Juan Berea Gómez-Naveira

Spanish home care. Policies and consequences on a micro level.

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1 Thesis Abstract

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The main goal of this study is to provide the reader with an overview over Spanish Elderly Care system focusing mostly on Home Care. To achieve this both Finnish and Spanish Home Care systems will be compared regarding accessibility, availability and quality of the service.

Last policy changes regarding Spanish Home Care will be analysed as well as its consequences on a familial level for both, short and long term. These political changes regarding Health and Social Care have changed the Spanish Elderly Care scenario. I find extremely necessary to provide a gender perspective in order to understand better how Dependency Law is affecting families and the way Spaniards take care of their oldies.

The results offer a view of the trends Spanish Home Care has been taking during the past years. Finnish Home Care system is used as a possible model regarding some challenges to provide if possible, good practices for the Spanish Home Care to improve in terms of accessibility, availability and quality of the service.

Keywords:

Home Care, Dependency law, de-familialization,Finnish model

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Työn tarkoitus on tarjota lukijalle mahdollisuus tutustua Espanjalaiseen vanhustyöhön, varsinkin Espanjalaiseen Kotihoitoon. Apuna tutustutaan Suomalaiseen kotihoitoon ja vertaillaan molempia systeemejä esim. Mahdollisuudet päästä palvelupiiriin, palvelun saatavuus ja laatu.

Espanjassa on ollut poliittisia muutoksia Kotihoidon ympärillä, tässä työssä pyritään saamaan selville miten muutokset ovat vaikuttaneet ihmisten elämään eteenkin perheisiin. Nämä muutokset, terveys- ja sosiaalialan tasolla ovat muuttaneet espanjalaista vanhustyön suuntaa ja tuonut vaikutuksia tulevaisuuteen. Koen erittäin tarpeelliseksi tarkastaa joitain lainsäädännön vaikutuksia sukupuolen näkökulmasta, sillä ymmärretään paljon paremmin poliittisia muutoksia.

Tulokset näyttää miten kotihoito on hoidettu Espanjassa mutta myös tulevat vaikutukset. Suomen Kotihoito käytetään vertailuna ja mahdollisesti apuna kehittymään Espanjalaista Kotihoitoa.

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Keywords:

Palvelupiirii,saatavuus, laatu, kotihoito

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2 Introduction

As a result of my stay in Finland for the past five years, I have decided to dedicate my final research to Spanish Home Care. The main reasons are my experiences in Finland and its good practices in elder care, as well as the need of bringing Spanish Home Care to a better level in terms of quality, accessibility and efficiency in order to improve elder's wellbeing.

Two systems with substantial differences regarding their elder care can be found in countries that fall under the Mediterranean model and those that are clustered in the Nordic model (Daly, 2001). In Finland which is regarded as part of the Nordic model or the "caring state", care for their citizens is provided universally and consists of public care provisions and are based on social citizenship. In contrast, Spain, an example of the "Mediterranean model" or a "non-caring state", relies highly on the family, and especially on women for doing unpaid care work for their dependent family members (Daly, 2001).

Ageing seems to be one of the upcoming challenges for the near future around the world. A continuously increasing life expectancy is creating this new scenario, where older people will represent the biggest age group in the population pyramid in a near future. In Europe, besides that, other factors have started to play important roles in trends and future policies such as decreasing fertility rates, migration and economical crisis. These issues will bring difficulties in order to organize and coordinate elderly services, but according to experts, the main problem will be to keep Welfare States sustainable, in other words, to get enough tax payers to create and finance these services within a country. Therefore it is not only a question of how our pension system will be financed, but also a matter of numbers. Will we have enough tax payers in order to sustain our Social Services?

As a negative result of the economical crisis in Spain since 2008, Spanish health care and social services have been influenced tremendously and the funding of both sectors has been decreased continuously ever since. This phenomenon is not only visible in Spain, but in many different countries all over Europe. Research and study of the Health and Social sector is highly necessary, since these dramatic political cuts can have consequences of unknown severity for individual's

wellbeing and societies as a whole.
We, as field experts need to stand against these financial cuts from a professional perspective, and what is more important, we need to analyze and research on the consequences of this political tendency of the 21st century.

Due to the enormous decrease of Nursing Homes as a way of care for our elders in the last decades in Europe, I believe home care will be the main way to give care in the future, not just for the elder population, but also to any kind of age range. Spanish Home Care has experienced through the past years an important change in numbers of service users, getting up to 83% increase from 2000 to 2011 (IMSERSO, 2012). Therefore this research will mainly focus on home care for the elder.

This research will not give a fixed solution to enhance Spanish home care. However, it will analyze both the Spanish and the Finish model in order to find the advantages, as well as disadvantages of both systems. By giving recommendations on how the Spanish system might be able to improve by taking on parts of the Finish model, this research might be able to contribute to the enhancement of Spanish home care and therefore the wellbeing of elder people.

3 Aim of the research

The aim of this research is to analyze the Spanish Home care model and to compare it to the Finnish model. Spanish policies related to home care will be analyzed and studied focusing on its quality and accessibility, taking as an example Finnish home care.

Since Spanish elders rely more on informal care than for instance in the Nordic countries, I want to discuss whether this is due to familialization from a State level. One of the goals of this research is to investigate about the impact of Elder policies on a familial level. Are Spanish relatives naturally willing to care of their older more than Finnish ones? If so, is this a result of their nature or a consequence of our Elderly Care policies? Do Elderly Care policies in Spain give possibilities for so called de-familialization?

During this research I will set a theoretical framework to work on, it will be presented and discussed. Furthermore I will locate try to locate areas of Spanish Home care that could be developed for instance, by using the Finnish model as an example.

4 Method

This research will be based on a literature study. The focus will lie on the policies regarding elder care in both Spain and Finland, and the impact that these policies have on elder care itself and consequently on the lives of the individuals.

Already existing empirical research as well as literature and surveys from both countries will be used in order to understand the possible dilemmas in home care that arise from different factors on the macro, as well as the micro level.

5 Research questions

- What are the main characteristics of the Spanish home care system?
- What are the consequences of the Spanish policies regarding Home care on a micro level?
- How could the Finnish model help to improve the Spanish home care model regarding its accessibility, effectiveness and equality?

6 Theoretical framework

6.1 Ways of understanding care: Formal and informal care

In order to understand different ways of care that exist within different societies, it is necessary to define formal and informal care.

Informal care is mostly provided by relatives, friends or neighbors for an individual in need of help because she/he is ill, frail or has a disability. The care they provide is mostly unpaid. Informal caregivers are not licensed nor qualified regarding care. They don't have contracts regarding care responsibilities and although they are not often paid, they sometimes start to obtain financial contributions. These financial contributions vary substantially from one country to another. They very rarely have limits regarding care, which quickly turns into a "job" with no rights to have "holidays" (Triantafillou et al, 2010.)

