Mobilecare

Social dialogue as a tool to improve the conditions of functioning of intra-EU labour mobility in home-based care services

NATIONAL REPORT OF SPAIN

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The ***Spanish National Report*** of the MOBILECARE project is structured in four sections: Desktop analysis; analysis of the online surveys carried out; analysis of the interviews carried out; and conclusions drawn from the *focus group* carried out.

To briefly compare the data obtained in the online survey phase and in the interview phase, at the end of this chapter we include some comparative comments between both phases.

Not having a common methodology template for all partners (except for the desktop analysis phase) may perhaps alter some of the objectives pursued in this research phase, which, in any case, are also unknown to us.

Finally, it is necessary to point out the limited space available to write this *National Report,* which has forced us to limit a good part of our comments and aspects that we believe to be of interest, especially those related to desk analysis.

I.- Desktop Analysis

We conducted our desk analysis in accordance with the proposal made by the project's coordinating expert in his document " *Methodology of the research phase* ", on page 4 of which he makes a "suggestion of 10 research questions" that he recommends answering. In our analysis, we grouped these questions into five thematic blocks that we summarize below as the first part of our *National Report* .

I: Legislative Framework : Questions 1, 2, 3 and 6

In this first section we refer to the conceptualization of social dialogue in Spain, addressing, secondly, the legislative framework for care, especially home care, in our country.

1. **How is social dialogue institutionally integrated into your country's social policy?**

In Spain, we differentiate between two types of social dialogue: one of a tripartite nature, which we call by that term *social dialogue* , and another bipartite, which we identify with *collective bargaining* that is carried out *" between representatives of workers and employers* " to establish the " *working conditions of employees"* , configuring itself as a right recognized in the *Spanish Constitution* and developed in the *Workers' Statute.*

Social dialogue ***The tripartite system*** is identified with social agreement and has a marked political character. Its objective is the co-determination of public policies by

governments, employers' organisations and trade union confederations, in order to reach consensus on major issues of economic and social policy that are considered to be of general interest or public interest (as opposed to *collective bargaining* that regulates the employment conditions of workers agreed between employers and trade unions). These issues include health and social services, which include home social care for dependent persons, both in care centres (public and private) and in private homes.

Social dialogue is developed through the creation of a *tripartite and equal body* , which guarantees the institutional participation of the most representative trade union and business organizations, with the same powers to defend and promote economic and social interests, and whose result are *social pacts* .

2. **Where are home care services located institutionally? Is it a public service?**

3. **What is the role of the State in providing universal and affordable access to home care services?**

6. **What is the level of regulation of home care services?**

We answer these three proposed questions jointly.

Article 43 of the *Spanish Constitution* establishes the right to health protection and health care for all citizens and the competence of the public authorities to organize and oversee them, specifying its principles and substantive criteria in Law *14/1986, General Health Law* , which defines, among other aspects: Public financing, universality and free provision of health services at the time of use; or the political decentralization of health care in the Autonomous Communities (Regions).

National Health System (NHS) is set up , which is the coordinated set of Health Services of the State and the Autonomous Communities (CC.AA.), Regions, which integrates all the health functions and services that, according to the law, are the responsibility of the public authorities. Part of this *System* is **home care** .

Furthermore, the *Public System of Social Services* is made up of professional social intervention services, which are the responsibility of the Autonomous Communities (Regions) and are made available to citizens to respond to situations of special need [dependency of the elderly or disabled, family protection, child care, etc.] and are established as one of the pillars of the Welfare State.

Within this framework, we refer to the *protection of the elderly* , as this is the objective of the project. The Spanish legal system grants a series of priorities and special protection to people in certain situations or risks, in which the elderly sector of the population may be immersed, establishing specific rights such as: not being discriminated against on the basis of age; the right to life and physical and moral integrity; the right to the protection of

the elderly; the right to access social and welfare benefits and to be cared for when in a dependent situation, among others.

