

Meeting needs and social services among the Spanish elderly, does region matter? Spatial patterns in the responsiveness to changing demographics and needs

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The European population's age structure is older than that of any other world region and is set to age further during the next few decades. Early policies to improve the wellbeing of older people were based on an implicit assumption that being old was itself a source of vulnerability. Recent policies in several European countries have emphasised, however, the need to target services and resources on particularly needy members of the older population (Sundström & Tortosa 1999). Models of ageing processes are used to define vulnerable older people as those whose reserve capacity falls below the threshold needed to cope successfully with the challenges they face (Grundy, 2006). Compensatory supports may intervene to mitigate the effects of challenges and rebuild reserve. The effectiveness with which support is provided to community dwelling older adults is important in preventing or delaying costly institutional placement. Its realisation may depend on general coverage rates of public services and the efficient targeting of frail elderly people who live alone.

The aim of this paper is to "explain" the formal social service coverage in Spain. The following research questions are raised: a) how services meet the needs of older people - are there many who need help but do not get it? and b) does that vary from one region to another?

We use Spain as an example to describe and analyse regional variation in services and care for elderly people. The decision-making process for these services lies with the regional autonomous governments. A strong regional autonomy in combination with increased decentralisation, can lead to large variations in the distribution of social services, which has turned out to be the case within care of the elderly in Spain. Cross-national individual data, regionally representative, are analysed to map out the variations in old-age care, to study compensating factors in the care system, and to explore the connection with regional demographic and socioeconomic conditions.

Background

A generation ago, researchers suggested that changes attributed to senescence should be universal in the species, degenerative, progressive and intrinsic. The application of all these criteria is problematic, however, and probably the concept of increased risk is more important than that of universality (Grundy 2006). The level of the 'reserves' in later life may in some cases be largely determined by life-course factors. Health status, for example, reflects genetic factors, early-life environments and exposures to favourable or unfavourable environments (Palloni et al 2002). Life-course perspectives have attracted considerable attention, but it is also important to acknowledge the very important effect of current circumstances on the wellbeing of older people. This includes, for example, the availability of welfare services.

Old age care has frequently been conceptualised as being either family-based or publicly-provided. One of the major cross-national differences is how these resources are allocated (Esping-Anderson 1999). Policies in the United States place primary responsibility on the contributions of family, with formal services often playing a supplemental role. In some countries, notably in Sweden and other Scandinavian countries, formal services are more likely to have a primary role in providing care. Recent work suggests there is more effective targeting of formal services in Sweden than in the United States (Johansson, Sundström & Hassing 2003; Shea et al 2003; Davey et al 2005; Sundström et al 2006). Dynamic concepts like 'substitution' and 'complementary' are hard to apply in cross-sectional studies. There may be complementary in individual cases but long-term substitution or its reversal in successive cohorts. High coverage rates of the public services may facilitate and support family care.

Previous research has identified a number of predictors of institutionalization (Puts et al 2005; Nuotio et al 2003). However, much less research has examined the potential role of the formal support system in terms of helping to maintain older adults in the community, either by reducing or delay institutionalization. Care patterns are influenced by the older person's household composition, essentially whether or not they live alone, and by life-course variables, especially whether they have adult children able who are willing to help (Sundström et al 2006)

Inequality has been the theme of an extensive research tradition. One important feature is general access to social services such as care for children and the elderly and support and services for people with disabilities. Equitable public care of disabled and elderly people is central to the notion of a social services state (Trydegard & Thorslund 2001), and it is not in accordance with established policy that the probability of receiving care and services in old age should depend on one's residential location. Several efforts have been made by researchers to explore and explain the geographical variation in the distribution of social services for the elderly, but most of the studies have been performed from an 'ecological' perspective. Various hypotheses have been examined, some concerning care needs in the population (Sundström et al 2006), others the structure of the regions in terms of size or urbanisation; factors linked to economic resources and political ambitions or prioritisations have also been looked

into (Jeger 2005). The supply of public services for frail elderly people may affect how they are allocated and how they are used. When services become scarcer, they are likely to be directed to those short of other kinds of support, hence the overlap with informal care may shrink. This can be studied in Spain by 'natural experiments', because regional variations in old-age care are large.