This kind of care work is primarily performed by women. Furthermore, it is often not a choice that has been made, but a necessity because the responsibility for care lies within the family and other options are often not available. Here, the importance of policies gets visible (Anttonen & Zechner, 2012.)

Formal care on the contrary, is paid work which is provided by trained, qualified and licensed professionals. Formal caregivers have contracts where care responsibilities are set and defined. These tasks are chosen according to each one's qualification. Formal caregivers are paid and their duties are regulated by working regulations (Triantafillou, 2010). It is either paid directly by the family or by the state and is provided either by public services or the private sector. Formal care is the main way of providing care in western and northern European countries, such as Sweden and Finland (Anttonen & Zechner, 2012).

Formal care is a relatively new topic that appeared in the mid-20th century. Historically, informal care was the one and only source of care for dependent individuals. As mentioned before, the balance between informal and formal care is

very different within European countries. This difference in balance is related to many different factors such as political, demographic and cultural (WHO, 2008.)

Informal care is still the main source of Home Care both in Northern and Southern Europe. Rodrigues et al (2012) states that the Northern countries rank highest in Europe when it comes to the involvement of family members in their relatives care. However, it needs to be considered that this implies lighter support. In Spain on the other hand, fewer people have to carry out caring duties, but the amount of time they have to invest in the care of their relatives is in average much higher than in the Northern countries. It is often the only option that families have due to the non-existence of an appropriate public support system and it seems that caring for an elder family member often becomes a full-time occupation. This means that more demanding care work is done by fewer people in the Southern Europe, while more people are involved in less heavy care work in Northern countries (Saraceno, 2010 & Ulmanen & Szebehely, 2014).

According to experts in Elderly Care, home care in Southern Europe would be completely unsustainable without the work of informal care givers. On the other hand, the situation Northern European countries are experiencing shows that informal care is less necessary, because municipalities provide options in forms of much broader personal and domestic services. In many countries, such as Scotland and Denmark, municipalities have chosen informal care to focus more on providing companionship and social support (WHO, 2008).

Research has also shown in other Nordic countries such as Finland, that older people do not want their close relatives to provide their intimate personal care but prefer to have their care and support needs supplied formally by employed care workers (WHO, 2008).

6.2 Home care concept and theoretical base

To give an overview on the concept of Home Care, I decided to use mainly non-Spanish literature since I believe this field is more developed in other countries such as Finland. Historically Spain has struggled over the years to define the Welfare State in a democratic context. It is important to know that Spain came out of a long dictatorship in 1975 and created its first constitution in 1978. This means that while the Nordic countries were improving their Welfare State and social protection for citizens, Spain was just in the beginning of trying to implement democracy (Losada, 2013). We could argue that developments in Welfare State have come later to Spain than for instance, to Nordic countries.

According to Finnish law, Home care is understood as the addition of Home help, defined by social care law (710/1982, 20-21 §) and home health care set by health law (1326/2010 3-13§, 20§, 25§)

"Home care, as the term indicates, speaks of an activity or work that is performed to assist someone living in his or her home" (Milligan, 2009,p.10).

The main goal of Home Care is to support a person's functional capacity and life management in order to let her/him live as long as possible at her/his home. Home care targets mainly elder people in need of regular care or chronic patients. The need of Home Care is mostly evaluated individually on each case, and furthermore discussed with the client, relatives and Home Care Staff (Mukku & Kaisanlahti, n.d.).

The Home Care client's independence is supported according to the client's individual situation. The aims of home care service are optimal health, preservation and enhance of quality of life and independence to live at home. Home care supports these by working from a preventive perspective, responding to the physical, psychical, social and cognitive needs of the individual and evaluating individually that the previously set goals are being met (Thomé,Dykes & Hallberg, 2003).

From a client angle the main targets of Home Care are quality of life, wellbeing, function capacity, health, life satisfaction and empowerment to live at home (Tepponen, 2009).

A Care Plan is a client-oriented tool which leads care and service to make it effective and executable. It is always discussed with the involved parts and later on set according to both, client's and relative's perspective. This means that the Care Plan has to be suitable for and checked by all involved members. The Plan also secures the client's care as well as individuality and continuity of the service. A precise and well oriented Care Plan allows a good communication and monitoring within Home Care staff (Päivärinta & Haverinen, 2002).
After a Care Plan (known as "hoito-ja palvelusuunnitelma" in Finnish and PIA in Spanish) is set, it will be followed by the staff, the relatives and the client him/herself until further notice. It is important to focus on this mentioned Care Plan. It will lead the way during care for professionals and other involved members. Through this previously discussed Care Plan, professional staff will set short- and long term. Not only in Home Care scenarios but also in residential care is a care plan considered as one of the main pillars of Care. Clear and realistic goals will make the whole "care" process easier to follow up for the client, the professional, staff and relatives.
Often, Home Care can be defined as the total sum of health related Home care and Social Home care services. In almost all of the country members of the European Union, home care locates somewhere in between the health care and the social system, having its own differences within each country. Some countries, as it will be discussed later on, provide these separately. In contrast to these mentioned countries, experts argue that a well-developed Home care model should provide this service as one, not making differences within these two parts (WHO, 2008).

Most of the health care systems that provide Home Care often include "rehabilitation, supportive, health-promoting or disease-preventive and technical nursing care, both for chronic and acute conditions, occupational therapy and physiotherapy" (WHO, 2008, p.13). Home health care receivers would be mainly elder people, patients with complex and/or terminal illnesses.

In the other hand, we have home help services, also known as social home care, historically provided by the social system. This service often includes household tasks, such as household, shopping, paperwork related help (paying bills, filling applications, etc.), social related activities or going for walks and personal hygiene care (bathing, dressing and so on).

Once again, most of the users of this service are elder people, often living alone. These mentioned services are often substituted by informal care, which will be explained later. Especially in southern European societies informal care plays an important role in Elderly Care (WHO, 2008).

6.3 "Ageing in place"

In many European countries, the trend is showing that long-term care tends to decrease towards home-based care, according to the concept of "ageing in place". (OECD, 2005) This is not only a result of what people usually prefer, but typically a more cost effective solution rather than institutionalization, especially when effective informal care is available (Genet et al, 2013). The trend around Europe shows the decreasing of institutionalization in long-term care.

Before a theoretical definition of Ageing in place is given, it is important to define the word "place". This term has several dimensions worth of defining;

- A physical element like home or neighborhood.
- A social environment involving all sorts of relationships with others and the ways that facilitate individuals to stay in contact with others.
- An emotional dimension, related to a sense of belonging and attachment.
- A cultural dimension, that has to do with people's values, beliefs, ethnicity and other meanings that might be symbolic.