For the protection of the elderly and their social assistance, we have a state agency, the *Institute for the Elderly and Social Services, IMSERSO* .

Finally, as a concrete element of the development of protection and assistance for the elderly, we must mention *the State Care Strategy* (20.10.2022) , developed within the framework of the *European Care Strategy* , with a roadmap that highlights: The *Dependency Shock Plan 2021-2023* , which promotes the *System for Autonomy and Care for Dependency (SAAD)* , which is the set of services and economic benefits aimed at promoting personal autonomy, care and protection for people in a situation of dependency, through duly accredited public and private services, and contributes to improving the living conditions of citizens; and *component 22 of the Recovery, Transformation and Resilience Plan* on the transformation of the long-term care model, whose main objective is the modernisation of all social services and the reinforcement of care and support policies, with investments totalling €3.5 billion during the period 2021-2023.

II.- Role of social partners : Questions 4 and 5

4. **What is the role of social partners (employers and trade unions) in providing universal and affordable access to home care services?**

The role of the social partners is embodied in *tripartite social dialogue* , the result of which is, for example, the *Agreement of the Social Dialogue Table on Personal Autonomy and Dependency* , signed by the Government of the Nation, trade unions and business organizations on March 18, 2021, which has had, among other developments, the approval, by the Government of the Nation, of the first *State Law on Social Services* (on January 17, 2023) where common state minimums are established in terms of social services; access barriers to social protection are reduced; and territorial mobility is made possible, among other measures.

5. **What is the role of NGOs in providing universal and affordable access to home care services?**

As we have pointed out, the *National Health System* and everything related to the care of dependent persons form a set of public and private services among which are NGOs that receive public subsidies to provide these services or that have self-financing systems, such as *Caritas Española* or *the Spanish Red Cross* .

In addition, along with NGOs, we must mention the existence of what are called " *collaborating entities and associations* ", such as *EULEN* (an international group: Spain, Portugal, the USA and Latin American countries) or *ASISPA* (a private non-profit association that provides home help, telecare and residences), among others, which participate with the City Councils, through subsidies received from the Public Administrations.

III.- Regulations for the professional practice of caregiver in home care : Question 7

7. Are there national standards for the provision of home care services?

We answer this question from two different perspectives: from home care as a public service instrument; and from the perspective of the care worker and provider of that care.

to) *Home care as a public service* is the type of assistance or care provided at home to those people who, due to their health status, cannot travel to a health center, distinguishing between health care and non-health care.

Healthcare is provided by healthcare professionals to patients with illnesses that require hospital care, but which can be provided at home, where, in addition to healthcare needs , they are cared for in activities related to their daily life activities (helping to bathe, dress and move patients; support with food preparation, etc.).

Non-health home care is provided by professional caregivers who are responsible for the comprehensive care of these dependent people, through what we call ***home help service*** **, SAD** , consisting of the set of actions carried out in the home of people in a situation of dependency in order to meet their daily life needs and increase their autonomy, encouraging them to remain in the home, which is provided by the Municipalities.

SAD service professionals must have, in order to practice their profession, a *Professional Certificate in Social and Health Care in Social Institutions* or in *Social and Health Care at Home* .

Finally, it should be noted that in Spain, since 2007, we have had a " *Special Agreement for non-professional carers of dependent persons who are recipients of economic benefits",* which establishes a series of conditions for those people who, without holding a professional qualification enabling them to carry out these functions, care for people in their environment in a " *non-professional* " manner. Under this *special agreement,* "non-professional" carers receive a protective action for retirement and permanent disability and death and survival, resulting from an accident, whatever its nature, or from illness, regardless of its nature, that may occur while caring for these people.

IV.- Home care needs of dependent persons : Questions 8 and 9

8. **What is the demand for home care services? How is it met? (institutional care, family care, hospitals, etc.)**

9. **What is the level of home care provision?**

The latest national and regional statistical data (dated 31.12.2022), published by government agencies in Spain, summarize the situation in our country and would answer the two questions raised by the expert:

- The population targeted by these services, people aged 65 and over, amounts to 9,687,776 and represents 19.99% of the total.