Data and Method

To address our research questions, we proceeded in two steps. First, we developed a logistic regression model predicting the use of each type of public support among the whole population, and by gender. We defined two major types of public support: long-term care services (home-help services and adaptations or assistive devices in the home) and active-ageing promotion services. From there, we developed three different logistic regression models for each group of regions, by their level of coverage in social services for the elderly.

We used a cross-national survey of Living Conditions of Older Adults in Spain conducted by the Spanish National Institute for Older Adults (IMSERSO). This survey includes information on use of community-based long-term care services, and active ageing promotion services, for a regionally representative sample of older people in Spain. The survey also collect information on health and functional status and demographics and socioeconomic characteristics (see <http://www.imsersomayores.csic.es/documentos/estadisticas/encuestas/ecvm/2004/principal/ecvmp04-ficha-tecnica.doc>). Our analytic sample consisted of 3,507 community-dwelling individuals aged 65 and older. Normalized sampling weights were applied to make the sample representative of the corresponding Spanish population.

Demographic characteristics.- We obtained information on age, gender and living arrangements. We examined several indicators for socioeconomic status; in the end the variables that seemed most relevant were educational status and an indicator on social class based on an index of beings.

Frailty.- The level of frailty is measured by need for assistance with IADL and ADL. IADL and ADL disabilities indicate the need for assistance and are important to consider when examining patterns of service use. IADL are shopping, cooking and other domestic activities. ADL are bath/shower, get up/go to bed, dress/undress and eating. The questionnaire asked respondents whether they had any difficulty performing the activity or did not do it. Individuals were considered to have a limitation if they had any difficulty or were not able to perform some of the activities.

Preliminary results

- In Spain, the state has taken over some of the support and care for old people in the community. But the social services still present, in spite of the recent effort by their extension, very low coverage; that vary between 15% of the services of active-ageing promotion, until 9% of the home-help services destined to help to maintain the autonomy of the older adults. The remaining care services (adaptations or assistive devices in the home) are so minority that they are practically marginal.

- The differences across regions are great in terms of coverage and accessibility, and exist both in long-term care services and active-ageing promotion services; for example: the services of care triplicate their coverage between some regions and others.

- The effort carried out for a greater extension of social services for the elderly has been focused, mainly, on the promotion of activities that favour a more active aging. The greater effort in this services, thought for the younger older-adults, is in consonance with the relatively young elderly that we have had in Spain in the last decade (at the older ages were the empty generations of the Spanish Civil War).

- The effort for the extension of social services has been, comparatively, more focused on active-ageing promotion services, in the regions with smaller availability. In those regions, the coverage of active-ageing promotion services duplicates the coverage of long-term care services.

- Social services for the elderly in Spain do not seem thought as universal services, but as substitute services. Both types of them, long-term care and active-ageing promotion, are primarily directed at people who live alone. Primary users of care services are not the most fragile ones, but those who do not receive care from their children by an intergenerational living arrangement. Similarly, when the activity and the integration of the older adult take place in the familiar network, the older adult does not make use of the community activities and services. Public services tended to intervene when there was no family or no functional family. It is the social vulnerability, more than the physic frailty, the trigger situation for the use of social services in Spain.

- As much as minor is the availability of services in a region, more they are concentrated on the lonely population. As the coverage increases, the user's profile became more wide and balanced.

- The active-ageing promotion services do not seem to fulfil their objective. Although they facilitate a bigger activity of couples that don't cohabit with children, from an urban upper-middle socio-cultural class; they do not arrive to the population with less educational and economic resources (with less access to the information, and more difficulties to carry out these activities without public help), neither to the residents in intermediate or rural areas. The

participation and integration of the rural and lower socio-economic segment, continue tilting on family informal networks. The active-ageing promotion services do not seem to arrive to their target population. And, from these results, one can wonder if it can be right to use tax-payers' money to subsidize holidays for healthy middle-class people.

- Home-help services are more centered in the most vulnerable population: alone, fragile, older, women (men receive most family help, whereas women of these generations, more able to maintain their residential autonomy and independence, make a bigger use of the public services), and among those that cannot buy these services in the market. In spite of it, the population's 85% not institutionalized with basic disability do not receive any public care service, depending completely on their family. Home-help services, directed well towards their target population, are without doubt, insufficient, leaving most of the population who need them, absolutely dependent on their family.