(Iecovich, 2014)

However, the home-space is not just a physical form of residence but also a tool that allows the elders to keep their life meanings through which their social identity can remain even when becoming chronically ill or disabled (Esther Iecovich, 2014).
According to Gitlin (2003), the home is an extension of the self, individualization, allowing preservation of the self and promoting a sense of personhood.

There are two main goals of aging in place. First, from the point of view of elders and relatives, most of the elderly population prefers to stay at home as long as it is possible because it promotes control over one's life and enables them to keep their own identity and well-being (Cutchin 2004).

Secondly, from a policy maker's perspective, residential or institutional care becomes much more expensive than providing care in the community and at the elder's home (Chappell et al. 2004; Kaye et al. 2009). The high public expenditures on residential care forced and it is still forcing policy makers and professionals to enable alternatives to respond to the needs of frail elders in their communities (Iecovich, 2014).

6.4 Dependency law

A fundamental point of Spanish democracy can be detected that is necessary in order to understand the trends and changes regarding Elderly Care. This point is the 14th of December 2006, when a law named "personal autonomy promotion and attention to people in a situation of dependency" was passed ("Ley 39/2006, 14 de diciembre, de Promoción de la Autonomía Personal y Atención a las personas en situación de dependencia") (BOE, 2013).

During this chapter the goal is to analyze and summarize what this law implies and represents for Spanish society. I will also analyze the completion of this ambitious change in a context of economic crisis and the effects and results that it has brought after 2006.

The law has been created as a new tool of social protection, complementing the already existing Social Security System, in order to care for people with some kind of dependency, no matter the origin and reason of the problem. SAAD (Sistema para la Autonomía y Atención de la Dependencia) is the system that should provide the basic conditions and provision of protection levels as mentioned through the law.

A board named “Consejo Territorial del SAAD” that works on an autonomous community level (such as Galicia or Cataluña) is created to provide cooperation between public institutions, to set the intensity of the offered services and the amount of the economic benefits. This board will also set the path of recognition of the dependency situation (Sociedad espanola de geriatría y gerontologia, n.d.).

The main goal of the law is to regulate the basic conditions to guarantee equality within citizens regarding the right to be cared for in situations of dependency. The law sets the following definitions:

Autonomy; the capacity of control to face and take by own will personal choices such as how to manage in daily activities

- Dependency; it refers to a permanent or impermanent situation, when a person no matter the reason, needs help from one or more people in order to manage with daily life activities.
- Daily life activities (DLA); fundamental tasks such as; personal care, essential mobility and so on.
- Informal care; care provided by non-professional people (relatives, friends) at the client’s home.
- Formal care; care provided by both, non- and profit organization in order to secure people in a situation of dependency. It can be provided at home as well as in a long care center.
- Personal assistant; someone who assists in daily life activities.

- The third sector; private but non-profit organizations as a result of citizen- or social initiatives that deal with social and human rights inequality.

According to the dependency law there are three recognizable levels regarding dependency. Each of them represents different needs and ways to approach individual cases. The levels are evaluated by different public sector professionals such as physicians and social workers (Organización colegial de enfermeria, n.d.).

Dependency levels:

- First level; regarding clients needing help to achieve daily life activities at least once a day or having intermittent and limited needs of help.

- Second level; given to people in need of help twice or three times a day, but not dependent yet on intense care because they still have some kind of personal autonomy.

- Third level; when help is needed several times a day and the potential client has lost complete personal autonomy and is in need of a caregiver continuously.

According to the dependency degree or level, potential clients will have access to a so called catalogue of services such as: prevention service; it attempts to prevent diseases and disabilities from getting to worse levels. It is coordinated by both social and health services. Teleassistance; while facing emergency situations in terms of insecurity, loneliness and isolation, it combines communication and information technology in order to give a quick response. Home care service; locally given help “in situ” in order to achieve daily life activities. Day and night service; combined with the service offered by day centers, it refers as the whole attention given in these kinds of institutions such as rehabilitation, psychosocial support etc. Residential care service; continuous services provided in residential care institutions according to one’s dependency degree (Organización colegial de enfermeria, n.d.).

These are the services that the law attempts to provide. As previously mentioned, autonomous communities have the obligation to facilitate the services. They are

provided by the social services network of each autonomous community through public and private institutions. On a general basis will this lead to quality and service availability differences within different regions in the Spanish territory as infrastructure changes from region to another.

The access priority will be determined by the dependency level in the first place and later on by the applier's economic situation (set by income and patrimony). In case accessibility to the mentioned services would not be possible, an economic compensation will be implemented and destined to pay the coverage of the needed service (Sociedad espanola de geriatría y gerontologia, n.d.).

There are three ways of economic aid; service related, in case the potential client does not have the chance to get into a service, it will be given in order to get the service from the private market. Informal care related, it is exceptional and it is meant to support economically informal care. Personal assistant related; it would be given to support personal autonomy through a personal assistant (Sociedad espanola de geriatría y gerontologia, n.d.).

6.5 De-familialisation

Three different patterns in decision making by governments can be detected: In the first case which is called familialisation by default, the government does not provide any public care services and does not give any financial support to the elderly and their families, which has as a consequence that the elder person and her/his well-being is highly depending on her/his family. The second case is supported familialisation. This means the implementation of policies that support and encourage the family as the main care giver and is mostly done by cash benefits for the care. However, even though this model offers some kind of support to dependent individuals and their informal care givers, also this model makes the elder person dependent on her/his family for support.

Moreover, both the familialisation by default and the supported familialisation leaves the families without a choice whether or not they want to, or are able to

care for their dependent relative. This leads to a limitation of the independency of both the elder person and her/his family members (Saraceno, 2010).

The third case is de-familialisation and stands for the independency of all parties from each other in upholding an adequate standard of living. Neither the elder person is dependent on her/his family for support, nor are family members obliged to intensely care for their older family members. A high amount of universal, publicly financed care services leads to this de-familialisation and the dimensions of public services provided by the state have an impact on the degree of de-familialisation (Saraceno, 2010 and Ulmanen & Szebehely 2014).

The private market can also play a role in de-familialisation and can contribute to its growth. However, it is necessary to note the class difference that occurs here. Only individuals that are affluent enough to pay for these services provided by the market can profit from this solution and can increase their independency through it. Individuals from lower classes are excluded from this option.

Another term added to this terminology by Ulmanen and Szebehely (2014) is “re-familialisation”. The enormous decrease of residential care in the last decades leads again to the increase of care provided by the family, which also leads to an increase in dependency of old people on their families.

7 Analysis

7.1 Population ageing in Spain and Europe

The phenomenon of population ageing is a topic that has created a public debate in almost every European country. As we all know, Europe is ageing rapidly and according to experts, this issue will bring many difficulties for ageing societies for both short and long term. On the other hand, population ageing could force ageing societies to offer some new approaches to how societies should prepare in advance, in order to prevent and solve these challenges, such as intergenerational cohesion across generations or how States support fertility rate or even migration in order to create a sustainable way to age (Zaidi, 2008).