- Home Care Services : Its main objective is to keep the elderly in their homes to avoid being uprooted from their surroundings and has two actions:

    - The *Telecare Service,* which has 988,623 users, 10.20% of whom are elderly, is a highly feminized service, 75% are women, and has a high percentage of users aged 80 and over (69.7%).

    - The *Home Help Service* , which serves 534,321 elderly people, 5.52% of whom are aged 65 and over. In this service, 71.9% of users are women and 68.9% are over eighty years old.

In addition to these exclusive home care services , we have other mixed or residential services, which we also believe are necessary to discuss:

- Social Participation Services , with 3,739 *Senior Citizens' Centres* , which have 3,771,465 members, 38.93% of the elderly. It is the service with the lowest feminisation: 57.7% of its members are women.

- Day Care Services , called *Day Centres,* which offer psychosocial care to elderly people in dependent situations, with a range of 105,447 places distributed in 3,545 centres. Of the 66,421 users, 68.7% are women and 66.5% are over eighty years old.

- Residential Care Services , which offer accommodation and maintenance to the elderly on a permanent or temporary basis. With a range of 5,991 centres with a total of 407,947 places. Of the 275,616 users, 69.9% are women and 77.8% are over 80 years old.

V.- Origin of people working in home care : Question 10

10. Why is home care provided by foreign carers from other Member States and third countries?

To answer this question we have to differentiate between the two types of *home care* we have referred to: non-healthcare institutional care (home help) and “family” care.

Institutional “non-health” home care (which includes home help services) is provided by professional carers who are responsible for the comprehensive care of dependent people who do not have pathologies that would require health care. The workers who provide these services are hired by public institutions (especially City Councils) and assigned to perform various care functions for dependent people in the private homes of users who need them. Consequently: they have an employment contract; they have a qualification that enables them to practice their profession; their working conditions are regulated by collective agreement; and their nationality may be European or from a third country, in which case they will have the corresponding work and residence permit and the homologation of their professional qualification.

In the case of *family home care* (hiring a "caregiver" directly by the user or their family), it is common that they do not have a qualification enabling them to care for people in the line we have indicated; that they have a contractual link with an inappropriate job category (domestic worker); and that there are doubts about compliance by their employers with the established employment conditions , among other situations that will be analyzed in detail in other sections of this *National Report* .

In Spain, the majority of home carers come from Latin America (therefore they are immigrants) and, from Europe, they usually come from Bulgaria and Romania, although they are not posted workers, but rather contracted workers. There is also a minority presence of people from Morocco (also immigrants).

The reasons why these foreign people are the ones who provide care are diverse, although we can specify the following:

- People from Latin America, because of the ease of the language, which is the same as in Spain, in addition to the “affectionate” nature of these people when dealing with the elderly.

- European people from Romania and Bulgaria, due to the existence of a large population of these countries in Spain, being cultures already rooted. In addition to the linguistic similarity in the case of people from Romania.

- In the case of people from Morocco, the proximity of the border and the existence of a very large population from this country with relative ease of adaptation to our country.

II.- Analysis of the online questionnaire

In the absence of a common questionnaire for all members, we have developed our own data collection questionnaire , based on what we believe to be most appropriate from the perspective of Spain. Furthermore, not having been aware of the non-existence of a common questionnaire for all members until December 20th, has delayed the collection of this data.

The Spanish questionnaire consists of 8 “personal identification data” questions that have served to establish the profile of the people surveyed; and 10 “research” questions with closed answers and sub-questions in some cases.

36 surveys have been collected online, through a platform created by our Organization for this purpose, and informative news has been published to bring the survey closer to workers.

Below we summarize the results obtained from the analysis of these surveys.

