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TITLE

Long-term care in Spain: difficulties in professionalising services

ABSTRACT

The aim of this paper is to analyse the difficulties in professionalising the long-term care system in Spain. Since 2006, the new Spanish law has recognised care as a subjective right and regulations are being designed to create a framework for its professionalisation. Nowadays, family remains as the most important group of providers care for their elders and women remain as the main informal caregivers. Why families resist using of public long-term care services and professional carers included in the new law? The hypothesis highlights socio-cultural factors as an obstacle to professionalisation of long-term care services in addition to political and economic factors. The results show qualitative data about expectations, preferences, and discourses that women caregivers have in relation to their responsibility. The empirical material includes twenty five interviews with different profiles of caregivers and six focus groups with family caregivers. The paper suggests that the Spanish ideal of care is a problem for the professionalisation of services because the family remains as the main provider of care without specific skills, knowledge and abilities.

Keywords: aging, social care, home care, residential care, family, ideal care, gender

INTRODUCTION

Social care has become a crucially important matter in the context of Europe, in line with the socio-demographic changes of recent years that are opening up a new gap in society, known as the care gap (Pickard 2012). People's greater longevity is associated with the increased likelihood of requiring some form of specific and continuous care in order to carry out life's basic functions on a daily basis. This problem is shared by the majority of welfare societies. It has also been reflected in theoretical debates on care work, and most specifically on long-term care (Bettio & Verashchagina 2012). Long-term care becomes a government problem

when these changes coincide with the decrease in social benefits and the increase in demand (Daly & Lewis 2000). What is new, then, is not the need for care but the increase in its size and intensity.

The care gap emerges in all European countries, although each country comes up with different answers according to the type of welfare regime. The family is involved in care in all countries but they differ according to the public support and social policies that reinforce or share the family responsibility (Saraceno, 2010). There is a discussion in the academic literature about levels of familialism in each country, strategies to care management, individual preferences and social impacts by gender, class and ethnic (Keck & Saraceno 2010; Bettio & Verashchagina 2012). Although, most studies on care regime analysis focus on political and economic factors (services, benefits and leave from work) without taking into consideration the socio-cultural factors. By contrast, several studies show that cultural factors can also influence care strategies (Pfau-Effinger 2005; Rosenthal Gelman 2014). Aiming to take a step forward in this direction, using as a reference point the concept of ideal care from Hochschild (2001) and Letablier (2007), the article argues that is crucial to weigh up the influence of socio-cultural factors to identify the levels of familialism. In summary, to understand the complexity of the care systems, it is necessary to relate socio-cultural factors with political and economic ones.

From this perspective, the paper proposes to know and analyse social imagery of the care regime in Spanish society. As with its neighbouring southern European countries, Spain is characterised by the central role of the family, a weak network of social services aimed at providing long-term care, and the hiring of immigrants to keep domestic care services going (Leitner 2003; Lyon & Gluksmann 2008). The article tries to find new answers on the Spanish case since, though there is a broad theoretical consensus on the suggested lines of thought, there is little empirical evidence to support them.

The specific aim of this article is to analyse the problems of professionalising long-term care services in Spain. These problems exist despite the introduction and implementation of the *Ley de Promoción de la Autonomía Personal y Atención a las Personas en Situación de Dependencia* (LAPAD)[1] and persist due to the central role of the family and the ease with which informal long-term care help can be hired. The LAPAD was passed in 2006 and was the first Spanish regulation, at state level, that recognised the universal and individual right to receive specific care when a person had been formally identified as a dependent. Hand-in-hand with this

[1] The LAPAD is a law on Personal Autonomy and Dependent Care.

new idea was the recognition of a vital professionalisation of the care service system in Spain. On balance, the first eight years since the LAPAD came into force tend towards the under-implementation of the measures recognised by law. During these years, the need for professionalisation seemed to be only a problem of job creation and not a way to reduce the level of familialism neither a way to approach the quality of services in long term care (Recio 2013).

Nowadays, family remains as the most important group of providers care for their elders and women remain as the main informal caregivers. Why families resist using of public long-term care services and professional carers included in the new law? Following the theoretical discussion, the article defends the hypothesis that highlights socio-cultural factors as an obstacle to professionalisation of long-term care services in addition to political and economic factors.