To give an overview of what Europe and particularly Spain are experiencing, we should define and analyze the main reasons for this fast population ageing. There are three main distinguishable factors that are driving Europe to this challenging scenario.

- The ageing of the so called baby-boom generation, which describes individuals that were born between 1945 and 1965. People born during this period of time will be reaching 65 around 2010 and beyond (Zaidi, 2008).

- A continuously higher life expectancy. This plays a critical role in ageing societies and the life expectancies of individuals in Europe seem to keep increasing (Zaidi, 2008). This is due to a better quality of life and the fundamental progresses experienced in medical science over the last decades (Fundación General CSIC, 2010).

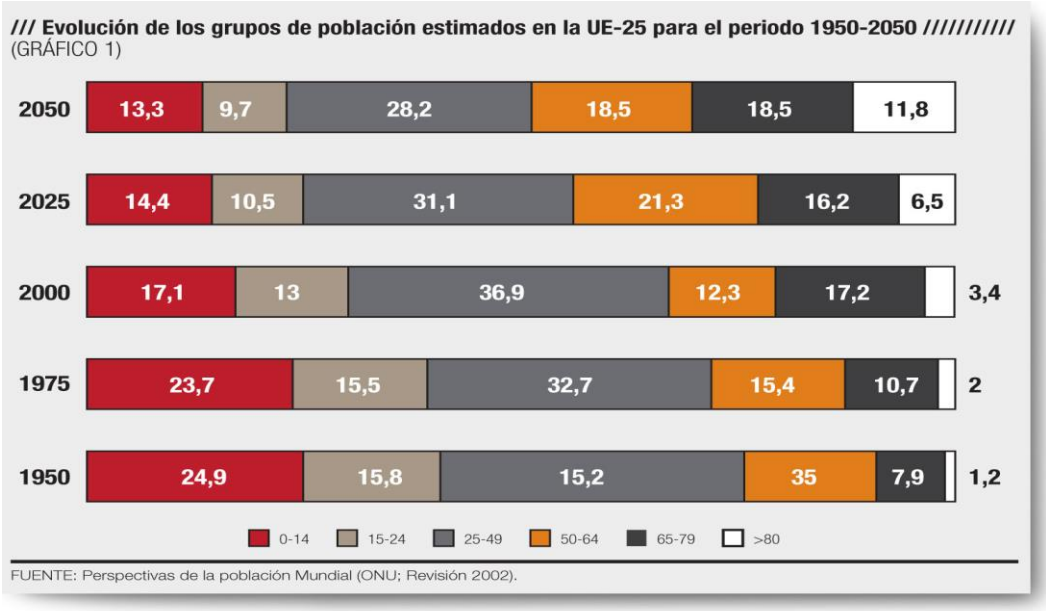
- The enormously lower fertility rate that manifested after the mentioned baby-boom generation (Zaidi, 2008). Some experts have come to the conclusion that, in order to create a sustainable generational replacement, the fertility rate should be around 2.1 children per woman. Spain, with its

fertility rate of only 1.32 children per woman, has one of the lowest fertility rates of all Europe. However, it should also be mentioned that every single country of the EU has lower fertility rates than 2.1 children per woman (Eurostat, 2007). This is turned nowadays into an issue, but it can also be seen as a success of societies from a gender perspective, offering more possibilities to woman when it comes to own decision making about life plans and child bearing.

According to the National Institute of Statistics, about 17% of the total population in Spain consists of individuals over 65 years old (INE, 2009). The repercussion of all these factors are that in the Spanish case, the population over 65 years old will represent more than 30% of the total population in 30 years time.

In various reports of the UN, researchers located Spain by 2050 as the most aged country of the world. The amount of citizens over 60 years old will get up to 40% (OECD, 2008).

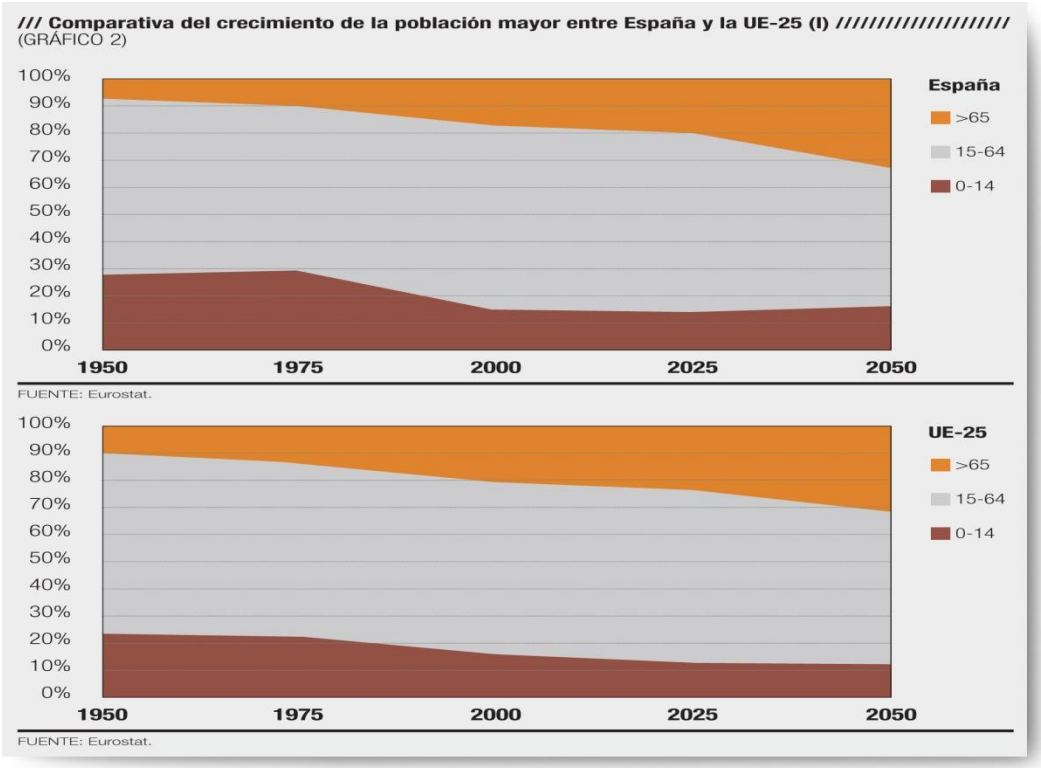
7.1.1 Figure 1: European population ageing evolution 1950-2050



(Fundación General CSIC, 2010)

In order to get an overview of the Spanish situation in a European context of population ageing, a figure made by Eurostat 2004 for by then the 25 members of EU is used. Age ranges are divided for period of time equivalent to 100 years. This plot shows the growth of people over 65 years old, growing from 10% by 1950 to 33% by 2050.