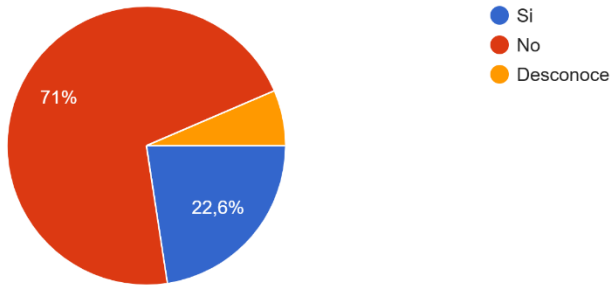
Profile of the person surveyed:

Women (75%), Spanish nationals (94%), aged between 35 and 54 (61%), who have been working in the care sector for more than three years (86%), with a full-time permanent contract (74%); who have the qualifications necessary to perform their job (97%) which is located in a public care centre (in 86% of cases); and are affiliated to a union in 88% of cases.

Research Questionnaire :

- 86% say they are aware of the existence of the collective agreement that regulates their working and professional conditions. Of these:
  - 48% consider that their collective agreement establishes adequate working conditions, compared to 42% who say it does not.
  - 71% believe that their agreement is not applied correctly and in its entirety by the employer. Only 22% consider that this application is adequate.

b) ¿Considera usted que su convenio colectivo se aplica correctamente y en toda su extensión por parte de su empresario?
31 respuestas



- The same 71% (compared to 22%) consider that their agreement is insufficient to guarantee the rights of workers in the care sector.

- 86% of respondents say they have employee representation (works committee or union) in their workplace.

- The attention that workers receive from the works council is rated as useful by 41% of respondents, adequate by 26% and inadequate by 18%.

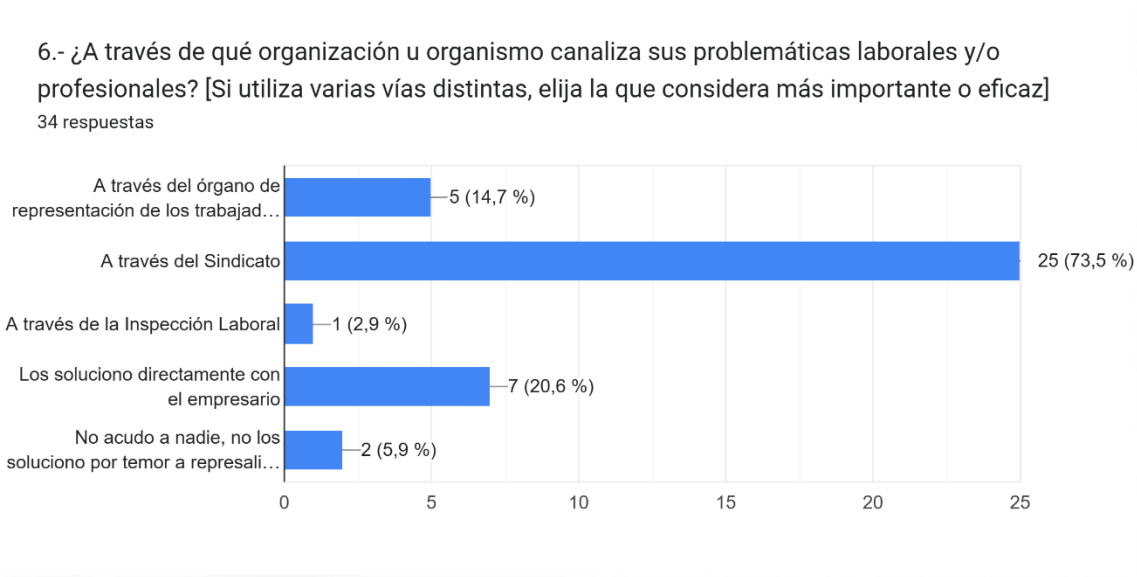
- As regards the assessment by the unions, 44% say that it is useful, 41% that it is adequate and 9% consider it inadequate.