THE LONG-TERM CARE REGIME

Levels of familialism

In all welfare regimes the family is involved in care but the levels of familialism differ according to the political, economic and social factors. Saraceno (2010), elaborating on the conceptual frameworks of Korpi (2000) and Leitner (2003), makes a distinction between four types of family social policy according to public resources and services to professionalization care: default familialism, where no public care alternative or family financial support exists; supported familialism, where policies are in place to lend assistance to families so that they can continue with their commitment to caring for family members; optional familialism, which is helped by the state by being given a choice between internally financed services and external providers; and defamilization, where state regulation is based on an individual assessment of social needs independent of the family situation. Saraceno (2010) argues that the higher the level of familialism by default, the higher the impact of gender and social class on what options are available: individuals with a low socio-economic status receive substantially higher levels of informal care, so the lower the parent's socio-economic status, the higher their (female) children's involvement. Women with a weaker position in the labour market are more likely to be at the forefront of familialism by default or the supported family. The degree of care coverage offered by public policies is crucial for the impact of gender, social class and generational differences on the options available.

The long-term care regime in Spain: An historic approach

The academic literature on care regimes places Spain within the Mediterranean model (Bettio & Verashchagina, 2012). As noted, Spain, along with the rest of southern Europe, is characterised by the central role of the family and the poor network of social services (Bettio *et al.* 2006; Lyon & Gluksmann 2008). Specifically, Spain is an example of default familialism, supported by a family-centred culture, a low level of social protection and a poor assumption of domestic duties by men. In addition, it is important to highlight that, with the persistent increase in female employment, immigrant women cover the gap in care services through informal recruitment by families (Parella 2003). The care drain, the movement of women from the South who emigrate to the North to attend to the growing care needs of the local population, is characteristic of Mediterranean countries (Bettio *et al.* 2006). Furthermore, as stated by Saraceno (1995), the Spanish case is also a good example of how a family care model has a bearing on the way public policy is regarded. Familialism by default has gone hand-in-hand with an assistance-based vison of public services that have been offered and perceived as a last resort when family doesn't exist.

Figure 1 compares the living arrangements of the elderly in Spain and in the European Union, underlining the importance of the family in Spain. First, it is more common for people without a partner to live with children in Spain than in the rest of the EU, and living alone is much less common. Second, it is fairly common for couples to share the household with another family member (often an adult child) in Spain but unusual in most of Europe.

<Insert figure 1 about here>

The characterization of the Spanish care regime is a consequence of the historical specificity of its social service system. The institutionalisation of Spain's social services is evidence of the tensions that have helped define the building of the Spanish welfare system. These tensions are a reflection of the difficulty of consolidating a public service system (against a backdrop of growing ideological pressures) that favours the limitation of the state's capacity as a protector (Rodriguez Cabrero 2011). Spain's social service system was set up under the dictatorship and allowed Catholic organisations to play an active role in providing charitable

assistance. These elements helped to develop assistance-based social services and to reinforce the role of women as one exclusively devoted to the home and caring for members of the family (Recio 2011).

The long-term care regime in Spain: The current context

Since 2000 there has been increasing debate on the suitability of the Spanish social service system and how it could be moved towards an universalist model with the ability to react to the demographic changes in the presence and absence of women in employment and in care work. In 2006 the LAPAD, the first law on social services at state level,[2] was passed. It set out to provide for the specific needs of people considered as dependents and to instigate a universal public care system by recognising the subjective right to care. In summary, the new law established that the Spanish long-term care model[3] is characterised as follows: it recognises access to service and benefits as an individual right of citizens with a common minimum content of rights anywhere in the Spanish territory; it is based on public accountability, participation and the collaboration of all administrations, in a mixed public-private management with the participation of users through co-payment; it regulates access to the services and benefits of the social services; it develops a public system based on care services in which monetary benefits should be a residual resource; it recognises the need for professionalisation within the system of care services for dependents and guarantees a quality public service[4]; and it includes the fostering of autonomy and the protection of situations of dependency (SAAD 2012). The law distinguishes between provision of services and economic benefits and prioritises service delivery through the territorial network of social services, including public and private centres. According to the service catalogue of the LAPAD, the services provided are prevention of situations of dependency and promotion of personal autonomy; phone home support; home care; day/night centres; and residential care. The economic benefits are the financial benefits that can be linked to pay services, to contract professional staff or as a "salary" for family caregivers.