- While, a 7% of the population receive this type of services; without any doubt they are old and vulnerable, but not disabled, and for who would be probably more appropriate other types of services. If complementary services (adaptations or assistive devices), at the moment marginal, would be more developed and better known by the population, probably would be reduced the inadequate use of home-help services.

- In regions with a smaller coverage, care services are most restricted to the most vulnerable population (alone and very fragile); as the coverage increases the user's profile became more wide, also reaching to the oldest old, to the most underprivileged population, and extending their availability and accessibility in great urban areas. With long-term care services, it seems they ration them harder/better in regions that spend little on older people. This will probably also mean that they get the care services later in the career of frailty and thus use the care services shorter time; a phenomenon other authors had observed in Sweden after cutbacks in long-term care services (Sundström et al 2002). This may (or may not) mean that more people get it before they die, but - as said - shorter time. In Sweden, now fewer old people on average use home-help or institutional care than before, but more in the long run now than in 1975 or earlier, before they die (Sundström et al 2002).

- In regions with a smaller effort in services for the elderly, the active-ageing promotion activities are concentrated, extraordinarily, on urban areas; offering, also, more access difficulties to oldest old, those with instrumental frailty, or those with less resources and less access to the information. As the coverage increases, these services become more accessible for all (the age and the socioeconomic level stop being a barrier, and only the basic frailty prevents the development of these activities)

Table 1. Coverage of different types of services by geographical area

	home-help				adaptations & asistive devices				active-ageing			
	Spain	Region-G1	Region-G2	Region-G3	Spain	Region-G1	Region-G2	Region-G3	Spain	Region-G1	Region-G2	Region-G3
Total	9,0	4,5	8,2	14,9	3,8	3,1	3,7	4,8	15,0	11,6	15,5	19,8
Frailty												
Not disabled	6,6	2,9	5,4	11,9	3,2	3,1	2,6	4,5	17,1	14,9	16,5	21,0
IADL	10,6	5,3	10,3	17,1	3,6	2,7	3,6	4,6	15,3	8,3	17,8	25,2
BADL	15,6	8,2	15,7	24,6	6,7	4,1	8,5	6,5	5,7	6,5	5,7	4,4
Lonely												
not lonely	6,5	2,8	6,0	11,0	4,1	3,3	3,6	5,7	15,3	11,4	16,3	20,5
lonely	18,1	11,5	15,4	29,9	2,9	2,3	4,1	1,1	13,7	12,1	13,3	17,1

* Region Group 1: low coverage; Region Group 2: medium coverage; Region Group 3: high coverage

Table 2. User's profile of long-term care services (odds ratios)

	home-help						adaptations & asistive devices					
	Total Population		Males		Females		Total Population		Males		Females	
	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.
age												
[65-74]												
75-84	1,9	0,000	2,0	0,004	1,8	0,014						
85+	1,8	0,005	1,3	0,548	1,9	0,001	1,2	0,612	2,9	0,027	0,8	0,509
gender												
[men]												
women	1,4	0,029					1,6	0,018				
frailty**												
[not disabled]												
some IADL	2,0	0,000	1,5	0,086	2,6	0,000	2,1	0,002	1,7	0,298	2,3	0,002
some BADL	2,6	0,000	3,2	0,000	2,4	0,000						
lonely												
[living with partner only]												
living with children	0,7	0,032	0,6	0,091	0,7	0,193	0,8	0,272	1,0	0,941	0,7	0,204
living with other people (not partner, not children)	1,7	0,025	0,8	0,692	2,3	0,005	0,9	0,872	2,3	0,160	0,7	0,396
living alone with children near	2,6	0,000	1,7	0,207	3,0	0,000	0,5	0,009	0,4	0,281	0,5	0,012
living alone, not children near	3,4	0,000	5,1	0,000	2,9	0,000						
education												
[secondary +]												
primary	1,7	0,030	1,7	0,164	1,7	0,115	1,0	0,931	0,6	0,232	1,2	0,398
less than primary	2,0	0,005	2,4	0,025	1,9	0,059						
social class***												
[not low social class]												
low social class	1,1	0,589	0,9	0,613	1,2	0,368	0,6	0,044	0,6	0,223	0,6	0,086
rural												
[<400.000 hab]												
metropolitan (>400.000 hab)	2,4	0,000	2,0	0,010	2,7	0,000	1,1	0,709	0,7	0,371	1,3	0,297