- Given the physical and emotional strain that care work entails, the workers surveyed acknowledged that:

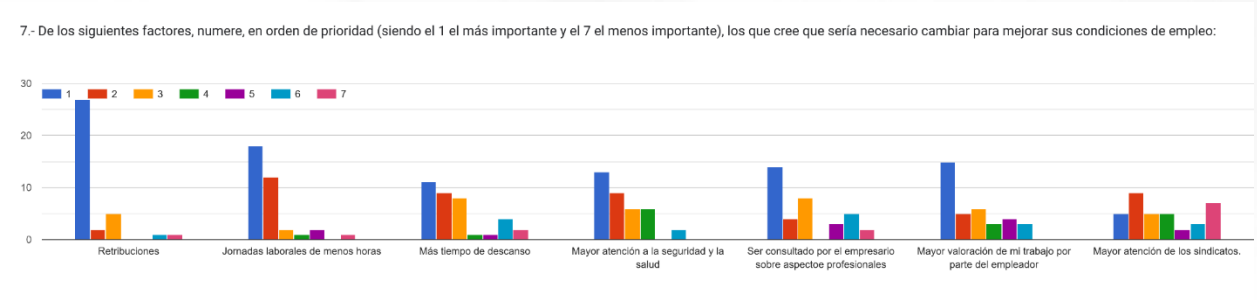
  - 58% undergo an annual health check-up, compared to 42% who do not.

  - 64% say they do not receive training in preventing occupational risks and caring for their health, compared to 36% who would receive such training, which they rate as acceptable in 61% of cases, compared to “inadequate” in 23%, and 16% acknowledge that the training received is good.

- 62% of respondents channel labour or professional conflicts through the union. 17% resolve these situations directly with the employer and 13% do so through the works council.



- Seven factors were identified as needing improvement and were asked to be ranked in order of importance, with the following results: 1) remuneration; 2) shorter working hours; 3) greater appreciation of the work performed by the employer; 4) being consulted by the employer on professional and organisational issues; 5) greater attention to safety and health in the workplace; 6) having more time for rest; and 7) having more attention from the unions.



- There is a lack of professional motivation and recognition: 56% of respondents consider themselves " *only sometimes* " motivated and professionally recognized in their workplace, compared to 36% who say they are " *never or almost never* " not motivated or recognized. Only 8% say they are motivated and recognized very often.

- 69% say they are not familiar with the Spanish regulations on healthcare in Spain, compared to 31% who are familiar with them.

  Of those who say they are aware of this regulation, 64% believe that it is not adequate to meet the needs of the elderly and/or vulnerable, while 36% consider it acceptable.

- Finally, it was requested that the place and the way in which the elderly and/or dependent people would be better cared for be evaluated in order of importance, and it was found that this care would be better according to the following priority:

