous communities. It is up to the State to establish the reference frameworks that guarantee citizens' fair access to services, regardless of their place of residence, and to propose minimum quality criteria for the entire SAAD, along with a common regulatory framework of labour affairs that guarantees basic rights for all workers in the care sector.

In this context, it is crucial to have **adequate coordination and cooperation** between all political actors across all levels of the administration, at the national, regional and local levels, for the proper functioning and achievement of the major improvements we propose.

An example of this institutional collaboration, as explained earlier, is the **Territorial Council**, which is directly involved in the change of model. This is reflected in the number of agreements reached, 44 in the 12 years between 2007 and 2019, compared to the 51 agreements reached in the last 4 years, from 2020 to 2023, as a result of the important collaborative work being done to effectively drive change in care in our country.

This Territorial Council relies on the information supplied by the **SAAD Information System (SISAAD)**, which provides centralised management of the Network of Services throughout the State, and guarantees better availability of information and reciprocal communication between the public administrations, while facilitating compatibility and the exchange of information between same, thus achieving better management, use and transparency of the data the system contains.

The Territorial Council is also responsible for the different measures of the *SAAD Shock Plan* which have had such a major impact on **improving the accessibility, affordability and quality of the system** and which have already been described above. One of these measures has been to prepare a **Census of Social Services Residential Centres in Spain**, incorporated into the *National Statistical Plan*, thereby guaranteeing its periodicity. Thanks to the collaboration and commitment of all the autonomous communities, it has been possible **to obtain aggregated information at the national level,** essential for understanding the reality of Spanish centres that care for people in situations of dependency and persons with disabilities, resulting in **information of great value for decision-making** that helps us move towards **evidence-based public policies**.

Another important inter-administrative cooperation body is the **Sectoral Conference on Demographic Challenge**, chaired by the head of the Ministry for Ecological Transition and the Demographic Challenge, representing the AGE, and also made up of the members of the Government Councils designated by virtue of their powers, in representation of the Autonomous Communities and Cities. The main function of this body is to **coordinate and cooperate on policies aimed at addressing Spain's demographic challenges**, in particular depopulation, progressive ageing and the effects of the floating population. The **Territorial Cohesion Fund** has

been set up since 2022 to co-finance actions promoted by the different public administrations, within the scope of their respective competences, and whose purpose is to promote or directly adopt measures aimed at boosting territories at risk of depopulation. This Fund has provided a qualitative leap in the mechanisms of governance and construction of public policy to combat territorial imbalances, by promoting multi-sectoral initiatives and actions aimed at generating opportunities in each autonomous community, adapted to its context.

As part of its demographic challenge policy, the Government is also promoting the creation of **Territorial Innovation Centres (CIT)**, conceived as reference points for economic and social development in which the competent administrations participate, but also social initiative and even entrepreneurial projects generated in the territory in question and which can contribute to the social and economic development of the area. The objective is to create a **network of centres (Red-CIT)** as a collaboration platform for the national rural innovation ecosystem, which allows for the scaling, replication and adaptation of initiatives and solutions generated in one territory so that they can be applied in others, including projects aimed at providing care for older people and support for independent living in the environment.

The advances in this rural innovation network are linked to the results of the projects of the **VIDAS Platform**, mentioned earlier, which also constitutes a source of cooperation and collective learning for the transformation of the care system towards deinstitutionalisation.

In short, at national, regional and local level, our country is on a resolved path of no return towards **redesigning the long-term care and support model**, convinced that care is what sustains life and, therefore, everyone's responsibility. Changing the model of care is a democratic priority and our roadmap is guided by the commitment to a rights-based and community-based approach.

Since this document on the Implementation of the European Care Strategy was conceived**, synergies have been established with the State Strategy for a new community-based care model: a process of deinstitutionalisation (2024-2030)**, sharing measures that pursue a **double shared goal**:

- To transform current services and institutions, by promoting a change of outlook and moving towards a model of comprehensive care that places people, their wishes and preferences at the centre and promotes their autonomy and participation.
- To develop alternatives and new services for a good life in the community, by promoting and consolidating alternatives so that people can live according to their will and preferences in the community.

Protection of all people with support and care needs is a priority in Spain, aimed at ensuring at all times the full and effective exercise of their rights, without forgetting the well-being of those who provide them with care and support.

5.2 Detailed description of the measures

The detailed list of the measures constituting Spain's response to the Council's recommendations is presented in annexes I and II. Annex I presents, in the aggregate, all the actions implemented or planned by the ministries which correspond to the description provided

in the previous section related to the political response. Information is provided regarding the responsible enforcement body, the proposed measure and its correspondence with the Council's recommendation or recommendations.

Annex II contains information on all the measures developed or planned by the Autonomous Communities. Information is also provided regarding the measure and its correspondence with the Council's recommendation and, in this case, also regarding the autonomous community that develops the measure.

For reasons of space, the list provided only contains basic information regarding each measure, since it includes 68 measures of the General State Administration and 499 measures of the autonomous communities.

6 Remaining challenges and EU support needs

6.1 Remaining challenges

As set out in this document and as reflected in the attached tables, Spain presents to the Council of the European Union a comprehensive and extensive response to the recommendations, in line with the ambitious change in care policy that is underway. Spain responds to each and every one of the Council's recommendations with actions carried out by both the General State Administration and by the autonomous communities. Numerous specific measures are incorporated for each of the recommendations, in addition to broad-spectrum measures covering several of the recommendations, including strategic, regulatory, and organisational changes, etc.

However, the objective is to make the change in care model a reality for all people, with any care need, and in all territories. Therefore, despite all the measures, plans, programmes and regulatory reforms approved and planned, we are aware that there is still a long road to be travelled to achieve this reality. At this point in the document, having described all the measures and actions, we summarise some of the major challenges that our country must face, concerning the principal spheres that constitute the care system.

One of the major challenges is **to ensure coverage of the necessary care when needed.** This has different implications, including requiring continued increases in funding, deployment and enhancement of services to increase the amount of resources available in the system; organisational modifications to improve the administrative processes required to provide care, reduction of the administrative burden and processing times thereby reducing waiting lists and waiting times.

In addition to the matter of the amount of resources available, there is a major challenge regarding **the quality of care**. There is a well-described care model we are addressing, which has technical and political support, but the ultimate goal is not only to provide services, but to generate an impact on people's lives. Therefore, ensuring the quality of care is crucial for the quality of life of the people who receive it. Quality analyses must be reoriented from traditional models aimed at inspecting the quality of care services to models that analyse care outcomes and impacts.

Another major challenge, which will moreover increase in coming years, will be to have a **robust, stable and well-prepared professional care sector**. To achieve this, it is necessary to address in depth the prestige and social recognition of the sector, to improve working conditions and to expand the training of professionals. Numerous actions are required not only to attract the personnel that will be needed given the ageing population, but also to retain them with good working conditions that make working in care not only an attractive occupation professionally, but also an important work niche for personnel with any level of training.

Having a system that provides quality care when needed and with trained and motivated staff will also have an impact on another of the major challenges of the current care system in Spain: the burden that still exists on family **caregivers**, who are mostly women. In a care model that is

still very family-based, they assume a responsibility for care with very serious consequences on their personal and professional lives, their health and their quality of life. The task of caring for a family member should not be an obstacle to developing one's own life. For this reason, it is necessary to deploy numerous measures to provide the necessary support so that the person can receive care and continue to develop their lives in their home and in their community while, at the same time, allowing their families to do so as well.

The **social change** that we have been seeing in recent years must continue to advance. It is crucially important to work towards a medium- and long-term cultural change in the care model, focusing on respect for people's dignity and personalised care, by creating smaller and more homely care ecosystems, and residential environments. Raising public awareness of the right to live in community in the face of any need for care and recognising the role of the community in care is paramount. It is also vital to promote community development that ensures the participation of people receiving care, so that their opinions are taken into account in the design of public policies and in the configuration of services.

To this effect, the system must be capable of learning; in other words, of analysing its own performance, identifying achieved objectives and areas for improvement and implementing changes when and where necessary. A system as complex as that of care in Spain, implemented with a large number of public and private actors, requires a refined system of monitoring, information processing, evaluation and knowledge management. Thereafter, it will be possible to build environments that identify good practices, enhance innovation and social research ecosystems, foster collaborative learning, and reveal many other pathways that help not only to improve policy and actions based on evidence, but also to promote cross-learning among all actors involved in the system.

To achieve this requires not only implementing concrete measures, but also developing and reviewing current regulations to facilitate community life and the process of deinstitutionalisation, by implementing the necessary legal reforms in the applicable legal framework. The articulation of a system of cooperation and governance with a rights-based approach will guarantee the participation of all actors in the care model’s transformation.

It is a model that understands care as a support for people to continue living their lives and, as such, must be organised around their lives, attending to and respecting their needs, preferences and desires at all times. Therefore, if their desire is to remain in their home or community and to continue with their activities, there must be sufficient and appropriate resources to make this a reality until the end of their lives. To achieve this goal, it is necessary to approach the entire system as a whole. Public and private organisations, processes, care and service providers, professionals and all partners must be well coordinated and aligned towards the same purpose.

6.2 EU support

The Member States of the European Union are embarked on an integrated and coherent change of their national long-term care policies. The encouragement and support of the European Commission is also making it possible to develop synergies and learning processes that build this joint process and enrich national approaches. Spain is decisively committed to this path, not only in terms of the change that is occurring nationally, but also in terms of the integrated work to

provide all other countries with the lessons learned from Spain's experience in recent years, in particular, from the substantial development generated on account of the pandemic.

The change in model is a profound challenge with organisational and financial repercussions, many implications and socio-demographic, labour, and economic ramifications, etc. The European Union, in light of the European Strategy and subsequent Council Recommendations, has a responsibility and numerous opportunities for promotion not only at the technical level, but also at the financial level to make the provision of quality, accessible and affordable care a reality throughout the Union.

Of the specific possibilities that the European Union could establish, we would highlight the following:

- **Funding change**: by continuing existing lines of funding or by pursuing additional avenues, the EU can provide resources for projects that improve long-term care infrastructure and services.
- **Technical assistance and consulting**: The EU has a great capacity to provide technical support and consultancy for the design and implementation of innovative policies and programmes in the long-term care sector. An example of this is the *Technical Support Instrument* or the *Mutual Learning Workshops* linked to developing the strategy's implementation.
- **Information systems**: development of digitalisation and technological media in the field, through, for example, establishment and creation of software and integrated computer systems that provide for data aggregation and analysis.
- **Training and upskilling**: funding and organising training and upskilling programmes for professionals and also for family or informal carers. It could also be positive to have training options for people receiving care to promote autonomy, self-care, healthy ageing, etc. A joint design of certain training options, based on basic competencies and not linked to national systems, would make it possible to benefit from joint progress and the obvious economy of scale.
- **Research and development**: support for research and innovation projects to develop and analyse the impact of technologies and new care models that improve the quality and efficiency of services and, ultimately, the quality of life and well-being of recipients and providers of care. It could also co-finance grants for pilot and experimental projects surrounding care, older age and ageing, and other related issues.
- **Social awareness**: development and dissemination of awareness-raising and information campaigns for cultural change regarding care. In this cultural change towards care based on proximity, in close and community environments, based on rights, it is also necessary to raise the awareness of society as a whole; a global approach could provide interesting value.
- **Transnational collaboration**: maintain and strengthen the Union's support to assist in the formation of international networks for the exchange of experiences and good practices in matters concerning care.

Some of the lines mentioned above are already available in one form or another, even if they are not directly aimed at funding the sphere of care (for example, innovation projects or research

lines). However, knowledge about them is not generally available or easily accessible. Therefore, a cross-cutting aspect that could be mentioned, affecting several of the actions mentioned above, relates to the information and dissemination given to calls for applications and the information available to access them at the right time.

Another line of action, equally cross-cutting and also directed at improving access to such resources, would be to undertake a redesign of administrative processes. Units of the public administrations in Member States, which could benefit from these resources, often do not have the knowledge or technical capacity to apply for or to manage them, because their administrative complexity hinders access to a great extent, added to a lack of availability in the national languages. Therefore, administrative simplification could be of great support to Member States, without in any case reducing control or assurance of the quality of expenditure and achievement of objectives.