7.1.2 Figure 2: European population ageing comparison:



(Fundación General CSIC, 2010)

This figure shows a comparison between Spain and Europe. According to this graphic will the Spanish population over 65 years old experience a faster growth than in other European countries.

Besides the growth of people over 65 years, another significant number can be analyzed as a repercussion of the low fertility rates in Spain. As a result, the age group between 15 and 64 years is decreasing. This implies the possibility of having a reduced size of the professionally active population for the future. This is one of the upcoming challenges for the Spanish, as well as other European economies in order to be productive and competitive, but what is more important,

to be sustainable (Fundación General CSIC, 2010).

The phenomenon of population ageing will bring difficulties to all European countries, but clearly Spain has a more challenging destiny. As we could assume, the need to face this challenge should happen sooner in the most affected countries, but experts agree that Spanish society has not approached this issue with the seriousness that would be necessary and appropriate (Fundación General CSIC, 2010).

Spanish and Finnish home care and policies

There is a must in this thesis in order to understand the situation of Spain and Finland from a policy perspective. Both country's policies and models will be analyzed to give a comparison overview on how home care is provided and works in each country. Discussion and recommendations will be given later on, based on policies and its repercussion on a micro level.

7.2 Spanish home care

7.2.1 Organization and home care providers

When it comes to Spanish Home Care system, it is necessary to mention that Spain is a decentralized country. This means that there are 17 autonomous regions that differ in levels of autonomy. These already mentioned regions are responsible for health care (also home care), education and taxation (Genet et al 2013).

Health care and social services are organized separately and their function is completely independent from each other. It is essential to mention that there are no institutions whatsoever that would coordinate these two services (Genet et al 2013).

There are two different components in Spanish Home Care, the “health” component, which is arranged by the health care system, and the “social” component, belonging to the social system (WHO, 2008). The main actors of Spanish Home care are; The Ministry of Health and Social affairs, autonomous regions, Local governments, Primary Health centers, “SAD” and local social service agencies and informal caregivers (Genet et al 2013).

The health system is discussed on a policy level by the national government, while budgets, health care facilities arrangement and implementation of national policies are under the management of region and local authorities (Genet et al 2013).

Home health care is provided by Primary Care centers, they are public and in some cases, non-profit organizations chosen by the National Health System. There is no competition regarding Primary Health centers. On the other hand regulations in Social Services are defined by national policies such as Dependency law. Local governments are in charge in organizing and providing Social Services, such as Social Home Care. Normally municipalities get private or non-profit providers in order to assure social home care services (Genet et al 2013).

7.2.2 Accessibility to the service

From an eligibility point of view, there are differences between home health care and personal and domestic care (social home care). This is due to the fact that competencies between health and social home care are completely separated from each other. The health organizations have created eligibility criteria and a list of possible services for health home care. Home health care is a universal service

and so it is health care in Spain. It is also free of charge. Universal service means that the service is available for everyone, based on residence (Genet et al 2013).

In contrast, eligibility criteria regarding social home care is based on the evaluation of potential needs of the service user (level of dependency). Currently, the already implemented Dependence law does not cover low and mild levels of dependence. There is a co-payment for this service that is set according to individual's income. This would mean that this service covers only certain levels of dependence and therefore, excluding those whose levels are not severe enough (Genet et al 2013).

In other words, the standards in order to access Social Home care are very high at the moment, being really selective in choosing service users.

7.2.3 Quality criteria

To understand existing or non-existing quality criteria regarding Home care it is essential to separate once again what is known as Home health care and social home care. (Genet et al 2013).

Home health care quality criteria

When it comes to home health, there are established processes focusing on quality of the service. These are set in the contract between each regional institution in charge of Health Care and the Primary Health centers on a local level. The quality of home care service is measured and assured by the regional department through evaluations made by professionals working on for the regional department but focusing on a local level (Genet et al 2013).

Some autonomous regions organize yearly satisfaction surveys but they are not specific to Home health care. This means that these surveys are not relevant in order to enhance home health quality (Genet et al 2013).

Regarding accreditation for service providers to be legally able to provide services, this is regulated by the different regions, appearing differences within these regions (Genet et al 2013).

Social Home Care

Respecting Social Home care, there is no criteria whatsoever in terms of quality. One of the reasons is that since in most of the cases the service is not provided by public institutions, sometimes it might be difficult to measure quality. Some of these cases are the ones that receive social home care through family caregivers. These family caregivers when receiving money according to dependence law are counted as a kind of home care (Genet et al 2013).

Social services do not carry out any kind of satisfaction surveys, but according to the dependence law, a complaint procedure is available and the institution service provider institution has as an obligation to answer to these complains (Genet et al 2013).

Accreditation for social home care providers is expected, but never compulsory. This means that institutions providing these services do not need accreditation in order to exist (Genet et al 2013).

7.3 Finnish Home care policies

One of the main aims of the national government is to provide an easy access to both, health and social services in order to enable elderly people to live at home as long as possible (Holma, 2008). The goal for 2012 was that around 91% of the elderly population would live at their own home and 13% of the 91% should be receiving regularly Home Care (Ministry of SAH, 2008) Occasional home care is not included in the 13%. Occasional home care is understood to be a short length of provided home care for instance after a hospital period.

7.3.1 Finnish home care organization and care provider

Finnish home care consists as well of Home health care and Social health care. These two parts can also be mentioned by different names, such as home nursing home and home help, but the concept would remain the same. Municipalities can choose whether to organize separately these services, but the trend shows that the number of Home care units combining home health and social care has increased over the past years and it seems to remain growing in a near future. (Tepponen 2009).

Many different countries such as Italy and Spain organize their home care models base on two different parts; the health component, as a part of Health System and the “social” component as a part of the Social System. However, in other countries such as Finland and Sweden, policy makers have admitted the advantages of a single organization proving Home care on a municipal level (Genet et al 2013).

The main actors in home care can be clearly distinguished: Ministry of Social Affairs and Health, municipalities, Social Insurance Institution of Finland (“KELA”) and private providers (Genet et al 2013).

In relation to how health and social services are organized, there is a slight difference between Spanish and Finnish system. While in Spain health care is organized on a regional level, in Finland both, health and social services are organized municipally. The minimum amount of inhabitants is 20,000 in order to provide independently these services as a municipality (Act on the restructuring of Local Governments and Services). In cases when inhabitants are under 20,000 these municipalities often cooperate with others in order to deliver health and social services (Genet et al 2013).

The role of the national government is to provide laws, information and supervision systems that have had an impact on home care on the municipal level (Genet et al 2013).