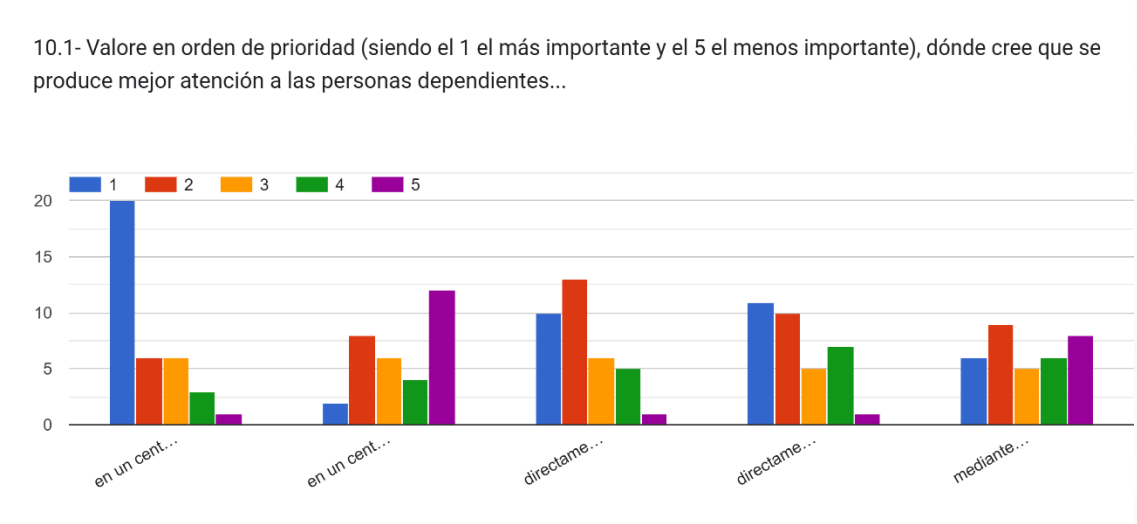
    1) In a public health center

    2) Directly at the person's home with caregivers directly hired by the interested party who provide their care on a full-time basis

    3) Directly at the person's home through itinerant home help workers

    4) Through people hired directly by the interested party, or their family, who combine care tasks with others related to caring for the person's home.

    5) In a private health center.



III.- Analysis of the Interviews

The eight interviews in Spain were conducted on 17.12.2024, in person and in a focus group moderated by the project expert, with the aim of seeking interaction between participants as a method to generate qualitative information.

In the absence of guidelines and a methodology for conducting these interviews by the project expert-coordinator, the project expert in Spain developed a series of questions that served to guide the meeting on:

- Knowledge of healthcare regulations in Spain and the situation of the public social services service;

- Roles of the public and private sectors in the care of older people;

- Establishment of care for the elderly based on the area where it is provided (institutional or private home) and on who provides the service (caregiver derived from an institution or hired directly by the user);

- Compliance with the regulatory regulations for caregivers of the elderly: Qualifying skills, working conditions, activities performed, etc.;

- Assessment of caregivers who work in a family home without the necessary employment, working conditions and technical qualifications.

Profile of the people interviewed:

The participants are between 35 and 55 years old, predominantly female (62% versus 38% men) and have the following occupations:

- 25% representatives of public and private entities working in the healthcare sector.

- 63% workers: of these, 40% are self-employed workers (immigrants who care for elderly people in their private homes) and 60% are public sector workers (residence homes and home help).

- 12% representing a union.

Conclusions drawn from the Interviews.-

- **Poor knowledge of the regulation of healthcare in Spain** : Widely known by the representative of the public sector and, to some extent, by the representative of the private company, the union and one of the workers in the public residential sector.

- **Deficiencies in the care of the elderly in the institutional areas of the public sector** :
    - Short staffing levels, with a lack of coverage for absences in direct care, which causes work overload and deteriorates the quality of the service that must be provided.
    - Lack of investment to renovate some residential centres to ensure better quality of service and care for residents

- Purchases of necessary care materials (diapers, bed linen, clothing, etc.) of inferior quality to that required
- Poor quality of some foods, served by suppliers who do not meet pre-established quality standards.
- Need to restructure care assistance in light of the gradual deterioration of residents.

- **Serious deficiencies in the functioning of the *System for Autonomy and Care for Dependency* , key instrument of the public social services system** : Delay in carrying out assessments of dependent persons; lack of real resources for their care and long time gap between assessment and receipt of the corresponding aid and subsidies.

- **Need for greater resources in the public sector, complemented by the private sector for the care of the elderly,** considering an increasingly ageing population.

- **Need to establish improvements in existing working conditions in the private sector of healthcare:** Poorer pay conditions, fewer days off, lack of work-life balance and, in general, heavier workloads.

- **Lack of personal and professional relationships between workers and their superiors:** Lack of empathy from bosses towards workers; absence of motivating elements that provide satisfaction in the work they perform; lack of participation by workers in work organization systems or in the resolution of unforeseen situations.

- Although home care was valued positively for allowing the person to remain in their environment, **it was concluded that The care provided in a residential centre was better** , where pathology situations, health care, physiotherapy, cultural activities, socialisation and cognitive and motor development of people could be dealt with, with group therapy options that did not exist in the home setting.