Following the publication of the European care strategy and subsequent recommendation of the EU Council, a vast amount of work has been generated in the technical units of the countries, moving in the same direction and seeking solutions to problems that are often shared: improvement of available services, shortage of personnel, quality management, etc. There is currently a great opportunity for joint learning and, above all, for management of all the aggregated and systematically-generated knowledge, helping work to design actions that will improve care in coming years to be done on the basis of all the previous work done and evidence already available.

6.3 An open reflection on care

Drafting this document has required an important effort of revision, analysis and synthesis to prepare its diagnosis; it has also required a detailed analysis of all political decisions and their implementation through regulatory, organisational, investment, planning and knowledge-generating measures and actions. It has also been necessary to establish the appropriate correspondence between the lines of action outlined in the national LTC policy, defined in the *Strategy for a new model of community-based care: a process of deinstitutionalisation*, and the lines of the recommendation of the Council of the European Union.

This process has resulted in this comprehensive and extensive document on the national LTC policy, which collects evidence, actions and challenges, from both the recent past and the present, as well as the future lines and long-term vision that will guide our actions in this process of transformation of the care system.

We trust that this work will not only serve to provide the Council of the European Union, the Commission and all other Member States with Spain's ambitious response to the recommendations made, but that it will also serve to continue the reflection on care, based on a detailed knowledge of our system, our challenges and the lines implemented and to be implemented in coming years so that these challenges cease to be.

The ultimate purpose of all political action reflected in this document is to ensure that people who require care and support not only receive such quality care and support when and how they need it, but also can continue to live where they wish and to develop their life projects, making

their own decisions and maintaining all their rights and dignity in any situation and in the face of any need for care. At the same time, it places the focus on the other two fundamental pillars of this equation: informal caregivers and professional carers. It is also important to guarantee their well-being, through better working conditions, addressing gender inequalities and facilitating a work-life balance, so that they can carry out care work in decent conditions and without violating their opportunities and rights. Public policy planning is sometimes far removed from the daily lives of citizens, but the LTC policy directly affects the people who receive and provide it, their dignity, opportunities, quality of life and their rights.

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Real Decreto-ley 21/2020, de 9 de junio, de medidas urgentes de prevención, contención y coordinación para hacer frente a la crisis sanitaria ocasionada por el COVID-19. *Boletín Oficial del Estado, 163,* de 10/06/2020. https://www.boe.es/eli/es/rdl/2020/06/09/21/con.

Real Decreto-ley 16/2022, de 6 de septiembre, para la mejora de las condiciones de trabajo y de Seguridad Social de las personas trabajadoras al servicio del hogar. *Boletín Oficial del Estado, 216,* de 08/09/2022. https://www.boe.es/eli/es/rdl/2022/09/06/16/con.

Real Decreto-ley 20/2022, de 27 de diciembre, de medidas de respuesta a las consecuencias económicas y sociales de la guerra en Ucrania y de apoyo a la reconstrucción de la isla de La Palma y a otras situaciones de vulnerabilidad. *Boletín Oficial del Estado, 311,* de 28 de diciembre de 2022, https://www.boe.es/eli/es/rdl/2022/12/27/20.

Real Decreto-ley 5/2023, de 28 de junio, por el que se adoptan y prorrogan determinadas medidas de respuesta a las consecuencias económicas y sociales de la Guerra de Ucrania, de apoyo a la reconstrucción de la isla de La Palma y a otras situaciones de vulnerabilidad; de transposición de Directivas de la Unión Europea en materia de modificaciones estructurales de sociedades mercantiles y conciliación de la vida familiar y la vida profesional de los progenitores y los cuidadores; y de ejecución y cumplimiento del Derecho de la Unión Europea. *Boletín Oficial del Estado, 154*, de 29/06/2023. https://www.boe.es/eli/es/rdl/2023/06/28/5.

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Resolución de 27 de junio de 2019, de la Dirección General de Trabajo, por la que se registra y publica el XV Convenio colectivo general de centros y servicios de atención a personas con discapacidad. *Boletín Oficial del Estado, 159,* de 04/07/2019. https://www.boe.es/eli/es/res/2019/06/27/(2).

Resolución de 24 de mayo de 2023, de la Secretaría de Estado de Derechos Sociales, por la que se publica el Acuerdo del Consejo Territorial de Servicios Sociales y del SAAD, por el que se definen y establecen las condiciones específicas de acceso a la asistencia personal en el Sistema de Autonomía y Atención a la Dependencia. *Boletín Oficial del Estado, 128,* de 30/05/2023. https://www.boe.es/eli/es/res/2023/05/24/(1).

Resolución de 30 de mayo de 2023, de la Dirección General de Trabajo, por la que se registra y publica el VIII Convenio marco estatal de servicios de atención a las personas dependientes y desarrollo de la promoción de la autonomía personal. *Boletín Oficial del Estado, 137*, de 09/06/2023. https://www.boe.es/eli/es/res/2023/05/30/(6).

Resolución de 21 de febrero de 2024, de la Secretaría General de Universidades, por la que se dictan instrucciones para la tramitación del procedimiento de homologación y de declaración de equivalencia a titulación y nivel académico de títulos extranjeros de educación superior regulado en el Real Decreto 889/2022, de 18 de octubre, por el que se establecen las condiciones y los procedimientos de homologación, de declaración de equivalencia y de convalidación de enseñanzas universitarias de sistemas educativos extranjeros y por el que se regula el procedimiento para establecer la correspondencia al nivel del Marco Español de Cualificaciones para la Educación Superior de los títulos universitarios oficiales pertenecientes a ordenaciones académicas anteriores.https://www.universidades.gob.es/wp-content/uploads/2024/02/report_Resolucion-de-21-de-febrero-de-2024.pdf.

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8 Annex I.

Measures proposed by the General State Administration to comply with the Recommendations of the EU Council.

ID	EXECUTIVE BODY	PROPOSED MEASURE	EU COUNCIL REC.
1	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Other Ministries and autonomous communities participate.	State Strategy for a new community-based care model: a process of deinstitutionalisation (2024-2023) and Operational Plan 2024-2025.	4 a, 4 b, 4 c, 5 a, 5 b, 5 c, 5 d, 5 e, 6 a, 6 b, 6 c, 6 d, 6 e, 6 f, 7 a, 7 b, 7 c, 8 a, 8 b, 8 c, 8 d, 8 e, 8 f, 9a, 9 b, 10 b, 10 c, 10 d, 10 g, 10 h.
2	Ministry of Social Rights, Consumer Affairs and 2030 Agenda and ACs in the Framework of the Territorial Council for Social Services and the SAAD.	Agreement on Common Accreditation and Quality Criteria for Centres and Services of the SAAD.	4 a, 4 b, 4 c, 5 a, 5 b, 5 c, 5 d, 5 e, 6 a, 6 b, 6 d, 6 e, 6f, 7 a, 7 b, 8 a, 8 b, 8 e, 9 a, 9 b, 10 b, 10 c, 10 h.
3	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Royal Board of Trustees on Disability. AC:	Spain's Disability Strategy 2022-2030 ensuring that persons with disabilities can access, exercise and enjoy their human rights.	4 a, 4 b, 4 c, 5 a, 5 b, 5 c, 5 d, 5 e, 6 e, 6 f, 9 b, 10 b, 10 c,10 d
4	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Imserso.	Development of the Inter-Administrative Cooperation Framework and criteria for distributing AGE credits for funding at the agreed level (suspended since 2011).	4 a, 4 b, 4 c, 5 b, 6 a, 6 b, 6 d, 7 a, 8 b, 10 b
5	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Imserso.	Royal Decree 675/2023, of 18 July, amending Royal Decree 1051/2013, of 27 December, which regulates the benefits of the SAAD established in Law 39/2006.	4 a, 4 b, 4 c, 5 a, 5 d, 9 a, 9 c
6	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Imserso.	Amendment to Law 39/2006.	4 a, 4 b, 4 c, 5 a, 5 c, 5 d, 5 e, 6 e, 6 f, 9 a.
7	Ministry of Social Rights, Consumer Affairs and 2030 Agenda.	Amendment to the General Law on the Rights of Persons with Disabilities	4 a, 4 b, 4 c, 5 d, 5 e, 6 e, 6 f, 10 b
8	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Autonomous Communities and Local Authorities.	Investment for the Long-Term Care and Support Plan: deinstitutionalisation, equipment and technology (C22.I1).	4 a, 4 b, 4 c, 5b, 8 f,10 b, 10 c, 10 h
9	Ministry of Social Rights, Consumer	Funding of construction and remodelling of residential facilities adapted to the MACP, of new	4 a, 4 b, 4 c, 5 a, 5 b, 5 c, 5 d, 6 e

ID	EXECUTIVE BODY	PROPOSED MEASURE	EU COUNCIL REC.
	Affairs and 2030 Agenda. Autonomous Communities and Local Authorities.	day care centres and of technology at the service of LTC (C22.I1).	
10	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Ministry of Equality. Autonomous Communities and Local Authorities. With the collaboration of the Ministry of Education, Vocational Training and Sports and the Ministry of Labour and Social Economy.	Plan for the modernisation of social services: technological transformation, innovation, training and strengthening of child care (C22.I2).	4 a, 4 b, 4 c, 5 a, 5 b, 5 c, 8b, 10 d
11	Ministry of Social Rights, Consumer Affairs and 2030 Agenda.	SAAD Evaluation Report (2022).	4 a, 4 b, 4 c, 5b, 8 f,10 b, 10 c, 10 h
12	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Imserso.	Imserso's Healthy and Active Aging Programs.	4 a, 4 b, 4 c, 5 a, 5 b, 5 c, 5 e, 6 e.
13	Ministry of Social Rights, Consumer Affairs and 2030 Agenda.	Draft Law on Families.	4 a, 4 b, 4 c, 6 e, 6 f, 9 b, 9 c
14	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Imserso. AC:	Resolution of 24 May 2023, of the Secretary of State for Social Rights, publishing the Agreement of the Territorial Council of Social Services and the SAAD, defining and establishing the specific conditions for access to personal assistance in the SAAD.	4 a, 4 b, 4 c, 5 a, 6 e, 8 a
15	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. AC:	Royal Decree 888/2022, of 18 October, establishing the procedure for the recognition, declaration and qualification of the degree of disability.	4 a, 4 b, 4 c, 5c, 6 e, 6 f
16	Ministry of Social Rights, Consumer Affairs and 2030 Agenda.	Order DSA/934/2023, of 19 July, amending the scales that appear as Annexes I, II, III, IV, V and VI of Royal Decree 888/2022, of 18 October, which establishes the procedure for the recognition, declaration and qualification of the degree of disability.	4 a, 4 b, 4 c
17	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Imserso.	Increase of SAAD funding by the AGE.	4 a, 4 b, 4 c, 6 c
18	Ministry of Social Rights, Consumer	Plan to reduce the waiting list of the SAAD.	4 a

ID	EXECUTIVE BODY	PROPOSED MEASURE	EU COUNCIL REC.
	Affairs and 2030 Agenda. Imserso. AC:		
19	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Other ministries. ACs and Local Administration.	State Strategic Framework against Loneliness.	5 a, 5 b, 5 e, 6 e, 6 f, 10 b, 10 g
20	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Imserso.	Operational Plan against Loneliness 2024-2026.	5 a, 5 b, 5 e, 6 e, 6 f, 10 b, 10 g
21	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Autonomous Communities and Local Authorities.	Accessible Spain Plan.	5 b, 5 d
22	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Royal Board of Trustees on Disability.	Creation of the Spanish Centre for Cognitive Accessibility.	5 d
23	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Imserso.	Grants for the promotion of tourism and thermalism activities for people with disabilities (regulated by Order TAS/980/2007, of 2 April).	5 e, 6e
24	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Imserso.	Creation of a technical presentation on the evaluation and quality of the SAAD.	6 a, 6 b, 6 c, 6 d, 6 e, 6 f 10 c.
25	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Imserso. Local Administration.	Coordination and promotion of the Network of Age-Friendly Cities and Communities in Spain.	5 d, 5 e, 6 e, 10 b, 10 g
26	Ministry of Social Rights, Consumer Affairs and 2030 Agenda, in collaboration with the Ministry of Education, Vocational Training and Sports and the Ministry of Labour and Social Economy.	Training programme for long-term care and public system personnel (C22.I2).	8 a, 8 b
27	Ministry of Social Rights, Consumer Affairs and 2030 Agenda.	Research Study on Deinstitutionalisation Processes and the Transition to Personalised and Community Support Models in Spain (EDI Project).	10 b, 10 c, 10 d