[2] Before the LAPAD, other regulations covered the social services but they were regional in nature, leading to a great variety of systems.

[3] The Spanish model is complex. Its design is a mix between the Nordic model (universal coverage, social service management and funding with taxes and contributions) and the Continental model (recognition of the subjective right, assessment of the level of dependence, freedom of choice and regional decentralisation of planning and management) (Rodríguez Cabrero & Marbán Gallego 2013).

[4] But there is a lack of definition of the concept of professionalisation in the LAPAD. In that sense, the references to the professionalization which was included in LAPAD are quite vague and are limited to identify the professional care with care that is not lends by family members. Also, the LAPAD included a section devoted to define the quality of service but it only mention the need for progress in quality employment and the need to define of training requirements.

The LAPAD protects people of all ages who obtain official recognition of their situation of dependence. For this recognition, it is necessary to submit an application to the public administration with a health report. A professional team assesses the dependency status. The assessment is based on the application of the legal instruments provided for it; the only aspects measured are those related to the ability to perform basic activities of daily life in the usual environment (Ribero 2013). Once the dependency level has been recognised, the next step is to assign the provision (services or economic benefits) according to the Individualised Care Plan, drawn up by the technical team from the medical and social reports, and the assessment team. The service delivery assigned is determined from the offer of the LAPAD catalogue and takes into account the family and socio-economic status of the dependent person. In fact, the kind of provision is determined by the professional team—basically by social workers—and the family of the dependent person. Both social workers and families assume that care work is a family responsibility, showing that cultural assumptions about the family role are deeply rooted in Spanish society. This means that the development of the LAPAD has built on the acceptance of a familislism model, as some authors have pointed out (Pérez Orozco & Baena 2006; Recio 2013).

In reality, however, the application of the law has not lived up to the philosophy behind the draft bill of the LAPAD. The main criticisms of Krüger & Jiménez (2013) are that, first, financial benefits are the norm despite the fact that the LAPAD established services as the principal means of support and, second, there is no control of how the family uses the cash benefits for the family carer. These authors suggest that the analysis of the LAPAD's implementation shows that it is a good law but its application conflicts with social reality. As can be seen in Table 1, the number of beneficiaries of financial for carers within the family is greater than the level of access to the services, so apparently the ideal of professionalising the system and promoting the use of public social services has been forgotten. In the assignation of service delivery, economic benefit takes the largest share, although the composition of the portfolio of services varies by level of dependency. The services and economic benefit are mutually incompatible. However, the competent public authorities may establish compatibility between services for support, care and attention to maintain the older dependent person in family home.

<insert table 1 about here>

The data show that the rate of coverage of social services is very low. As Martínez-Buján (2011) explains, the types and amounts of care involved in these social services depend on the regional and local governs.

<insert table 2 about here>

Del Pozo et al. (2011) analyse the relationship between socio-demographic and health variables (including informal care) and the healthcare service delivery assigned in the Individualised Care Plan during the first phase of the implementation of the LAPAD (2007-2010). The results of their study show that a total of 83.7% of the sample were assigned economic benefits, 15.3% were assigned services and 80% received informal care in addition to dependency benefits. The variables associated with receiving economic benefits, and not services, were being married, having a high annual income, place of residence (rural areas versus urban areas), receiving hygiene-dietary treatment, and having informal care.

The eruption of the financial crisis in 2007 prevented the law's implementation as initially envisaged to modernise the long term care regime. In spite of the economic and political factors, the cultural factors also have hindered the modernising influence of the new regulation. The European comparison of home care provision according to the providing subject highlights the importance of the family in the Spanish case. As shown in Table 3, the countries where more than 70% of home care provision is a family responsibility are Germany, Greece, Italy and Spain.

<insert table 3 about here>

The preference for financial benefits over services is present in a lot of countries that offer the option. This trend can be explained for the social class and the framework of choice (Keck & Saraceno 2010). On one hand, in the case of low income families the economic benefit could be perceived as a plus for the domestic budget. On the other hand, the economic benefit could offer more freedom to choice the kind and the price of service. For example, the monetary transfer may be used to pay care provided by immigrant women hired in the informal labour market as the Spanish case (Martínez Buján 2011).