Table 3. Coverage of different types of services by geographical area (odds ratios)

	home-help						adaptations & assistive devices					
	Region-G1		Region-G2		Region-G3		Region-G1		Region-G2		Region-G3	
	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.
age												
[65-74]												
75-84	1,1	0,717	1,3	0,219	3,3	0,000						
85+	0,9	0,787	1,6	0,129	2,5	0,019	2,0	0,296	1,1	0,833	1,0	0,945
gender												
[men]												
women	0,9	0,870	1,6	0,031	1,4	0,144						
frailty**												
[not disabled]												
some IADL	2,6	0,026	2,8	0,000	1,5	0,108						
some ADL	4,0	0,003	3,5	0,000	2,0	0,019	1,8	0,238	3,0	0,001	1,4	0,519
lonely												
[living with partner only]												
living with children	1,2	0,752	0,8	0,494	0,5	0,018						
living with other people (not partner, not children)	0,0	0,998	2,9	0,002	1,1	0,831	0,7	0,534	0,9	0,860	0,7	0,328
living alone with children near	4,8	0,002	2,8	0,000	2,4	0,002	0,5	0,547	0,9	0,827	1,3	0,651
living alone, not children near	6,6	0,000	3,6	0,000	2,7	0,003	0,5	0,242	0,7	0,417	0,2	0,025
education												
[secondary +]												
primary	1,9	0,524	1,8	0,155	2,0	0,050						
less than primary	2,2	0,396	1,8	0,134	2,4	0,011	1,0	0,971	2,6	0,004	1,5	0,257
social class***												
[not low social class]												
low social class	1,5	0,224	1,4	0,087	1,2	0,479						
rural												
[<400.000 hab]												
metropolitan (>400.000 hab)	0,7	0,667	1,5	0,075	2,8	0,000	0,4	0,107	0,4	0,022	1,4	0,446
							0,6	0,329	0,9	0,650	2,3	0,049

Table 4. User's profile of active-ageing promotion activities by gender and geographical area (odds ratios)

	active-ageing													
	Total Population				Males		Females		Region-G1		Region-G2		Region-G3	
	Bivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.	Multivariate Exp (B)	Sig.
age														
[65-74]														
75-84	0,7	0,000	0,8	0,012	0,7	0,049	0,8	0,179	0,5	0,002	0,9	0,399	0,9	0,498
85+	0,3	0,000	0,5	0,002	0,4	0,030	0,5	0,057	0,4	0,031	0,5	0,054	0,6	0,281
gender														
[men]														
women	0,8	0,023	1,0	0,685					1,0	0,995	1,2	0,289	0,7	0,041
frailty**														
[not disabled]														
some IADL	0,9	0,236	1,0	0,694	1,2	0,141	0,6	0,014	0,6	0,009	1,2	0,253	1,2	0,369
some ADL	0,3	0,000	0,4	0,000	0,5	0,057	0,4	0,001	0,6	0,108	0,4	0,023	0,3	0,008
lonely														
[living with partner only]														
living with children	0,5	0,000	0,6	0,000	0,5	0,000	0,7	0,024	0,5	0,004	0,6	0,016	0,6	0,050
living with other people (not partner, not children)	0,6	0,012	0,7	0,056	0,7	0,327	0,6	0,100	0,5	0,159	0,7	0,364	0,6	0,184
living alone with children near	0,7	0,008	0,7	0,055	0,7	0,255	0,8	0,221	0,9	0,553	0,6	0,042	0,8	0,519
living alone, not children near	0,7	0,038	0,7	0,088	0,8	0,426	0,7	0,190	0,6	0,207	0,8	0,434	0,6	0,211
education														
[secondary +]														
primary	0,7	0,004	0,8	0,082	0,9	0,454	0,7	0,051	0,5	0,024	0,8	0,391	0,9	0,834
less than primary	0,5	0,000	0,7	0,023	0,9	0,646	0,5	0,005	0,7	0,151	0,6	0,025	0,9	0,813
social class***														
[not low social class]														
low social class	0,6	0,000	0,7	0,001	0,7	0,021	0,7	0,029	0,7	0,099	0,9	0,615	0,7	0,104
rural														
[<400.000 hab]														
metropolitan (>400.000 hab)	1,6	0,000	1,4	0,002	1,5	0,020	1,4	0,040	2,0	0,002	0,6	0,059	1,8	0,002

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