ID	EXECUTIVE BODY	PROPOSED MEASURE	EU COUNCIL REC.
28	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. State Council of Older Persons.	Permanent collaboration with the State Council of Older Persons (created and regulated by Royal Decree 2171/1994, of 4 November).	10 b
29	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Territorial Council.	Co-governance with the Territorial Council of Social Services and the System for Autonomy and Care for Dependency.	10 b
30	Ministry of Social Rights, Consumer Affairs and 2030 Agenda. Imserso.	Census of Social Services Residential Centres in Spain.	10 c
31	Social Rights, Consumer Affairs and 2030 Agenda. Involvement of 137 Tertiary Sector organisations, and also Local and Autonomous Community Administrations. Governed through a Social Innovation Platform (VIDAS Platform).	Funding of 20 pilot projects of social innovation for the deinstitutionalisation and modernisation of social services.	10 d
32	General Courts (binding for all Public Administrations and citizens).	Reform of Article 49 of the Spanish Constitution.	4 a, 4 b, 4 c, 5d, 5 e, 6 e, 6 f
33	All Public Administrations.	Law 8/2021 of 2 June reforming civil and procedural legislation to support persons with disabilities in the exercise of their legal capacity.	6 e, 6 f
34	Presidency of the Government. Applicable to all Public Administrations.	Complete transposition of Directive (EU) 2019/1158, of the European Parliament and of the Council, of 20 June 2019, on work-life balance for parents and carers, and repealing Council Directive 2010/18/EU, through Royal Decree-Law 5/2023, of 28 June, adopting and extending certain measures to respond to the economic and social consequences of the War in Ukraine, to support the reconstruction of the island of La Palma and other situations of vulnerability; transposing EU Directives on structural modifications to commercial companies and on the work-life balance of parents and carers; and implementing and complying with EU Law.	9 b
35	Public Prosecutor's Office.	Instruction 1/2022, of 19 January, of the Public Prosecutor's Office, on the use of mechanical or pharmacological restraints in psychiatric or mental health units and residential and/or social-health	6 e, 6 f

ID	EXECUTIVE BODY	PROPOSED MEASURE	EU COUNCIL REC.
		centres for older people and/or people with disabilities	
36	Council of Ministers.	Royal Decree-Law 16/2022 of 6 September on the improvement of working conditions and Social Security of domestic workers.	7 a, 7 b, 7 c, 8 e, 8 f
37	Council of Ministers.	Royal Decree 902/2020 of 13 October on equal pay for women and men.	7 a, 8 f
38	Council of Ministers.	Royal Decree 901/2020 of 13 October regulating equality plans and their registration and amending Royal Decree 713/2010 of 28 May on the registration and filing of collective bargaining agreements and labour agreements.	7 a, 8 f
39	Council of Ministers.	Royal Decree 629/2022, of 26 July, amending the Regulation of Organic Law 4/2000, on the rights and freedoms of foreigners in Spain and their social integration, after its reform by Organic Law 2/2009, approved by Royal Decree 557/2011, of 20 April.	7 c, 8 c, 8 d
40	Ministry of Science, Innovation and Universities.	Royal Decree 889/2022, of 18 October, establishing the conditions and procedures for homologation, declaration of equivalence and validation of university studies from foreign education systems and regulating the procedure to establish correspondence to the level of the Spanish Framework of Higher Education Qualifications for official university degrees belonging to previous academic systems.	7 c, 8 a, 8 d
41	Ministry of Science, Innovation and Universities.	Resolution of 21 February 2024, of the General Secretariat for Universities, issuing instructions for the processing of the procedure for homologation and declaration of equivalence in qualification and academic level of foreign higher education qualifications regulated in Royal Decree 889/2022, of 18 October, which establishes the conditions and procedures for homologation, declaration of equivalence and validation of university studies from foreign education systems and which regulates the procedure to establish correspondence to the level of the Spanish Framework of Higher Education Qualifications for official university degrees belonging to previous academic systems.	7 c, 8 a, 8 d
42	Ministry of Education, Vocational Training and Sports.	Incorporation in professional skill certificates and vocational training qualifications of the competency standards related to a person-centred approach and oriented at the promotion of autonomy and independent living in the community.	8 a, 8 b
43	Ministry of Education, Vocational Training and Sports. AC:	Reskilling and Upskilling of the active population linked to professional qualifications (C20.I1).	8 a, 8 b
44	Ministry of Equality	RD 6/2019, of 1 March, on urgent measures to guarantee equal treatment and opportunities	9 c

ID	EXECUTIVE BODY	PROPOSED MEASURE	EU COUNCIL REC.
		between women and men in employment and occupation.	
45	Ministry of Inclusion, Social Security and Migration.	Extract from the resolution of 1 April 2024 of the State Secretariat for Migration, announcing grants for 2024, of the programme of associations of order ESS/1613/2012, of 19 July (Associations).	4 a, 4 b, 4 c
46	Ministry of Inclusion, Social Security and Migration.	Extract from the resolution of 1 April 2024 of the State Secretariat for Migration, announcing grants for 2024, of the programme of associations of order ESS/1613/2012, of 19 July (older and dependent persons).	4 a, 4 b, 4 c
47	Ministry of Health.	Development of community health lines of action within the framework of Primary and Community Care actions.	4 a, 4 b, 5 a, 5 e
48	Ministry of Health.	Update of the consensus document on the prevention of frailty in the older person.	4 a, 4 b, 5 e, 10 d
49	Ministry of Health.	Progress on recording social and family context-related conditioning factors in the Digital Medical Record and real-time identification of people with health and social vulnerabilities.	4 a, 4 b, 5 e
50	Ministry of Health.	Continuation of the Population Stratification Project using Adjusted Morbidity Groups.	4 a, 5 e
51	Ministry of Health.	Actions to implement models for comprehensive demand management, optimisation of processes and improvement of coordination between levels of care, social and health care and social care.	4b, 5 e, 10 b
52	Ministry of Health.	Improve integrality and bidirectional coordination between levels of care and with social and social-health care.	4b, 5 e, 10 b
53	Ministry of Health.	2022-2024 Mental Health Action Plan: "Community Mental Health Plan".	4 b, 5 e
54	Ministry of Health.	Creation of a working group to develop recommendations for the improvement of Home Care in the National Health System.	5 a, 5 e
55	Ministry of Health.	Promotion of specific intervention strategies aimed at people with chronic health conditions and limitations of activity, in especially complex situations or suffering from multiple pathologies, with special attention for case management and home care.	5 a, 5 e
56	Ministry of Health.	Prevention and Health Promotion Strategy of the National Health System.	5 e, 10 b
57	Ministry of Health.	Campaign focused on a vulnerable group, such as older people, with particular attention to undesired loneliness and to improving accessibility to the health system in the event of mental health problems.	5 e
58	Ministry of Labour and Social Economy. Social agents.	Resolution of 30 May 2023, of the Directorate General for Employment, registering and publishing the VIII State framework agreement on care services for dependent persons and developing the promotion of personal autonomy.	7 a, 7 b, 8 f
59	Ministry of Labour and Social Economy. Social agents.	Resolution of 12 February 2024, of the Directorate General for Employment, registering and publishing the VIII State framework collective	7 a, 7 b, 8 f

ID	EXECUTIVE BODY	PROPOSED MEASURE	EU COUNCIL REC.
		agreement on care services for dependent persons and developing the promotion of personal autonomy (private residential homes for older people and the home help service).	
60	Ministry of Labour and Social Economy. Social agents.	Resolution of 27 June 2019, of the Directorate General for Employment, registering and publishing the XV General collective agreement on care centres and services for people with disabilities.	7 a, 7 b
61	Ministry of Labour and Social Economy. Social agents.	Resolution of 25 December 2023, of the Directorate General for Employment, registering and publishing the Partial Agreement on economic matters of the XV General collective agreement on care centres and services for people with disabilities.	7 a
62	Ministry of Labour and Social Economy.	Ratification of ILO Convention 190 on the elimination of violence and harassment in the world of work.	7 b
63	Ministry of Labour and Social Economy.	Draft Organic Law on the Right to Defence.	7 b
64	Ministry for Ecological Transition and the Demographic Challenge in coordination with other ministries. Implementation of Axis 8 involves the Ministry of Health, the Ministry of Equality, and the Ministry of Social Rights, Consumer Affairs and 2030 Agenda.	Government Plan of Measures to Combat Demographic Challenge (Plan 130).	5 a, 5 b, 5 c, 5d, 5 e.
65	Ministry for Ecological Transition and the Demographic Challenge. In collaboration with other ministries and the Local and Autonomous Community Administrations.	National Strategy to tackle the Demographic Challenge.	5 a, 5 b
66	Ministry for Ecological Transition and the Demographic Challenge (MITECO) and the CIUDEN Foundation (Energy City, a state public	Red-CIT	5 b, 10 d

ID	EXECUTIVE BODY	PROPOSED MEASURE	EU COUNCIL REC.
	sector foundation attached to the Ministry for Ecological Transition and the Demographic Challenge through the Autonomous Organisation Just Transition Institute).		
67	Ministry for Ecological Transition and the Demographic Challenge.	Awarding of grants to finance innovative projects for territorial transformation and the fight against depopulation (Order TED/1358/2021, of 1 December).	5 b
68	Ministry for Ecological Transition and the Demographic Challenge.	Sectoral Conference on Demographic Challenge (constituted by virtue of an Agreement adopted at the first meeting of said Sectoral Conference, held on 23 July 2020).	10 b

9 Annex II.

Measures proposed by the Autonomous Communities to comply with the Recommendations of the Council of the European Union.

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
1	Andalusia	Design of a protocol that responds to the need to establish how to preferentially process, within the framework of the procedure for recognition of the situation of dependency and of the right to benefits of the SAAD, those administrative files which, for reasons of urgency or social emergency, require a prompt response from the Public Administration.	4a
2	Andalusia	Personalised monitoring for users Control of habits at home: Presence or movement, temperature, luminosity, power consumption or door opening sensor to help detect any unusual behaviours by users.	5a
3	Andalusia	Establishment of audiovisual and written communications with users using technological supports such as tablets through a video call system in individual and group sessions. Development of healthy lifestyle campaigns and training programs using a multimedia visualization system. Creation of a communication system with users through chats for text conversations. Installation of advanced mobile telecare devices, gas and smoke detectors. (Currently implemented)	5c
4	Andalusia	Centre for Virtual Active Participation	5c
5	Andalusia	Application of easy reading to all types of application forms and in different languages; application and communications through other channels, not exclusively online, as it increases the dependency of homeless people (as a general rule, communications must be made through the same channel as for all other citizens, incorporating the necessary support); creation of an accessible guide of resources with information on the resources available for the care of homeless people.	5d
6	Andalusia	Amendment to the current regulations governing the type of residential centres for older persons to adapt them to the new requirements of collective coexistence integrated in the community.	5d
7	Andalusia	Programme 31R. Care for dependency, active ageing and disability	5e
8	Andalusia	Integration of FAISEM into spaces of provincial coordination, together with the associative movement of family members and users, mental health services, social services and Tertiary Sector entities and providing housing for application of the housing first method aimed at people with serious mental disorders.	5e

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
9	Andalusia	Publication of regulatory bases for grants that prioritise the awarding of grants to programmes that promote the model of person-centred care living in the community.	6b
10	Andalusia	Reconditioning of the network of residential centres for older people owned by the Junta de Andalucía with adequate equipment according to the Person-Centred Care model	6e
11	Andalusia	Reconditioning of the network of Active Participation Centres for Older People	6e
12	Andalusia	Detection of possible situations of risk of abuse and gender-based violence affecting users.	6f
13	Andalusia	Reinforcement and/or development of healthy living and health promotion campaigns aimed at the general population, and specifically at people with disabilities, older people, people with parental responsibilities and homeless people, from a positive health approach.	6f
14	Andalusia	Training courses aimed at care professionals for older people in residential centres and active participation centres.	8a
15	Andalusia	Personalised monitoring for carers of the Andalusian Telecare Service	9a
16	Andalusia	A definitive information collection system will be established to evaluate the strategy and propose the initial dashboard, which will include the following information: -Indicators -Description of the indicators -Most recent data -Source -Person responsible for the collection of information -Design of information collection tools	10c
17	Andalusia	Preparation of a Care and Protection Strategy: systematic study of the scientific literature, analysis of available data and proposal for a public policy for the deinstitutionalisation of children.	10d
18	Aragon	Creation of a working group to ensure that every Regional Service has protocols for responding to emergency situations.	4a
19	Aragon	Regulatory development to increase the intensity of services in accordance with state regulation for the Dependency System.	4c
20	Aragon	Expand the complementarity of services between home help and the day centre	5a
21	Aragon	Grants to support local commerce in small towns and municipalities.	5b
22	Aragon	Implementation of Advanced Telecare.	5c
23	Aragon	ACAP project, use of innovative assistive technology for the home. Bluetooth devices for measuring constants and predicting risk situations by analysing data using an algorithm.	5c
24	Aragon	Programme Connected to Life, training in TRIC (Technology of Relations, Information and Communication) in municipalities with less than 20,000	5c