- **In order to carry out care tasks, it is necessary to have the necessary qualifications or qualifications** . This situation is true in the public and private institutional sectors, although, in many cases, workers perform higher-level tasks for which they were not prepared and for which they did not receive the corresponding remuneration. However, this is not always the case in home care, where these qualifications are not required by users and the work performed is not monitored.

- **Working conditions are better and their compliance is more guaranteed in the public sector** than in the private sector, being almost non-existent in direct contracts by the user.

- **Employment in the field of home care is often carried out in the category of "housekeeper"** with functions, conditions and remuneration that have nothing to do with the care provided; situations of black economy, fraud in hiring or professional intrusion may arise .

- **There is a lack of attention and defense of the interests of people working in private homes by unions**

- **There is a lack of control and monitoring of the recruitment, professional qualifications and working conditions of home carers by labour authorities and trade unions.**

Comments on the results obtained in the survey and interview phases:

In the analysis of these two phases of research we have observed a series of **coincidences** , which we highlight below:

- There are deficiencies in knowledge of the regulation of healthcare in Spain.

- There are deficiencies in political management in the care provided to older people in the institutional areas of the public sector.

- There are deficiencies in the functioning of key instruments in the care of dependent persons, such as the *SAAD* (System for Autonomy and Care for Dependency).

- There is a lack of personal and professional relationships between care workers and their superiors. [This situation, referred to in the interviews carried out, is also present in the online questions about the lack of motivation and the ordering of aspects that need to be improved, where this personal relationship appears in options 3 and 4 of the seven improvements proposed].

- There is consensus that care in residential care centres in the public sector is the best option, although care in private homes provided by professional "full-time" carers is valued positively.

- There is agreement on the obligation to have a qualification or specific enabling skills for care workers; although, while this control is exercised in the public sector, it is not monitored in the case of home care workers where, in addition, hiring in job categories other than those of care workers (specifically, "housekeepers") was noted.

There are also a significant number of differences, perhaps motivated by the different profiles of the people surveyed and interviewed and by the different questions raised in each of these actions. The most striking **differences** are the following:

- Although interviews claim that working conditions are good in the public sector (better than in the private sector or for home carers), online surveys give a negative assessment of the application of these working conditions and claim that they are insufficient to guarantee the rights of care workers (71% of respondents in both cases). However, 48% of respondents say that working conditions are acceptable.

- While interviews state that "there needs to be a private care sector to complement the public sector," the assessment of this private service ranks last in terms of the criteria on " *where the best care for the elderly and/or dependent people would be provided* ."

- Finally, while online surveys acknowledge the existence of employee representation (company committees and unions) in the workplace, in 86% of the responses, with a useful or adequate assessment, the interviews detected a lack of attention and defence of the interests of workers in private homes, as well as a lack of control and monitoring by the competent authorities.

IV.- Conclusions of the Focus Group: Recommendations and Good Practices

The Focus Group was held on 18.12.2024, with some participants in the interviews conducted the previous day coinciding, with the aim of providing continuity to the debates produced in those interviews.

The expert presented the guidelines for a *Political Document of Recommendations and Good Practices in Spain* , highlighting two very different aspects: The role of social dialogue and its influence on improving the conditions of care services; and the

challenge of establishing specific improvements for caregivers in their private homes.

In the debate, the difference between tripartite social dialogue and collective bargaining (bipartite social dialogue) was taken into consideration, and it was agreed that the political document of *Recommendations and Good Practices* should contemplate two different blocks to maintain this difference:

A first block on " Improvement actions within the framework of the *Tripartite Social Dialogue* ", as strategic policies in the healthcare field and from the perspective of caregivers, with differentiated proposals for the European and national framework.

And a second block of " Actions to improve the working conditions of home and care workers ", with proposals focused on improving the employment and working conditions of home carers, based on the broad and consolidated structure of labour relations in Spain, with guarantees of participation of workers in the improvement of these labour relations that duly respond to satisfying their professional needs and their working conditions.

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