7.3.2 Accessibility to the service

There are only national recommendations concerning accessibility to services but is not regulated on a national level, however, the access to health and social care services do not depend on economic situation or the possibilities to rely on informal care (Blomgren et al. 2008). Eligibility criteria depend usually on medical history, the physic-mental and psycho-social capacity as well as on the social environment. That turns in practice into a possibility for everyone in need of health home and/or or social home help regardless of possible informal caregivers or income. (Genet et al 2013).

The Social Insurance Institute of Finland “KELA” is the institution that provides economic benefits for those in need, also for Home Care. These benefits that cover the service costs need a referral from a doctor in order to be processed. From a bureaucracy point of view, it is a very functional system as only one public institution in charge of social benefits makes it easier for service users to apply for the mentioned benefits (Genet et al 2013).

7.3.3 Quality criteria

Quality criteria is not regulated as such nationally, however, the state organizes different projects to develop services in terms of quality. Recommendations and guidelines set by the state have not had the estimated impact. In contrast to Spain, accreditation for organizations in Finland providing Home care services have minimum requirements in order to be offer services (Genet et al 2013).

Municipalities are in charge of quality criteria for each service provider, normally by setting a list of requirements in the contract (staff’s educational level, satisfaction surveys, etc). On the other hand, it is not clear when it comes to services directly organized by municipalities themselves (Genet et al 2013).

There are significant differences from municipality to another when it comes to ways to measure quality of the service. The most usual way to accomplish this is

through client surveys about; service functionality and availability (Genet et al 2013).

7.4 Unmet needs, trends and challenges of Spanish home care

7.4.1 Unmet needs

Home health care unmet needs are difficult to spot, but usually the coverage of home nursing home is much broader and accessible than home social care. However, lack of funding is expected to increase unmet needs in home health care. Normally Primary care receives more attention from regional administrations than Home health care (WHO, 2008)

Usually, estimated hours of care by home care do not correspond with the assigned hours to the service user. This is a result of home care infrastructure capacity problems. It is also prove than home adaptations and home care equipment are often not publicly funded, which once again, means that to purchase certain tools and changes in order to enable dependent in order to stay safely at home depends on individual's income. The same process is happening from an income perspective to those dependents with stable economic situations such as middle and high class, who automatically drop out of home social care (Genet et al 2013).

Regarding social home care, dependent people with mild and less severe problems are dropped out of the system, since Dependency law is experiencing a decreasing funding due to the economic crisis.

7.4.2 Trends and challenges for Spanish Home care

There are enormous differences between theory and practice in Spain. After the creation of Dependency Law in 2006, the coverage was supposed to reduce familialization, however, benefits do not apply to everyone in need of care and therefore many dependent people are dropped out of the system. Apart from that,

the administrative process in order to obtain recognition set by Dependency law is very slow and bureaucratically very complicated. This makes access to service difficult for potential service users (Genet et al 2013).

The current economic crisis has brought new difficulties in order to fund health and social home care, this difficulty is seen on micro level, where service users have reported that received money was less than expected according to Dependency law. Service users have also reported the hours of care to be insufficient.

When it comes to funding, there is a crucial point, 2011, when 135 article of the constitution was changed by the two biggest political representations in the Spanish parliament PP and PSOE (BOE, 2011). The reform on this article set the devolution of the debt with the EU over any other investment, which turned in reality as priority over for instance, services like Health care or Social services. Funding these services will be therefore set as a minor priority compared to the debt.

Between the main challenges some can be seen as very fundamental, especially a better funding from regional and local administrations, many potential users are not receiving any benefits due to Dependency law poor coverage. Another one is coordination between health home care and social home care, institutions or regulations in order to integrate home care based on both, health and social services are missing. This is essential to provide better home care in terms of quality (Genet et al 2013).

Home Care developments should have different directions during the future, a fundamental investment in public infrastructures for home care is necessary to facilitate defamililialisation and to provide access to all those in need of both, health and social home care. Potential users dropped out of social benefits or formal home care, are at high risk of social exclusion and poverty (WHO, 2008).

As previously discussed, there are a lot of challenges for Home care in terms of quality and accessibility to service. However, the current model in Spain is also in need of a policy change which would have an impact on a micro level, affecting directly dependents and relatives responsible for informal care. Dependency law has brought a complete new approach to Spanish Elderly Care, yet, it has not

offered a solution for Spanish elderly people. A more effective funding of Dependency law is necessary in order to develop and enhance home social and informal care (WHO, 2008).

A possible consequence of this law might be seen in the future. The chain of supported de-familialisation comes to a critical phase for the next generation. As already mentioned, dependency law still relies mostly on informal caregivers, especially on children. Spain is experiencing a massive emigration in young people, over 400,000 Spanish migrants during the economic crisis. (Iglesias, 2014). This may lead to a big number of people who will not live in Spain and therefore will not be able to provide care for their elder parents. Besides all the potential users not receiving home care but substituted by informal care, Spanish migrant's parents will not be, in many cases, be in a situation where informal care is not given.

7.5 The dependency law in practice

The implementation of the independency law in 2006 rose high expectations regarding its outcomes. It implied a conversion of political strategies from institutionalizing old people, towards a system where old people would have the possibility to stay in their own home and within their social network. However, the outcomes of this law were not as good as expected beforehand and no implementation of an effective home assistance service took place (Saraceno, 2010).

One reason for the bad results of the law is the way, funding is distributed. First of all, only 2/3 of the individuals that are eligible for the benefits receive them. Furthermore, 1/3 of the grant is used in order to support informal care givers, such as family members. Only 13% of the grant is sued for residential care, and even lass, namely 7%, is used for home care services. These measurements of the dependency law enabled a shift in Spain from familialisation by default to supported familialisation. While this could be seen as a step in the right direction

by supporting families that need to care for an independent family member, strictly it can still be seen as a failure of implementing effective home care services for elder people. Instead of aiming to actively change the system into one that takes away the heavy burden and responsibility of families to care for independent family members, it only takes “half a step” and starts giving out small financial support. However, most families keep on carrying the responsibility for their elder people (Agrela, 2011).

It is arguable that the political preferences of the government get visible in the amount of money they invest in support for informal care: Instead of aiming to implement a better public service system, they keep putting the focus on the care within the family. This does not only contributes to the maintaining of dependency of old people on their families, but also prevents families from making a choice whether or not they want to care for their dependent family members, and to what extent. It reinforces the role of women in providing informal care, and shows little thought on the side of the state about the problematic reality of women that have to carry the burden of the informal work (Agrela, 2011 and Saraceno, 2010).

Where elder care in Finland is recognized as a public problem which needs to be solved through public interventions, in Spain, elder care is still accepted as a private problem, even after the independency law in 2006. The Spanish government still seems to not acknowledge elder care as an important social problem that needs public interventions but instead seems to find it enough to sustain a sys-tem of supported familialisation. The family is still a very attractive and cheap option for the government, and the shift from familialisation by default to supported familialisation will not solve the problem.