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
		inhabitants and Active Ageing programme in centres of the IASS.	
25	Aragon	Grants of the ISEAL programme (Social Initiatives for Local Employment) in the line of social transport adapted to the regions of Aragon.	5d
26	Aragon	Implementation of the essential social services set out in the Catalogue of Social Services of Aragon aimed at local care.	5d
27	Aragon	Vital Moments Project: launch of a more user-friendly website for people with disabilities and in situations of dependency, to include a simulator for the person to assess their life moment and request an assessment of disability and/or dependency	5d
28	Aragon	Provision of services for the prevention of dependency and promotion of personal autonomy in centres of the IASS. Expansion of the number of centres providing services through Tertiary Sector and private entities.	5e
29	Aragon	Accreditation of centres to provide Services for the prevention of dependency and promotion of personal autonomy.	6a
30	Aragon	Action within the framework of the change in care model in the residences of the IASS.	6a
31	Aragon	Amendment of the technical specifications for contracting the indirect management of residences and day care centres of the IASS network in line with the AICP (person-centred) care model.	6a
32	Aragon	Amendment of the framework agreements for the social coordination of places in residences and day care centres, aimed at introducing criteria and requirements in line with the AICP (person-centred) care model.	6a
33	Aragon	ACAP Pilot Project (Connected Supports for Personal Autonomy)	6e
34	Aragon	Training programme for the Pilot Research Project on the implementation of co-living units in residences of the IASS. The project includes a training programme in the ACP (Person-Centred Care) model and accompaniment for professionals and teams in its implementation	6e
35	Aragon	Design of a pedagogical supervision and continuous training programme for professionals of the CuidArte Programme and Services for the prevention of dependency and promotion of personal autonomy.	6e
36	Aragon	Design of restraint-free care protocols, within the framework of the pilot research project on the implementation of co-living units in residences of the IASS and in the AICP.COM pilot project.	6f
37	Aragon	Adjustment of the number of residential places to care capacity based on a new higher ratio of direct care staff.	7a
38	Aragon	Actions included in the CuidArte programme and Services for the prevention of dependency and promotion of personal autonomy (pedagogical supervision groups), in addition to the pilot research study on the transformation of co-living units (training and analysis of situations).	7b

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
39	Aragon	Project of connected Supports for personal autonomy (ACAP)	8b
40	Aragon	Rehabilitation processes at home, individualised support for special needs, support for shared housing.	9b
41	Aragon	Training service for family caregivers	9b
42	Aragon	CuidArte Programme, emotional support groups for family caregivers.	9c
43	Aragon	ACAP Project (Connected supports for personal autonomy) The project experiments in rural and urban areas coordination between different levels of the administration (autonomous community, regional and local) for the comprehensive care of people at home, mobilising and coordinating the resources of both public and other Tertiary Sector entities. Resource mapping in the communities where the new professional figure of support manager is implemented.	10b 10d
44	Aragon	AICP.COM research project: pilot research project on the implementation of co-living units in residential centres of the IASS	10d
45	Canary Islands	Monetary contributions to all municipalities of the CAC for the maintenance of Information, Guidance, Assessment and Diagnostic Services for Children and Families	4a
46	Canary Islands	Implementation of social emergency services that can help people in specific times of crisis and need.	4a
47	Canary Islands	Promotion by increasing the score of projects that cater to children with functional diversity.	5d
48	Canary Islands	Reinforcement and/or development of plans and programmes aimed at families and people with parental responsibilities with the objective of providing them with personalised support and accompaniment in situations of risk of exclusion, social isolation or conflict.	5e
49	Canary Islands	Reinforcement of home and outpatient care and rehabilitation and recovery services and resources to curb, reverse or reduce the risk of dependency, especially in situations of unexpected illness or disability.	5a
50	Canary Islands	Reduction of the digital divide through application of universal design in digital public services and support for the acquisition of digital devices and competencies by individuals and families with support needs.	5c
51	Canary Islands	Development of common quality standards that take into account the particularity of non-institutional environments and that incorporate the perspective of the people who receive support, and all other agents involved, including the inspection services.	6a
52	Canary Islands	Conducting research, with the participation of experts through experience, families and representative organisations, to identify causes related to the risk of institutionalisation of people in need of support.	10f
53	Canary Islands	Multidisciplinary research addressing different aspects of deinstitutionalisation, such as the impact on people's quality of life, potential benefits for the environment and for the population in general, economic viability and best	10f

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
		transition practices, ensuring that evidence is integrated into public policy and decision-making.	
54	Canary Islands	Promotion of the evaluation systems of processes and structures, and of impacts and outcomes.	10f
55	Canary Islands	Development of common models to assess impacts on people's quality of life, on centres and on services.	10f
56	Cantabria	Resolution on the recognition of the degree of dependency and the right to the corresponding benefit within the legally established period	4a
57	Cantabria	Improvement of the benefits and services included in the catalogue of the SAAD. Expansion of compatibilities between services and benefits of the SAAD.	4b
58	Cantabria	Establishment of co-payment for services of the SAAD based on the economic capacity of the persons in dependency situations	4c
59	Cantabria	Home Help Service	5a
60	Cantabria	Study of needs for resources of the SAAD in each basic social services area	5b
61	Cantabria	Home Telecare Service	5c
62	Cantabria	Universal Accessibility Strategy	5d
63	Cantabria	Benefit for the Promotion of Autonomy and Prevention of Dependency	5e
64	Cantabria	Grants for the promotion of autonomous living	6e
65	Cantabria	Constitution of dialogue tables with tertiary sector entities and trade union organisations in the field of disability and dependency	7a
66	Cantabria	Requirements for entities awarded home help services to comply with risk prevention regulations	7b
67	Cantabria	Creation of the Unit for the Promotion of Autonomy and Care for Dependency	9a 9b
68	Castilla-La Mancha	Long-term care is ensured through healthcare and through residential, community or home protection services, within the catalogue of services and benefits of the SAAD and of the social services network, by means of timely, comprehensive and affordable care based on economic capacity.	4a, 4b, 4c
69	Castilla-La Mancha	Regulatory development of Law 2/2023, of 10 February, on Early Care in Castilla-La Mancha.	4a
70	Castilla-La Mancha	Training Programme	5a
71	Castilla-La Mancha	Programme for the promotion of personal autonomy. Social and Occupational Integration Programme	5a
72	Castilla-La Mancha	Programme for the promotion of personal autonomy (Day centres) for people with disabilities	5a
73	Castilla-La Mancha	Investment and maintenance of day centres and centres for older people owned by the JCCM. Grant for the maintenance of places in day care centres, centres for older people and for the development of programmes and projects of care for older people in Castilla-La Mancha	5a
74	Castilla-La Mancha	Maintain and develop Advanced Telecare and Assistive Products	5c
75	Castilla-La Mancha	Improving access to and the loan of assistive products to facilitate the autonomy of people in dependent situations	5d

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
76	Castilla-La Mancha	Actions and networks of coordination between Social Welfare, Education and Health to address complex cases	5e
77	Castilla-La Mancha	Inspect compliance with quality standards, technical requirements and conditions of the centres through control and supervision services and systems.	6a
78	Castilla-La Mancha	Increase the budget for contracts and concerted actions	6b 6c
79	Castilla-La Mancha	Include in PCAP clauses of contracts for the provision of long-term care, accreditation of compliance with quality assurance standards, as an additional solvency requirement.	6d
80	Castilla-La Mancha	Design, monitoring and evaluation of Personal Support Plans, with the assistance of a support group and reference persons.	6e
81	Castilla-La Mancha	Project to identify and implement 5 person-centred care indicators. Phase II. Comprehensive Person-Centred Care Project Pilares (Pillars) Foundation	6e
82	Castilla-La Mancha	Increase services for the promotion of personal autonomy (SEPAP-Mejora-T) with the modality of itinerant services in municipalities with small populations.	6e
83	Castilla-La Mancha	Provision of support teams in Primary Care Social Services aimed at prevention, detection and intervention in situations of violence against children.	6f
84	Castilla-La Mancha	Training courses for public staff of centres providing long-term care services	8a 8b
85	Castilla-La Mancha	Training and Support Plan for Carer Families (I)	9a
86	Castilla-La Mancha	Training and Support Plan for Carer Families (II)	9b
87	Castilla-La Mancha	Training and Support Plan for Carer Families (III)	9c
88	Castilla-La Mancha	Coordination actions of the Territorial Council for the Promotion of Autonomy and Care for Dependency to design, implement and monitor actions and investments in the field of long-term care policies	10b
89	Castilla-La Mancha	Development of Working Days and Meetings regarding deinstitutionalisation	10d
90	Castilla-La Mancha	Celebration of working days, workshops and events for professionals	10d
91	Castilla-La Mancha	Celebration of working days, workshops and events for professionals	10d
92	Castilla-La Mancha	Maintenance of the Agreement between Councils (measure without budgetary impact).	10d
93	Catalonia	Programme of support for projects related to the prevention of undesired loneliness	4a
94	Catalonia	Planning a network of CUES (Emergency and Social Emergency Centres) of the territorial social services	4a
95	Catalonia	Experimental projects for the prevention of institutionalisation aimed at people at risk of social exclusion derived from a situation of addiction, psychosocial problems for reasons of disability and/or a mental disorder	4a
96	Catalonia	Deployment of Integrated Social and Health Care	4b

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
97	Catalonia	Personal budget development and pilot	4c
98	Catalonia	Development of a new model of care in the home environment	5a
99	Catalonia	To agree on the intervention model of the SAED (care service in the home environment) together with the local authorities. The model is based on a home intervention with a community vision.	5a
100	Catalonia	Specific line for the development of housing cooperatives through a call for tertiary sector entities 2024	5a
101	Catalonia	Execution of Next Generation Funds financed through the Ministry of Social Rights Lines 3 and 4	5c
102	Catalonia	Execution of Next Generation Funds financed through the Ministry of Social Rights, Line 2	5c
103	Catalonia	Accessibility code with new sensory and cognitive accessibility obligations in various chapters of the new Code	5d
104	Catalonia	Provision of care circuit and protocols and provision of assistive products for autonomy and accessibility in the home, among interregional social services	5d
105	Catalonia	Chapter 4 of the new Accessibility Code covers all new accessibility obligations in public transport.	5d
106	Catalonia	Boosting SAIARs through the review of the social services portfolio.	5d
107	Catalonia	Approval of the Accessibility Code (November 2023).	5d
108	Catalonia	Digital transformation of the Department of Social Rights, which will facilitate the exchange of information between local authorities and the Department and the interoperability of the Social Rights Information System and the Department of Health.	5e
109	Catalonia	Coordination protocol between the inspection services of the Department of Health and the Department of Social Rights.	5e
110	Catalonia	Preparation of an inspection plan and introduction of ACP (person-centred care) criteria	6a
111	Catalonia	Development of a quality plan	6a
112	Catalonia	Development of an inspection guide.	6a
113	Catalonia	New law on the social services system	6a
114	Catalonia	First social impact hiring	6a
115	Catalonia	Radars plans under the competence of the local authorities.	6e
116	Catalonia	OMNIA Points for Digital Inclusion	6e
117	Catalonia	Plan for civic centres.	6e
118	Catalonia	Experimental Projects for Integrated Social and Health Care in the home environment, in mental health facilities and in homes for older people	6e
119	Catalonia	Increase in rates (5% on average)	7a
120	Catalonia	Training for carers	9b
121	Catalonia	Contracts and grants to local authorities for caregiver support groups.	9c
122	Catalonia	New system of satisfaction surveys and publication of inspections.	10c
123	Catalonia	Detailed and disaggregated preparation of dependency and disability statistics.	10c
124	Catalonia	Publication of satisfaction surveys and inspections.	10c

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
125	Catalonia	Preparation of an evaluation plan	10c
126	Catalonia	Grants linked to experimental projects that facilitate deinstitutionalisation processes in the area of older people, people with disabilities and people with mental health problems.	10d
127	Community of Madrid	Preparation of the new Decree regulating the procedure for recognising the situation of dependency and access to the public system of care services and benefits for dependency in the Community of Madrid (I)	5a
128	Community of Madrid	Preparation of the new Decree regulating the procedure for recognising the situation of dependency and access to the public system of care services and benefits for dependency in the Community of Madrid (II)	5b
129	Community of Madrid	Preparation of the new Decree regulating the procedure for recognising the situation of dependency and access to the public system of care services and benefits for dependency in the Community of Madrid (III)	5c
130	Community of Madrid	Implementation of new advanced telecare and home help services, adapted to the care needs of people in dependent situations cared for in a community environment	6a
131	Community of Madrid	Strengthening the network of local day care centres.	6b
132	Community of Madrid	Technical and technological equipment for autonomy in publicly owned centres and indirect management with funds of the European Union's Recovery, Transformation and Resilience Plan	6c
133	Community of Madrid	Development of an advanced telecare project in the Community of Madrid, financed through MRR (Next Generation EU) Funds, and within the investment line C22.I1 "Long-term care and support plan: deinstitutionalisation, equipment and technology", Investment Project No. 2: Incorporation of technologies for autonomy and home care	6c
134	Community of Madrid	Creation of the residents identification module in the Social and Health Portal (resolution 4754/2022, of 7 November)	6e
135	Community of Madrid	Creation of the Social and Health Coordination Commission (agreement of the Council of Government of the Community of Madrid, of 7 February, BOCM of 14 February) Design and implementation of a regional plan for active ageing and the prevention of dependency, based on collaboration with Local Councils and other agents involved (health,..)	6e
136	Community of Madrid	Preparation of the Order of the Family, Youth and Social Affairs Council, establishing the requirements and quality standards for the accreditation of social care centres and services forming part of the Public System of Social Services of the Community of Madrid, in the field of the promotion of personal autonomy and care for people in situations of dependency	7a

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
137	Community of Madrid	Contract "Continuous improvement of the catering service offered in homes for older people during 2024-2027"	7a
138	Community of Madrid	Inclusion, in framework agreements, of the requirement for certification in the UNE 158000 family of standards, dedicated to care for dependency	7d
139	Community of Madrid	Establishment of the criteria that will govern the registration system for the personal assistance service (Resolution of 30 May 2023, BOCM of 12 June)	7e
140	Community of Madrid	Design and implementation of a care unit for older people in situations of abuse in centres funded by the Community of Madrid Development of the PREDEA network unit for the prevention, detection and care for persons with intellectual disabilities in situations of abuse or mistreatment	7f
141	Community of Madrid	Training Centre Preparation of a staff training plan in residential centres for older people with contracted places. Launch of the Long-Term Care School (Improvement of the Training Programme)	8a
142	Community of Madrid	Preparation of the new Decree regulating the procedure for recognising the situation of dependency and access to the public system of care services and benefits for dependency in the Community of Madrid	9b
143	Community of Madrid	Launch of the Long-Term Care School (Improvement of the Training Programme)	10b
144	Community of Madrid	Implementation of the Contingency Plan for health emergencies in residential homes for dependent older people with contracted places.	10f
145	Autonomous Community of Navarre	PAISS extension: Integrated Social and Health Care Programme	4a 5e 6e 8b 9b
146	Autonomous Community of Navarre	Maintain and foster the participation of AP and SM in children's networks Maintain and promote comprehensive assessments (medicine, nursing and social work) in the Chronicity Strategy (both in children and in adults)	4a
147	Autonomous Community of Navarre	Maintain and promote comprehensive assessments (medicine, nursing and social work) in the Chronicity Strategy (both in children and in adults)	4a
148	Autonomous Community of Navarre	Development of actions in the framework of the dementia profile, Chronicity Strategy (Dementia Unit, concerted with Josefina Arregui...)	4a
149	Autonomous Community of Navarre	Decentralisation of the Early Care Service.	4a
150	Autonomous Community of Navarre	PAISS extension: Maintain and develop actions within the Chronicity Strategy Maintain the annual review of the eligibility of people in places of the RAEM (Assisted Residency for Mental Illness), analysing these people's health and social support needs with the aim of boosting their transition to more community-based housing resources	4b

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
151	Autonomous Community of Navarre	Extension of the PAISS programme (integrated social and health care programme) aimed at people with complex social and health needs requiring a comprehensive intervention from both systems to avoid institutionalisation or unnecessary hospital admissions in situations of loss of function or loss of necessary support. It is currently implemented in three areas of social services (Estella, Tudela and Tafalla) and its expansion is intended to continue.	4b
152	Autonomous Community of Navarre	Expansion of the home help service through a call for proposals for grants to local authorities to increase the intensity of care provided to users, in addition to care in the evenings and at weekends.	4b
153	Autonomous Community of Navarre	1) Extend the parenting support workshop for people with TMG (serious mental illness) to other people cared for with dependent children and parenting difficulties 2) Maintenance and promotion of the School for Fathers and Mothers	4b, 9b
154	Autonomous Community of Navarre	Boost and support funding of local support networks, with the objective of extending successful experiences existing in the Autonomous Community. It will be implemented through a call for proposals for grants addressed to local authorities.	5a
155	Autonomous Community of Navarre	Rehabilitation of 2 abandoned villas belonging to a former centre for people with disabilities, and adaptation to house people with disabilities (and different degrees of support).	5a
156	Autonomous Community of Navarre	Preparation of a law regulating collaborative housing, with older people as one of the priority groups.	5a
157	Autonomous Community of Navarre	Piloting a home support programme for people with mental illness in the rural environment (Tudela area), managed by a tertiary sector entity.	5b
158	Autonomous Community of Navarre	Development of the advanced telecare system and its coordination with social services and primary healthcare centres.	5c
159	Autonomous Community of Navarre	Information and training in the handling of the Personal Health Folder and pilot with video calls in the Mental Health Network (First Psychotic Episodes Programme)"	5c
160	Autonomous Community of Navarre	Development of other Personal Health Folder functions (carrying out administrative procedures such as updating data, requesting a change of doctor, remote monitoring...)	5c
161	Autonomous Community of Navarre	Promotion of teleconsultation through the Personal Health Folder and remote monitoring in AP	5c
162	Autonomous Community of Navarre	Autonomous Decree 92/2020, regulating the operation of residential, day and outpatient services for older people, people with disabilities, mental illness and minors.	5d
163	Autonomous Community of Navarre	Development of a simple guide comprising all services and benefits of the social services portfolio for people in situations of dependency, for delivery to health centres and social services and providing information to users. It is also available in electronic format.	5d

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
164	Autonomous Community of Navarre	Adaptation of informed consents to L8/21 and universally accessible	5d
165	Autonomous Community of Navarre	Preparation of materials to support communication in the HUN and SM	5d
166	Autonomous Community of Navarre	Expansion and maintenance of the remote translation system	5d
167	Autonomous Community of Navarre	Adaptation of the Advance Directives document under universal accessibility criteria	5d
168	Autonomous Community of Navarre	Monitoring of recommendations for improvements with respect to the physical spaces of residential resources indicated in the external evaluations and inspections of resources.	5d
169	Autonomous Community of Navarre	Reporting on the evaluation of Humanisation Strategy	5d
170	Autonomous Community of Navarre	Information and communication actions of the 5 Health Promotion programmes (ISPLN), awareness-raising campaigns and development of materials, information and communication actions on social media, etc.	5e
171	Autonomous Community of Navarre	Maintain the development of actions to promote Emotional Wellbeing in the Interdepartmental Working Group	5e
172	Autonomous Community of Navarre	Extension of the PAISS programme (integrated social and health care programme) aimed at people with complex social and health needs requiring a comprehensive intervention from both systems to avoid institutionalisation or unnecessary hospital admissions in situations of loss of function or loss of necessary support. It is currently implemented in three areas of social services (Estella, Tudela and Tafalla) and its expansion is intended to continue.	5e
173	Autonomous Community of Navarre	Maintenance and development of the Hospital Discharge Planning programme from Social Health Work (currently in hip fractures and strokes)	5e
174	Autonomous Community of Navarre	Revision of Day Centre Programmes of the Rehabilitation Unit for adaptation to new support needs	5e
175	Autonomous Community of Navarre	1) Maintenance and development of the ISPLN Local and Social Action Programme. Grants for Health Promotion, economic and technical advice. Health School Programmes: School for Older People, School for Fathers and Mothers, School for Carers. 2) Collaborate with AP to integrate the psychology profile in their teams	5e
176	Autonomous Community of Navarre	PAISS extension: Maintain and develop actions within the Chronicity Strategy	5e
177	Autonomous Community of Navarre	Autonomous Decree 92/2020 establishes the obligation to implement the model in all resources. Implementation	6a

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
		of the measures is monitored through the Inspection service.	
178	Autonomous Community of Navarre	Periodic publication of the record of inspections carried out by the Department's inspection service	6a
179	Autonomous Community of Navarre	Establishment of a system for arranging residential places for older people (framework agreement called open house), through which centres receive more funding if they have better staff ratios and wage conditions.	6b
180	Autonomous Community of Navarre	New tender for the service to promote the autonomy of people in situations of dependency, through a framework agreement, expanding the number of providers that can apply for it	6d
181	Autonomous Community of Navarre	Implementation of the comprehensive person-centred care model in services and resources (dialogic methodology).	6e
182	Autonomous Community of Navarre	Implementation of dialogic networks in the protection system and community setting.	6e
183	Autonomous Community of Navarre	Creation of protection desks at community level.	6e
184	Autonomous Community of Navarre	Participation of service users and family members and carers in the development of the individual care plans, which play a fundamental role in defining the individual's life project and how they wish their care to be provided.	6e
185	Autonomous Community of Navarre	Strengthening comprehensive and individual care plans within the Chronicity Strategy (EC)	6e
186	Autonomous Community of Navarre	Continue with the implementation of the PAD (Advance Decisions Plan) through professional awareness-raising actions and improvements in the procedure	6e
187	Autonomous Community of Navarre	Encourage the participation of associations of people with MS and their families in programmes, commissions and Plan evaluation	6e
188	Autonomous Community of Navarre	Maintenance and promotion of the Frailty Care Programme	6e
189	Autonomous Community of Navarre	Launch of the Person-Centred Care Network.	6e
190	Autonomous Community of Navarre	Plan for implementation of the dialogic approach by professional teams.	6e
191	Autonomous Community of Navarre	Piloting the creation of an "autonomy support" team at the Tudela social services centre to accompany basic services in providing support to people at risk of dependency.	6e
192	Autonomous Community of Navarre	Piloting a loan service for assistive products, dependent on the Department.	6e
193	Autonomous Community of Navarre	Abuse Prevention Guide.	6f

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
194	Autonomous Community of Navarre	Implementation and monitoring of Autonomous Decree 92/2020, which establishes the mandatory nature of a plan for the elimination of restraints (both physical and pharmacological) in the services.	6f
195	Autonomous Community of Navarre	Review of the social intervention agreement in 2024.	7a
196	Autonomous Community of Navarre	Promotion of the I Dependency Agreement of Navarre offering improved wages and employment conditions for people working in the sector and increasing the funding for services contracted by the Administration.	7a
197	Autonomous Community of Navarre	Disability training for professionals	8a
198	Autonomous Community of Navarre	Training offer to EAPs (Primary Care Teams) and residential centres for the prevention and detection of psycho-behavioural disorders in dementia	8a
199	Autonomous Community of Navarre	Training programme for professionals in Person-Centred Care (ACP)-dialogic approach.	8b
200	Autonomous Community of Navarre	Implementation of the dialogic approach in social services.	8b
201	Autonomous Community of Navarre	Maintenance of the training offer aimed at professionals in relation to ethical-legislative-legal aspects of people with dementia and their families	8b
202	Autonomous Community of Navarre	Amendment to the regulations governing personal assistance to adapt it to current requirements within the framework of a global system of benefits.	8b
203	Autonomous Community of Navarre	Monitoring the deployment of the reference professional in all residential centres, as regulated in Autonomous Decree 92/2020.	8b
204	Autonomous Community of Navarre	Increase in grants for parenting skills programmes aimed at families with children with disabilities or mental health disorders.	9b
205	Autonomous Community of Navarre	Modification of financial benefits for dependent people to support care in the family environment, increasing aid for those who hire support for home maintenance. This aid would complement the existing aid for the hiring of professional carers	9b
206	Autonomous Community of Navarre	1) Maintenance and development of the ISPLN Local and Social Action Programme. Grants for Health Promotion, economic and technical advice. Health School Programmes: School for Older People, School for Fathers and Mothers, School for Carers.	9b
207	Autonomous Community of Navarre	Maintenance of the offer of workshops and individualised training-support for families of chronically ill patients from AP (Primary Care)	9b
208	Autonomous Community of Navarre	Maintenance of updated information on health-related social and community resources	9b
209	Autonomous Community of Navarre	Publication on the Government of Navarre's institutional website of information aimed at caregivers	9b