7.6 Gender inequality

Historically, care work has always been a gendered activity where women had to carry the responsibility of carrying for dependent family members. Also when it comes to formal care work in these days, the domain is highly feminized (Razavi & Staab, 2010). Until today informal care work is most often done by women and many researchers emphasize that the burden of this informal care is often invisible

and it is also difficult to measure the actual amount of care work provided. Depending on the severity of dependency, informal care work often consists of very heavy and intensive care work and can be a large burden for the care provider, which in most cases are the women of a family (Saraceno, 2010).

A positive change that can be seen in the last decades is the increase of the amount of women entering the labor market in Spain, which leads to a slow movement towards a dual breadwinner model. While it is stressed through the women-friendly discourse that women's labor market participation is the key factor for gender equality, it however also leads to a shortage of informal care. Moreover, the shortcoming of formal provision by the state together with the decrease of women´s time for informal care leads to a "care crisis". There are barely any efficient policies that could at least assist women in this difficult situation of reconciliation work and family. Even though women are more and more involved in the labor market, they still do most of the informal care work for dependent family members and most of the tasks in the household, so one can say that the workload for women only increased. Therefore, care as a social economic cost is still mainly the burden of women (Saraceno, 2010).

This heavy burden of possible informal care together with employment leads to a high risk of dropout from the labor market. Gender and class interacts at this point. Especially women with a weak stand in the labor market or low wage jobs are in danger of dropping out of their paid employment in order to care for a dependent family member. This leads to economic losses for the family but furthermore, it leads to a decrease of the women's independency: the women themselves are again economically dependent on their spouses. Furthermore, wage losses and the gaps in payments towards their old age pensions increase the risk of old age poverty for these women (Saraceno, 2010).

In many cases, migrant woman have taken over the Spanish women when it comes to informal care. Studies show that migrant women, especially come from former Spanish colonies, represent a big number of the total of migrants in Spain. This means that while the number of Spanish woman have been increasing in labour market it has been to the detritment of migrant woman (Dahl, Keränen & Kovalainen, 2011).This leads to a situation, where migrant women leave their own

countries and become often the economic head of the family. The repercussion of the care migration is certainly experienced in women's countries, where the care chain is broken. This trend is being reported to happen in other European countries such as Italy, however, policies do not show to care much about consequences that are not seen within the country, no matter what they might be (Dahl, Keränen & Kovalainen, 2011).

Overall, one can conclude that while the Spanish government finds it sufficient to sustain a system of supported familialisation because it is cheaper at this very moment, women are still "the losers" after all and will have to face consequences sooner or later.

7.7 Preferences of care in Spain

According to Dependency Law (2006), a legal obligation for relatives to pay for care of their elderly do not exist, however, this is a theoretical concept, since in reality Spanish Home care infrastructure has not increased and Home Care has its weaknesses filled by informal and family caregivers. In relation to who should be responsible to provide care for the elderly, 53% thought that the responsibility relies on the close relatives (Eurostat, 2007).

As stated in the Spanish Eurobarometer (Eurostat, 2007), formal Home care is seen as an unpopular preference of care, only 15% of Spanish respondents agreed that formal home care was a good option, compared to the average in Europe, that was 24%. In Finland the results were 51% for professional home care as a preference (Eurobarometer, 2007).

This given numbers show preferences of Spanish and Finnish relatives regarding home care. However, there are other results that show the possible factors these numbers are built on. When the asked question was if public agencies and authorities should offer proper home or institutional care the number went up to 65% of the total population (Eurobarometer, 2007).

Regarding the opinion of Spanish population, 81% thinks that dependent people have to rely too much on their relatives (Eurobarometer, 2007).

Apparently there is an important difference when it comes to what people want in terms of availability and quality of service and what people prefer regarding care in reality. On one hand, only 15% thought Home Care to be a good option for their elder people, but on the other hand , up to a 65% of Spanish population agreed that home and institutional care should develop from both, availability and quality perspective. These two results show contradiction to a certain extent.

This lack of home and institutional care might lead to force relatives to take care of elderly. Although care preference may be due to a historical reason, since Spanish used to be a strong catholic country where multigenerational families and informal care were common, the current results of care preferences of Spanish people derivates from poor availability of home and institutional care.

7.8 Population ageing related challenges

Researchers in Spain agreed that due to the population ageing, investment in order to research on this topic is fundamental. A better fund from public administration is seen as a need within Spanish research community (Fundación General CSIC, 2010).

As international research on European population ageing point, there are five crucial areas to develop in order to be prepared for population ageing.

- Pension policy; a better system is needed to prevent old age poverty and social exclusion.
- Health and long-term care policy; population pyramid is changing and so are the needs of the elder people.

- Employment policy; due to the decrease of professionally active population, some matters regarding employment (such as retirement age) must be reformulated.

- Migration and Integration policy; migration is playing an important role in ageing societies and this has to be studied as whole, researching on the consequences in both, origin and destiny countries.

- Infrastructure development; apart from developing policies and social benefits, there is a need in developing health and social infrastructures for old people, since the number is continuously increasing. (Fundación general CSIC, 2010).

8 Discussion

During this following chapter, the goal is to present briefly the results of my research. As previously discussed, policies play an important role on a micro level, and on preferences of care, but also have impact on other areas, such as gender inequality.

Home care system, policies and the Finnish model were analyzed to later on provide solutions to the risen challenges and problems.

1. **What are the main characteristics of the Spanish home care system?**

As presented in the analysis, Home care is divided clearly into two components; health and social home care. These two parts are organized on different levels, making cooperation between both really challenging. While Health Home care seems to be working relatively well, Social Home care is showing weaknesses in; **funding**, due to poor funding on a national level. **Accessibility,** Dependency law and the bureaucratic process leave out of possibilities for service many potential users. **Quality,** benefits and the amount of hours of care are reported to be insufficient as well as the quality of the service.

All these challenges will increase tremendously due to population ageing and increase of people in situation of dependency. A lack of public services and social benefits can be clearly identified nowadays, but this might be just the beginning of a problem, because Spain, regarding population ageing seems to be one of the most affected ones.

2. **What are the consequences of the Spanish policies regarding Home care on a micro level?**

Policies do have an impact on a familial level. In the Nordic countries, policies tend to head towards de-famililalization, where individuals are independent and informal care is a choice between many ways of care. Dependency law for instance, also has a repercussion on preferences of care. Spanish people do not see formal

Home care as main solution, but on the other hand most of the Spanish population hopes services to be more accessible and better from a quality point of view. Spanish policies show political interest when it comes to dependent people, forcing them to rely in many cases on their relatives, without leaving space for other alternatives. This leads to a system closer to supported familialization rather than de-familialization, where people with some kind of dependency are not supported to be independent. This familialization process might make families struggle when it comes to take care for their elders.