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
210	Autonomous Community of Navarre	Txiribuelta Project	9b
211	Autonomous Community of Navarre	Maintenance and development of Health School Programmes: School for Carers	9b
212	Autonomous Community of Navarre	Maintenance of the offer of workshops and individualised training-support for families of chronically ill patients (dementia, palliative care, etc.) from AP	9b
213	Autonomous Community of Navarre	Commitment to funding the necessary supports to keep people who have participated in the "Living Better at Home" project and who have left a residential facility within the community.	10d
214	Autonomous Community of Navarre	Promotion of the Community Health Strategy from the Community and Social Action Programme.	10g
215	Autonomous Community of Navarre	Maintenance and promotion of both individual and community actions in the framework of the Fragility Care Program	10g
216	Autonomous Community of Navarre	Promote the Residential and Foster Care Board to design a strategy to raise awareness and attract foster families.	10g
217	Valencian Community	Preparation of a Guide to Undesired Loneliness for Older People: Preparation of a study and report on the state of affairs in the Valencian Community.	4a
218	Valencian Community	Programme for detection and intervention in cases of undesired loneliness and referral to community resources.	4a
219	Valencian Community	Streamlining the procedure for assigning places in subsidised centres dedicated to the care of people at risk or in situations of social exclusion	4a
220	Valencian Community	Offer of accommodation and housing resources for older people in urgent need through community resources	4a
221	Valencian Community	Programmes of the Care and Monitoring Service for People with Mental Health Problems (SASEM) of local authorities with a population of 20,000 inhabitants or more and reinforcement or development of professional teams for these programmes.	4a
222	Valencian Community	Implementation of the computer application that streamlines management of the allocation of places in shelters and housing designed to care for people at risk or in situations of social exclusion	4a
223	Valencian Community	Review of the Valencian Inclusion Income	4c
224	Valencian Community	Promotion of the network of caring cities for older people in the Valencian Community	5a
225	Valencian Community	Organisation and activation of associations to carry out community activities from local community resources.	5a
226	Valencian Community	Courses and workshops carried out at the Active Ageing Centres aimed at training older people in new technologies.	5c
227	Valencian Community	The SSOM promotion campaign in "search for individuals and families interested in welcoming children and adolescents with special characteristics"	5d

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
228	Valencian Community	Carrying out the sports activities planned during the celebration of the III and IV Conference on Sport, Mental Health and Disability	5d
229	Valencian Community	Call for individualised financial benefits aimed at contributing to the removal of architectural barriers existing in the individual home or in buildings where older people live.	5d
230	Valencian Community	Annual call for personal aid to facilitate the autonomy of people with disabilities (acquisition of technical aids and assistive products; removal of architectural barriers and functional adaptation of the home; adaptation of vehicles; transport to attend treatments and care centres).	5d
231	Valencian Community	Annual call for grants for local authorities and non-profit organisations to improve conditions of accessibility to the physical environment (among others, actions to promote the accessibility of communication, establishing mechanisms and technical alternatives that make communication and signage systems accessible in publicly or privately owned buildings).	5d
232	Valencian Community	Preparation of the initial draft of the Universal Accessibility Law.	5d
233	Valencian Community	Development and implementation of a coordination protocol between the SASEM service and the Mental Health Units (USM) of the Health Council.	5e
234	Valencian Community	Courses and workshops at the Active Ageing Centres directed at older people regarding existing resources (home help, promotion of personal autonomy, support for dependency)	5e
235	Valencian Community	Preparation of service quality evaluation documents in the Active Ageing Centres	6a
236	Valencian Community	Administrative contracting clause requiring the contracted company to comply with ISO quality requirements	6d
237	Valencian Community	Expansion of the Programmes of the Active Ageing Centres	6e
238	Valencian Community	Annual call for grants for the development of programmes that promote the autonomy of people with disabilities (intervention programmes, supported employment; collaboration and revitalisation of custodial organisations; promotion of independent living; social cooperation; family respite; co-living; promotion of leisure and free time; raising awareness; training).	6e
239	Valencian Community	Annual call for proposals for grants to carry out independent living projects through individualised itineraries for people with disabilities	6e
240	Valencian Community	Inclusion and community development programmes	6e
241	Valencian Community	Continuation of the AICP.com pilot project of the transformation process towards the person-centred care model, implemented by the Pilares Foundation.	6e
242	Valencian Community	Development and implementation of “restraint-free care plans” in residential centres for people with mental health problems.	6f

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
243	Valencian Community	Training for professionals (including residential resource professionals) on the reduction and elimination of the use of restraints, and on the prevention of and care for situations of abuse in older people.	6f
244	Valencian Community	Execution of 3 editions (one per province) of the programmed courses: 1) Promotion of the rights of people with disabilities; 2) Non-coercive practices in residential care for people with mental health problems and 3) Prevention, detection and intervention with victims of sexual violence in residential care centres for people with disabilities.	6f
245	Valencian Community	IVAP training in the person-centred care model and a comprehensive approach to Dysphagia in the social and health field directed at professionals.	8a
246	Valencian Community	Execution of the three training courses planned by the Valencian Federation of Municipalities and Provinces on: 1. Care and follow-up for people with serious mental health problems from primary care; 2. Introduction to managing serious mental health problems; 3. Tools for group and multifamily intervention and 4. Implementation of specific training for SASEM professionals contracted with the Manantial Foundation.	8b
247	Valencian Community	Training programmes on undesired loneliness for both professionals and volunteers.	9b
248	Valencian Community	Annual call for proposals for grants for vacation stays for people with disabilities or serious mental disorders, allowing carer families to have a work-life balance and offering respite and support for family rest.	9b
249	Valencian Community	Follow-up seminars with the Sense Llar platform, to evaluate concerted action	10d
250	Valencian Community	Dissemination of the “CUIDEM” Manual.	10g
251	Valencian Community	Promotion of campaigns and events to promote the recognition of older people and their role in society, and to prevent ageism.	10g
252	Extremadura	Hiring of professionals to implement reception and information actions	4a
253	Extremadura	Development of enquiries regarding interventions and procedures for people with disabilities.	4a
254	Extremadura	Development of information and training sessions to consolidate community support networks for the prevention of institutionalisation.	4a
255	Extremadura	Existing Day Centres for people with disabilities in the Autonomous Community	5a
256	Extremadura	Development of the “Proximity Services” programme and Multipurpose Resource Centres of the local authorities of Extremadura	5a
257	Extremadura	Flats for Independent Living of people with disabilities due to a mental disorder	5a
258	Extremadura	Care programmes for people with cognitive impairments in Day Centres and at Home	5a
259	Extremadura	Work Placement Program	5a

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
260	Extremadura	Development of activities to promote autonomy and active ageing in “Hogares Club (Club Home)” centres for older people.	5a
261	Extremadura	Submission of a Proposal to amend the regulatory bases for personal income tax subsidies in the Autonomous Community of Extremadura.	5a
262	Extremadura	Activation of routes for specialised transport for people with disabilities in rural areas	5b
263	Extremadura	Funding and aid to local authorities at risk of depopulation for the adaptation of residential and day care centres, and multipurpose resources.	5b
264	Extremadura	Personalised advanced home telecare service (TAP)	5c
265	Extremadura	Implementation of “Cyberclassrooms” and digital training activities and training in new technologies at centres for older people.	5c
266	Extremadura	Programme for the adaptation of Residential Centres to the new model of person-centred care and adaptation to the common accreditation criteria	5d
267	Extremadura	Funding of adaptations and transformation of residential resources	5d
268	Extremadura	Deploying New Housing Models with Supports	5d
269	Extremadura	Care Unit for students with disabilities of the University of Extremadura	5d
270	Extremadura	Creation and opening of new information points	5d
271	Extremadura	Universal accessibility programme for municipalities	5d
272	Extremadura	Increase in specialised transport routes for people with disabilities in 2024	5d
273	Extremadura	Specialised transportation programme for people with cognitive impairments to Day Centres specialised in dementia	5d
274	Extremadura	Municipal economic collaboration programme for services to promote autonomy for autonomous people or people with dependency grade I and programmes in day centres for people in situations of dependency	5d
275	Extremadura	Offices for the Rights of Persons with Disabilities	5d
276	Extremadura	Programme “The Army takes care of you”	5e
277	Extremadura	Extension of treatment programmes to promote autonomy and functional recovery	5e
278	Extremadura	Home Help Programme for local authorities in Extremadura	5e
279	Extremadura	Assertive community programme	5e
280	Extremadura	Training and information sessions carried out for the implementation of participation bodies at the community level	6e
281	Extremadura	Development of regulations governing minimum accreditation criteria for Centres and Social Services Specialised in Care for Older People in Extremadura	6d
282	Extremadura	Funding of programmes aimed at the social and work inclusion of people with disabilities and people with mental health problems	6e
283	Extremadura	Experimental project “My House: a life in community”	6e
284	Extremadura	Programme on “Unleashing older people and the patient with Alzheimer's” and obtaining “centres free of restraints” certifications.	6f

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285	Extremadura	Hiring professionals linked to community care and development	8b
286	Extremadura	Training sessions on person-centred care	8b
287	Extremadura	Training and information sessions (for carers)	9b
288	Extremadura	Personalised support and accompaniment programme for people with disabilities and legal support measures	9b
289	Extremadura	Programme of accompaniment for undesired loneliness.	9b
290	Extremadura	Grants for Family Support and Respite Programmes	9b
291	Extremadura	PROPREFAME Programme	9b
292	Extremadura	Implementation of support, accompaniment and guidance services for caregivers	9b
293	Extremadura	Deployment of occupational day care centres for people with disabilities in the autonomous community	9b
294	Extremadura	Public calls for social concerts under Decree 122/2022, of 28 September, implementing Law 13/2018, of 26 December	10b
295	Extremadura	Funding of research projects in fields related to deinstitutionalisation	10d
296	Extremadura	Events and programmes to promote deinstitutionalisation	10d
297	Extremadura	Identification of social and health areas in Extremadura with populations at risk of premature institutionalisation;	10e
298	Extremadura	Funding of programmes to generate awareness among the population, and to promote a positive image of people with disabilities and people with mental health problems.	10g
299	Extremadura	Deployment of residential and community participation alternatives for people with disabilities, facilitating access to cultural, sports and work resources	10g
300	Extremadura	Promoting the participation of people with support needs in community participation and inclusion projects.	10g
301	Extremadura	Preparation of the Impact Study in Extremadura of the Agreement on Common Criteria for the Accreditation and Quality of Centres and Services of the System for Autonomy and Care for Dependency (SAAD).	10h
302	Galicia	Creation of intermediate care centres dedicated to caring for people who, after a hospital stay, and on a non-permanent basis, require specific residential care because they are dependent for the basic activities of daily living.	4a
303	Galicia	Strategic actions to promote universal accessibility and the Galician Strategy for Active Ageing and Wellness Programme in Spas	4b
304	Galicia	The Network of Centres for Modernisation and Technological Inclusion (CeMIT Network) is an initiative of Amtega that, in collaboration with the municipalities of Galicia through the FEGAMP, has the collaboration of 90 municipalities and is made up of 96 classrooms equipped with the latest technology, Internet and video conferencing systems. Its objective is to achieve a more digitally autonomous society and every Galician has a classroom half an hour away from home	5c
305	Galicia	“Safe and Effective Food” Programme.	5e

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306	Galicia	Experimental intervention programme with a transdisciplinary approach based on the methodology of comprehensive care centred on people with disabilities Programme "Count on us. Promotion of autonomy". Personal autonomy and care programme. Physiotherapy and care programme. Cognitive stimulation programme.	5e
307	Galicia	Active ageing programme for people with disabilities due to mental disorders.	5e
308	Galicia	Improving access to quality services, including access to housing and person-centred care, especially healthcare	5e
309	Galicia	Call for proposals for grants for social initiative organisations to carry out programmes of general interest for social and health purposes in the field of mental disorders, including: - Community intervention programmes for people with severe mental disorders (including addictive disorders) - Programmes for the social inclusion and promotion of employment for people with mental disorders (including addictive disorders)"	5e
310	Galicia	Granting of financial aid, on a non-competitive basis, for caregivers within the Family Respiro (respite) programme for carers. Non-professional regular carers who continuously care for one or more dependent or disabled people or those in need of third parties for activities of daily living, accredited by a medical and social report, may benefit from this programme's aid.	9b
311	Galicia	Support and accompaniment programme for homeless people or people in situations of extreme vulnerability, developed by the Spanish Red Cross of Galicia within the framework of an agreement signed with the Regional Council.	4a
312	Galicia	Creation of the Statute of the Older Person	6e
313	Galicia	Prevention of situations of dependency and promotion of personal autonomy, for people with intellectual disabilities.	6e
314	Galicia	Educational Inclusion Programme	6e
315	Galicia	Work placement programme for women with disabilities. Programme for the promotion of personal autonomy. Programme to Support Social and Labour Inclusion. Entrepreneurship support programme for people with disabilities. Technical skills programme in carpentry.	6e
316	Galicia	Programmes to support social and occupational inclusion, including actions to design and monitor the social and/or social and occupational inclusion project, as well as social support	6e
317	Galicia	Diagnosis, design and monitoring actions for the social and/or social and occupational inclusion project	6e
318	Galicia	"Inclusion 2.0" Programme	5c
319	Galicia	Grants for the start-up of Casas del Mayor.	5a
320	Galicia	"Inclusive active leisure" programme.	5d

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321	Galicia	Aid programme to implement labour equality, work-life balance and corporate social responsibility	7c
322	Galicia	Programmes for personal autonomy and independent living: "Become Independent"; "Inclusion Camps" Programme; Leisure and social integration programme; Programme for the promotion of autonomy; Programme for personal care and autonomous living and Personal Autonomy Programme. Leisure management.	5a
323	Galicia	Programme “Walk with me, support me, and I learn with you”	5a
324	Galicia	Xunta de Galicia Telecare Programme	5c
325	Galicia	Programme of specialised home care	5a
326	Galicia	Collaboration agreements with different organisations to fund activities for active ageing and the prevention of dependency	5d
327	Galicia	Programme for improving mobility and accessibility for people with disabilities.	5d
328	Balearic Islands	Assisted housing for people with physical disabilities and at risk of social exclusion. Model of high intensity housing support	5d
329	Balearic Islands	Frequency of revisions and adjustments to individualised support programmes to meet residents’ needs. Half-yearly reviews of the PIA.	4b
330	Balearic Islands	Half-yearly monitoring of the assignment of early care sessions to the different services according to their waiting list.	5e
331	Balearic Islands	Pilot test in the Directorate General of application of the easy-to-read regulations, following the provisions of the UNE 153101:2018 EX easy-to-read standard. Simplification of the process to apply for the dependency and disability assessment. Separation of the dependency and disability applications into two forms.	4a
332	Balearic Islands	Social Dialogue Table, for promoting and developing the agreements of the Pact for Disability established in the Consell de Mallorca	4a
333	Balearic Islands	Monitoring of the allocation of places of the Service for the Promotion of Personal Autonomy to the different services according to their waiting list, and based on the 349 modules assigned per year	4b
334	Balearic Islands	Implementation of guidelines to apply for different services of the Directorate General of Dependency Care, following the provisions of the easy-to-read Standard UNE 153101:2018 EX.	5d
335	Balearic Islands	Creation of the universal accessibility offices OPAU, incorporating personnel trained in universal accessibility and implementing measures for cognitive accessibility in the administrations.	10g
336	Balearic Islands	Collaboration in the INSUPERABLES LEAGUE of the foundation of the Balearic Islands football federation.	10g
337	Balearic Islands	Monitoring of people who have an agreed place, ensuring a minimum biannual review of their work plan.	6e
338	Balearic Islands	Protocols of monitoring interventions and on-site visits to care centres for people with disabilities	6e

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
339	Balearic Islands	Continuity to apply the regulations of the Council of Mallorca, regulating the operation of social services for people with disabilities included in our social services portfolio, establishing the criteria for authorisation and accreditation of the services.	6e
340	Balearic Islands	Constant coordination between accreditation, consultation, billing departments and organisations	6a
341	Balearic Islands	Implementation of the provisions of the Regulation regulating social services for people with disabilities. Agreement specifications. Last revised June 2023	10c
342	Balearic Islands	Creation of the department's first ethics committee.	6a
343	Balearic Islands	Increase in the intensity of the Home Help service	4a
344	Balearic Islands	Assigning advanced telecare terminals	5c
345	Balearic Islands	Launch of an Adapted Leisure Programme for implementation by Tertiary Sector organisations	10b
346	Basque Country. Alava Provincial Council	"Etxean Bai" pilot project	5c
347	Basque Country. Alava Provincial Council	Implementation of the "Gizarea" relationship-centred care philosophy in the social services of the regional network of Alava, regardless of their area of care and their nature.	6a
348	Basque Country. Provincial Council of Bizkaia	Dependency Assessment Regulations that regulate a maximum resolution period of 2 months, which includes the preparation of the PIA in the same act, giving access to the resources in the portfolio; there are also valuation procedures and urgent PIA in social and health situations that require it	4a
349	Basque Country. Provincial Council of Bizkaia	Under the regulation of Social and Health Governance of the Basque Country, the Social and Health Operational Plan for Bizkaia 2023-2026 is being developed with 19 operational projects approved by the Territorial Council in which the Provincial Council of Bizkaia, the Public Health System and City Councils participate.	4b
350	Basque Country. Provincial Council of Bizkaia	The Public Social Services System aimed at LTC has co-payment regulations adapted to the different purchasing powers of users and that preserve a decent life.	4c
351	Basque Country. Provincial Council of Bizkaia	Deployment of ETxetic centres that combine community intervention to offer support in home care with non-face-to-face interventions supported by new digital technologies	5a
352	Basque Country. Provincial Council of Bizkaia	The deployment of ETxetic is taking into account the territorial diversity of Bizkaia and the third centre is located in the Enkarterri area, which is the area with the highest risk of depopulation.	5b
353	Basque Country. Provincial Council of Bizkaia	The support service for staying at home ETxetic proposes digital solutions to facilitate access to support services and also focuses on training users to be able to integrate these digital solutions. Participation in the European HENKO project for comprehensive palliative care at home.	5c
354	Basque Country. Provincial Council of Bizkaia	Progressive deployment of the independent living support service with tertiary sector organisations specialised in providing support to these people.	5d

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355	Basque Country. Provincial Council of Bizkaia	178 places in social and health residential care for temporary situations of convalescence and recovery of capacities.	5e
356	Basque Country. Provincial Council of Bizkaia	Regulatory development of the residential care model through Co-Living Units. Prior training for motor equipment and process monitoring and follow-up.	6a
357	Basque Country. Provincial Council of Bizkaia	Support from Euskalit to pilot self-diagnostic tools and improvement plans based on advanced management.	6c
358	Basque Country. Provincial Council of Bizkaia	Cross-cutting line across all projects within the LTC personalisation model.	6e
359	Basque Country. Provincial Council of Bizkaia	Use of the tool Malos Tratos for prevention and detection of abuse towards older people in all visits to evaluate dependency	6f
360	Basque Country. Provincial Council of Bizkaia	Regional Reference Centre with a specialised professional team that trains and accompanies change processes in residential centres towards the model of personalised care. Transition Plan Driving Project for Training that makes it possible to attend regulated training courses during working hours, subsidising the cost of the replacement person.	8a 8b
361	Basque Country. Provincial Council of Bizkaia	Carer's Statute, case coordination and ETxetic	9a
362	Basque Country. Provincial Council of Bizkaia	Zaintza Eskola. Training workshops and psycho-emotional support from the etxeTIC service; residential respite services and low intensity respite for hours at etxeTIC and in Day Centre services at weekends	9b
363	Basque Country. Provincial Council of Bizkaia	Existence of a LTC Coordinator and simultaneous Social and Health Coordination.	10a
364	Basque Country. Provincial Council of Bizkaia	Creation and promotion of projects through the Regional Social and Health Commissions which evaluate needs and activate local projects.	10b
365	Basque Country. Provincial Council of Bizkaia	Identification of social indicators that are collected in each evaluation of dependency and treatment of these.	10c
366	Basque Country. Provincial Council of Bizkaia	Annual process for submitting and selecting BBPP in the field of personalising LTC placed at citizens' disposal on the institutional website.	10d
367	Basque Country. Provincial Council of Bizkaia	Development through the coordination bodies established in Social and Health Governance.	10e
368	Basque Country. Provincial Council of Bizkaia	Through awareness-raising actions (TOPAKETAK); Training sessions aimed primarily at families in residences; community action from ETxetic and general awareness actions by the department	10g
369	Basque Country. Provincial Council of Bizkaia	Action 6. Progressively adapt the Network of Centres of the Historical Territory of Gipuzkoa	4a, 4b, 4c
370	Basque Country. Provincial Council of Bizkaia	Action 17. Strengthen the innovation, personalisation and governance strategy of residential centres in Gipuzkoa	4a, 4b, 4c

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371	Basque Country. Provincial Council of Bizkaia	Action 1. Diagnosis of the quality of physical spaces	4a, 4b, 4c
372	Basque Country. Provincial Council of Bizkaia	Action 2. New centres	4a, 4b, 4c
373	Basque Country. Provincial Council of Bizkaia	Action 3. Architectural adaptation programme	4a, 4b, 4c
374	Basque Country. Provincial Council of Bizkaia	Action 22. Deploy the territorial strategy for the transition to a new model of home-based care	5a
375	Basque Country. Provincial Council of Bizkaia	Action 19. Deploy the territorial strategy of Local Care Ecosystems	5a
376	Basque Country. Provincial Council of Bizkaia	Action 24. Promotion of social and community volunteering in the field of care and support	5a
377	Basque Country. Provincial Council of Bizkaia	Action 10. Promote the digital transformation of social services and tertiary sector organisations	5c
378	Basque Country. Provincial Council of Bizkaia	Action 32. Digital transformation diagnosis	5c
379	Basque Country. Provincial Council of Bizkaia	Action 33. Development of a digital transformation plan	5c
380	Basque Country. Provincial Council of Bizkaia	Action 16. Develop a comprehensive strategy of personalised care, assistance and support for people with intellectual disabilities	5d
381	Basque Country. Provincial Council of Bizkaia	Action 1. Anticipate, monitor and design futures	5e
382	Basque Country. Provincial Council of Bizkaia	Action 3. Generate awareness, prevent and promote healthy habits and lifestyles	5e
383	Basque Country. Provincial Council of Bizkaia	Action 4. Preserve and promote the functional capacity of older people	5e
384	Basque Country. Provincial Council of Bizkaia	Action 5. Strengthen the HARIAK strategy for undesired loneliness	5e
385	Basque Country. Provincial Council of Bizkaia	Action 23. Deploying a territorial strategy to address cognitive impairment diseases	5e
386	Basque Country. Provincial Council of Bizkaia	Action 5. Strategic diagnosis of staff ratios	7a
387	Basque Country. Provincial Council of Bizkaia	Action 6. Design of adaptation plans	7a
388	Basque Country. Provincial Council of Bizkaia	Action 7. Implementation of adaptation plans	7a