As a consequence of Spanish policies, gender inequality can be distinguished. As discussed during the research, women seem to get the negative effects of supported familialiazation, since the State expect often dependents to rely on their families and therefore in many cases to rely on women. Policies seem to take us back in time, where families used to rely on a woman “carer” role, creating more challenges on a long term.

3. How could the Finnish model help to improve the Spanish home care model regarding its accessibility, effectiveness and equality?

As an Elderly Care professional and after analyzing the data used for this research, it is fairly clear the need of seeing Finland as a model when it comes to Home care. There are many ways the Finnish model could be used in order to improve Spanish Home care. The integration of Health and Social home care in Finland is much more developed than in Spain, this is a fundamental need for Spanish Home care to provide better quality services. Regulating quality and accreditation procedures could be also imported from the Finnish model, as tool to provide quality and accessibility to Home care.

From the Finnish model, universality of access to service should be also taken in account. A better coverage for Social Home care in Spain could help to provide Home care service for all those in need. From a bureaucratic perspective, the Finnish model seems to be more citizen friendly, by making the process of applying for social benefits more accessible and simplifying in general the bureaucratic steps to take. The Finnish model should be used as a mirror,

regarding defamilialization. This would have an impact for instance, on promoting gender equality as well as a model heading towards defamilialization, where families are not in theory, nor in practice, forced to take care of their elderly relatives.

9 Conclusions and recommendations

The economic crisis has brought new problems to the already existing ones. There are several conclusions about how to develop Home care as a whole. Some of the conclusions are on a policy level, especially about Dependency law and funding of Health and Social System. The other visible group of conclusions would be regarding Home Care as an addition of both, health and social home car, focusing on the quality of the service itself.

As previously discussed, accessibility to Home health care is not the main issue at the moment. Coverage of Health System is universal and applies for everyone. When it comes to quality, standards are normally quite high. Yet, satisfaction surveys are not focused on Home care specifically. Satisfaction surveys focusing only on Home care would help to get more information about what is needed in Home health care.

Social Home care seems to need a development to enhance quality and accessibility to the service. First of all, there is no public administration in charge of quality measure for non-public institutions providing Social Home care. Besides creating an institution or delegating this task to a public administration, accreditation of private or non-profit institutions should be compulsory to reach a good quality of service. A better monitoring from public administration regarding quality of Social Home care is fundamental in order to improve from a quality angle. From an accessibility perspective, it is proven that many potential users are dropped out automatically from the service. The main reasons for potential users to be dropped out are: mild dependency level and income. At the same time, poor coverage is directly related to a lack of funding of Dependency law so there is not much space for hope as long as policies regarding Dependency law do not apply for everyone with a recognized dependency level.

From an income point of view, decisions for social benefits should not be income based, so middle and high- class would also have potential access to the service. The law should also apply for those with mild and less sever dependency levels Coverage regarding Dependency law needs development to prevent social exclusion, poverty and mainly to reduce the number of potential service users that

are dropped out of the benefits. Besides increasing social home coverage, the amount of hours of care has been reported by service users to be less than needed. On the other hand, the process to apply for benefits set through the Dependency law is bureaucratically very complex and hard. An easier and better regulated bureaucratic process would eliminate to some extent thresholds for potential service users.

Social home care infrastructure needs to be developed by for example, through investing in public agencies in charge of Social Home care on a municipal level, which are proven to be insufficient.

Funding related problems could be changed only after a reform of the article 135 of Spanish constitution. In this scenario, regional administrations would not have as a priority to pay back the debt over for instance, investing in Health or Social care. This is a very unrealistic recommendation since it depends directly on policy makers on the highest level. However, health and social systems are always dependent on politics, and there is no other way to enhance Health and Social systems but through politics.

According to studies shown along this thesis, there are many policy makers pointing that coordination between health home care and social home care is necessary in order to provide better quality service. The Finnish model could be useful to develop cooperation within these two components since many municipalities of Finland have been organizing those services as one and this trend is expected to increase in Finland. Spanish Home care components should interact with each other, but this would be only possible by creating cooperation provided by a public administration.

However, there are no academic studies responding professional needs. An implementation of an academic degree which would facilitate this coordination would be useful. “Geronomi koulutus”, elderly care degree, could be used as an example. It is a degree on a University of Applied Sciences level, created in the early 90’s in Finland. Elderly care degree moves continuously in an area between Health Sciences and Social Work providing a broad view and cooperation of both, Health and Social related services. This would be a convenient practical

recommendation to promote and enhance integration of the both components of Home care. Besides Home Care, it would also help to develop Elderly care in Spain, as well as to be professionally prepared for the population ageing related challenges.

From a familial perspective, Dependency law has not led to defamilialization but to supported familialization. Instead of investing in Home care and long-term care infrastructure, the government has decided to only invest in certain levels of dependency level by offering as reported, insufficient amount of hours of care and cash benefits. This means the problem has not been solved, while many potential service users are not eligible, many others receive little help from the social services. These policies head to a scenario, where both, service users receiving benefits and those dropped out are still dependent on their relatives. This does not provide an alternative for families but forces them to still care for their elder dependent ones. It can arguable that governments need to support families and informal caregivers since it can become a cheaper way to provide care. However, this cannot be the only way to support and the State should provide families choices whether to take care or not of their dependent relatives, instead of forcing families to do so, because there is no other offered choice.

Once again, women become the “losers”, if families are forced to care for their elders. This role is often taken by women, who have in some cases, to drop out of the labor market in order to care for dependents. By “forcing” women to stay at home as informal caregivers, a dependency towards the economic head of the families is being created, often, to husbands. This will have a repercussion in a long term by leading to women old age poverty. Policies are not promoting gender equality, in contrast, inequality from a gender perspective is being supported by policies such as Dependency law.

9.1 Further research

An interesting topic for a possible further research would be to study the regional differences regarding Home care in Spain. The possible research would reveal regional quality and funding differences.

9.2 Research process:

Through this research I have learnt substantially about Spanish Home care and policies. This was a way to connect my knowledge about Elderly Care received in Finland during the past years. I have to admit, searching for right bibliography and literature has been quite challenging, but luckily some European research centers have published some interesting reports about the Spanish Home care situation. Though, it has been fruitful process to learn and give an overview of the topic. Hopefully I can use this knowledge in the future, to help developing Spanish Home care public services in the future.

Regarding the results, it is always difficult to give specific conclusion when discussing on a policy level. Practices in Finnish home care in terms of quality are, on the other hand, more visible and distinguishable.

Dependency law has brought a complete new approach to Elderly care in Spain. However, as researchers, we should look up to the Finnish model when it comes to de-familialization and gender equality. There is still a long way to the top.

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