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389	Basque Country. Provincial Council of Bizkaia	Action 8. Functional diagnosis	7a
390	Basque Country. Provincial Council of Bizkaia	Action 9. Strategies for improvement	7a
391	Basque Country. Provincial Council of Bizkaia	Action 8. Develop support programmes for carers Action 12. Emotional care programme	7a
392	Basque Country. Provincial Council of Bizkaia	Action 13. Development of pilot experiences	7a
393	Basque Country. Provincial Council of Bizkaia	Action 31. Strengthen the role of professional persons responsible for social and health coordination	7a
394	Basque Country. Provincial Council of Bizkaia	Action 12. Strengthen the development of training programmes in personalised and community care for professionals/ Action 19. Development of a formal training programme	8a
395	Basque Country. Provincial Council of Bizkaia	Action 13. Promote training programmes in care for caregivers.	8a
396	Basque Country. Provincial Council of Bizkaia	Action 14. Develop the Care Academy and talent management/ Action 21. Development of continuing education programmes (professional people)	8a
397	Basque Country. Provincial Council of Bizkaia	Action 37. Deploying learning networks, transferring innovations with an impact	8a
398	Basque Country. Provincial Council of Bizkaia	Action 27. Promote equality between men and women in long-term care	8f
399	Basque Country. Provincial Council of Bizkaia	Action 28. Provide support to cooperatives for care at home	9a
400	Basque Country. Provincial Council of Bizkaia	Action 22. Development of a continuing education programme (family members)	9b
401	Basque Country. Provincial Council of Bizkaia	Action 23. Strengthen the ADINPREST programme	9b
402	Basque Country. Provincial Council of Bizkaia	Action 25. Promotion of social, organisational and institutional governance in the promotion of transitional social policies	10b
403	Basque Country. Provincial Council of Bizkaia	Action 26. Managing social and institutional dialogue for the development of social services	10b
404	Basque Country. Provincial Council of Bizkaia	Action 29. Strengthen social and health coordination for care in residential centres	10b
405	Basque Country. Provincial Council of Bizkaia	Action 30. Strengthen social and health coordination for care at home	10b

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406	Basque Country. Provincial Council of Bizkaia	Action 16. Development of the collaboration and participation network	10b
407	Basque Country. Provincial Council of Bizkaia	Action 17. Development of direct participation models	10b
408	Basque Country. Provincial Council of Bizkaia	Action 18. Development of a community support programme	10b
409	Basque Country. Provincial Council of Bizkaia	Action 24. Development of a Learning and Innovation Network	10b
410	Basque Country. Provincial Council of Bizkaia	Action 32. Promote the culture of evaluation at the territorial level	10d
411	Basque Country. Provincial Council of Bizkaia	Action 33. Develop a Territorial Quality of Life Assessment Programme Action 43. Develop the quality of life assessment	10d
412	Basque Country. Provincial Council of Bizkaia	Action 34. Promote the creation of the Agency for the Evaluation of Care in the Territory of Gipuzkoa	10d
413	Basque Country. Provincial Council of Bizkaia	Action 35. Update and deploy the Transition Monitor Action 42. Develop a Green Paper monitor	10d
414	Basque Country. Provincial Council of Bizkaia	Action 36. Develop a programme for evaluating the cost-benefit of social services	10d
415	Basque Country. Provincial Council of Bizkaia	Action 2. Analyse future needs and compliance with the social services map in Gipuzkoa	10e
416	Basque Country. Provincial Council of Bizkaia	Action 4. Diagnosis of the specialisation of residential centres	10e
417	Basque Country. Provincial Council of Bizkaia	Action 39. Carry out territorial information and awareness campaigns on care	10g
418	Basque Country. Provincial Council of Bizkaia	Action 27. Evaluation of funding instruments	10h
419	Basque Country. Provincial Council of Bizkaia	Action 28. Define a strategy for the development of new financing systems	10h
420	Basque Country. Basque Government	Local care ecosystems	5a
421	Basque Country. Basque Government	Support app for carer families.	5a 5c
422	Basque Country. Basque Government	BeTion Telecare Service	5a 5c
423	Basque Country. Basque Government	Predictive telecare (under development)	5c

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424	Basque Country. Basque Government	Bases for a model of independent living in the Basque Country	5d
425	Basque Country. Basque Government	Social and health strategy to support carer families	5e
426	Basque Country. Basque Government	Social and health care strategy in the Basque Country	5e
427	Basque Country. Basque Government	Euskadi Lagunkoia	5e
428	Basque Country. Basque Government	Social and health strategy to support carer families	6b
429	Basque Country. Basque Government	Agreement on the bases for a future country pact on care	7a
430	Basque Country. Basque Government	Social and health strategy to support carer families	9b
431	Basque Country. Basque Government	Support app for carer families.	9b
432	Basque Country. Basque Government	II Strategic Plan for Social Services	4a, 4b, 4c, 5a, 5b, 5c, 5d, 5e, 6a, 6c, 6e, 8f
433	Basque Country. Basque Government	Agreement on the bases for a future country pact on care	10b
434	Basque Country. Basque Government	Care Congress held in November 2023 (Advancing towards a Basque Pact for Care)	10d
435	Basque Country. Basque Government	II Strategic Plan for Social Services	10e
436	Principality of Asturias	Multichannel information and citizen care services with a presence in the territory, aimed at facilitating the exercise of rights or access to services and benefits	5d
437	Principality of Asturias	Improving accessibility in community social services	5d
438	Principality of Asturias	Development of the Asturian agenda for disability in Asturias 2024-2030 with a specific axis of universal accessibility.	5d
439	Principality of Asturias	Development of the OVAU (Virtual Office for Universal Accessibility)	5d
440	Principality of Asturias	Development of workshops to promote healthy living and of social centres and day care centres.	5e
441	Principality of Asturias	Agreement with organisations for Transport Routes.	5d
442	Principality of Asturias	Unified model of supervised housing for people with serious mental disorders in Asturias	5e

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443	Principality of Asturias	Programme to reduce undesired loneliness. Increase in the amount of Municipal SAD through the Concerted Plan.	5e
444	Principality of Asturias	Joint training in the field of Social and Health Coordination for professionals who work with these populations. Through the Adolfo Posada Institute of Public Administration	8a
445	Principality of Asturias	Programme for the detection of older people in situations of vulnerability. Collaboration between Territorial Area Social Services Teams and Municipal Social Services	4a
446	Principality of Asturias	Ovaps projects (Offices for Autonomous and Participatory Living).	5d
447	Principality of Asturias	Accessible and understandable tools developed within the framework of the Cuidas Network.	6e 5d
448	Principality of Asturias	Participation mechanisms promoted by the Cuidas Network.	6e
449	Principality of Asturias	Preparation of guides and documents: quality standards and methodological guidelines to promote person-centred care, within the framework of the implementation of the “CUIDAS” Strategy.	6e
450	Principality of Asturias	Development of guides for the promotion of the model of independent living in the community for professionals.	6e
451	Principality of Asturias	Evaluation of interventions and implementation of results in the area of the Care Strategy, Inspection Service and Quality of Centres.	6e
452	Principality of Asturias	Training and support process for centres within the framework of the CUIDAS Strategy	6b
453	Principality of Asturias	Incorporation of reference professionals in care centres and services.	5e
454	Principality of Asturias	Training in person-centred care and personalisation methodologies.	8a
455	Principality of Asturias	Trainings programmed in the “CUIDAS” Strategy	8a
456	Principality of Asturias	Development of training standards and their implementation in social services and intervention.	8a
457	Principality of Asturias	Renovation, improvement of spaces and provision of private rooms in resources to promote privacy and intimacy (CUIDAS Strategy).	5d
458	Principality of Asturias	Individual grants for assistive products and housing aid	6e
459	Principality of Asturias	Architectural reforms and creation of living units in residential centres.	6e
460	Principality of Asturias	Preparation of technical documents to adapt resources to non-institutionalising models, within the framework of the CUIDAS Strategy.	6e
461	Principality of Asturias	Resource adaptations, contemplated in the CUIDAS Strategy	6e
462	Principality of Asturias	Preparation of contracting specifications with improved ratios compared to the SAAD agreement	6d
463	Principality of Asturias	CUIDA strategy and creation of new care centres (multiservice centres, frailty care and dependency prevention) funded by the MRR.	4b

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464	Principality of Asturias	Implementation of Independent Living Offices	6e
465	Principality of Asturias	Strategy for the transformation of the long-term care model for adults (CuidAS Strategy), using resources created by the MRR.	5a
466	Principality of Asturias	Launch of the Single Electronic Social History in the Principality of Asturias	5e
467	Principality of Asturias	Pilot project with the Adolfo Posada Institute of Public Administration and CECOEC, for training and support for private organisations.	10d
468	Region of Murcia	Annual call for individualised aid for people with disabilities to eliminate architectural barriers and adapt single-family housing.	5d
469	Region of Murcia	Annual call for financial aid for older people aimed at the refurbishment, adaptation and repair of the main home	5d
470	Region of Murcia	Agreement with the Spanish Committee of Representatives of Persons with Disabilities of the Region of Murcia to study the accessibility of tourist resources.	5d
471	Region of Murcia	Help line for the accessibility of tourist resources in the Region of Murcia.	5d
472	Region of Murcia	Auditing, reporting and execution of actions in the area of accessibility, including the accessibility chain, creation of a signage system, colour codes, pictograms, minor works, communication and technological support, language clarification and easy reading	5d
473	Region of Murcia	Basic Income Benefit for Insertion in the Region of Murcia	4c
474	Region of Murcia	Development of workshops to promote active ageing in Social Centres for Older People	5e
475	Region of Murcia	Implementation of the autonomy promotion service for older people in the CARM	5e
476	Region of Murcia	Grants to local corporations for Family and Children's programmes, funded through the CARM with funds from the Ministry (AFI). Programme funded by FSE+ and CARM (60/ 40%). Regional Family Care Services (SCAF)	9b
477	Region of Murcia	Promotion of the Services for Promoting Personal Autonomy in the educational stage, as a social and educational support for children with disabilities in situations of dependency.	9b
478	Region of Murcia	Undesired Loneliness Project	4a
479	Region of Murcia	Review of protocols for detecting situations of lack of protection from the health sector.	4a
480	Region of Murcia	Processing of the Law on Families of the Region of Murcia	9c
481	Region of Murcia	Adaptation of the text of the regulations for residences and day care centres in easy reading	5d
482	Region of Murcia	Continuity of the clear language working group to achieve the principles of simplicity and clarity of administrative language in the actions of the CARM, preparation of information guides for administrative procedures and adaptation of administrative decisions in Easy Reading, training and awareness-raising for public employees who care for citizens, including the elaboration of a protocol for the care of individuals.	5d
483	Region of Murcia	Training in new technologies at Social Centres for Older People	5c

ID	AUTONOMOUS COMMUNITY	PROPOSED MEASURE	EU COUNCIL REC.
484	Region of Murcia	Continuous training plan for person-centred care.	8a
485	Region of Murcia	Grants for person-centred training in day care centres and homes for people with disabilities and older people	8a
486	Region of Murcia	Modification of the technical specifications for contracting the management of Home Help and Telecare services in line with the Person-Centred Care model	6d
487	Region of Murcia	Development of Decree 62/2019, which incorporates quality criteria in public procurement.	6d
488	Region of Murcia	Implementation of advanced remote assistance through the execution of Next Generation Funds funded through the Ministry of Social Rights Lines C22.I1	5c
489	Region of Murcia	Execution of Next Generation Funds funded through the Ministry of Social Rights for the provision of computer equipment in homes and social centres for older people	5c
490	Region of Murcia	Increased intensity of the Home Help Service (for people in situations of dependency). Increased intensity of the Home Help Service (for people in situations of dependency).	4a
491	Region of Murcia	Increase and consolidation of the specialised service for the promotion of personal autonomy for people with intellectual disabilities	5a
492	Region of Murcia	Development of new models of social concert in the form of the Service for the Promotion of Personal Autonomy: Promotion, maintenance and recovery of functional autonomy.	4b
493	Region of Murcia	Funding for the construction and remodelling of residential resources and housing adapted to the new person-centred and community-centred model (resources for older people and people with disabilities)	5a
494	Region of Murcia	Consolidation of specialised care services for limited-stay housing for independent living and learning for people with intellectual disabilities	5a
495	Region of Murcia	Development of new models of social concert in the form of housing inserted in the community with more or less support needs.	5a 5d
496	Region of Murcia	Call for grants to implement a coordinated project between health, social services and Imas (FSE+) for people with chronic mental illness.	5e
497	Region of Murcia	Review of treatment protocols for abuse from different areas and preparation of new protocols if necessary.	6f
498	Region of Murcia	Social and health coordination project for people with serious mental illness in the nine health areas of the Region of Murcia	10b
499	Region of Murcia	Decrees of minimum conditions to be met by centres for older people and for people with disabilities.	6a