Despite the family's importance to the Spanish care system, the LAPAD's deployment seems to have had some impact on job creation[5], though it has had little impact on the care regime due to the greater use of monetary transfers. Martínez Buján (2011) analyses the repercussions of the monetary transfers predicted in the

[5] According to the National Institute for Statics, between 2008 and 2012 work opportunities rose by 48.7% in the subsector of 'Social Services Activities, without accommodation' and by 16.4% in the subsector of 'Services in residential establishments'.

LAPAD on the reorganisation of family care work. She points out how the large volume of provision for personal care has helped to silence the professional care service. The financial benefits are often used to hire informally home care by immigrant women. That is, the policy of giving economic benefits has helped to finance the black market and informal contracts in that job sector. In addition, the lack of mechanisms for follow-up and control has reinforced this irregular means of hiring care employees. In fact, there was a lack of definition of the concept of professionalisation in the LAPAD. The need for professionalisation seemed to be only a problem of job creation and not a way to approach the quality of the employment (Recio 2013).

Similarly, Krüger & Jiménez (2013) draw the conclusion that the LAPAD simply fails to change the social policy model towards a formal commodification with greater professionalisation of long-term care services. In their view, following the analytical line of thought in the proposal put forward by Saraceno (2010), familialism by default will tend to disappear in the medium term in Spain, so these changes are reduced to just two options: supported familialism or optional familialism. Budgetary restrictions due to the economic crisis may explain why supported familialism persists, though Krüger & Jiménez (2013) think that optional familialism could be a political choice in the long term. They point out that supported familialism involves more incentives to family carers, while optional familialism opens the way towards a greater professionalisation of the system. From another perspective, Rodríguez Cabrero & Marbán Gallego (2013) argues that the Spanish long-term care system has a dual nature, in which the socialisation of social risk (with more public responsibility) is simultaneous with re-familiarisation and a re-feminisation of care. In addition to the impact of the economic crisis, these processes explain why the social majority prefer cash benefits, which the LAPAD had expected to be residual. Miguélez & Recio (2010) describe the Spanish case as a hybrid welfare model born out of ambivalent politics. While policy proposals of a social-democratic nature have been developed, they have been subject to liberal policies in which the family and Catholic culture are what counts where care provision is concerned. Rodríguez Cabrero's studies (2011) on the advances in regulating dependency services in Spain also indicate that this type of social service has taken advantage of the country's family culture. Recognising the power of choice among users between access to a service or obtaining economic provision is a good example of this. The reality shows a significant preference for financial benefits for family carers, to allow them carry out the care work for the dependent in need. Some European studies show that monetary

transfers are reinforced thanks to the regulations that defend individual choice about who receives the care over how they would like to be cared for (Bettio & Verashchagina 2012). However, other studies suggest that the use of formal services is increasing slowly in relation to specific situations, such as employment of the family caregiver (Keck & Saraceno 2010). By contrast, it is suggested that the limited number of hours offered by home care services and the expensive cost of care service in the formal sector could explain the preference for cash in order to buy cheaper services in the informal market. Thus, the degree of care coverage offered by public policies (such as number of hours offered by home care services) is crucial for the impact of social class and gender differences on the options available.

In summary, the first few years of the LAPAD's implementation confirm some degree of failure with regard to the professionalisation of long-term care services: almost 50% of help is via financial provision to family carers, 88% of the principal carers are household members, and 91% of the population would still prefer to be cared for by the family (SAAD 2012; Durán 2012). Given these data, this paper considers the importance of family responsibility and informal recruitment of caregivers in Spanish long-term care patterns.

CULTURAL FACTORS AND IDEAL CARE

Several studies analyse the political, economic and cultural differences that are at the heart of the social policy developed by Europe in answer to its care needs. The results highlight the existence of care regimes that do not always fit in with their welfare regimes. By way of demonstrating this, they characterise the political answers that the state articulates in dealing with socio-demographic changes that have care needs as their aim (Martínez Bujan 2011). Some authors criticize this approach as being excessively rational and economically-biased. They put forward the alternative of the importance of cultural and ethnic factors that can also influence care strategies (Mutran 1999; Pfau-Effinger 2005; Rosenthal Gelman 2014). Yet other authors have recognised how important these cultural aspects are in the current context, in which the state is freeing itself of responsibilities. Rodríguez Cabrero & Marbán Gallego (2013) states that in European welfare regimes a reconstruction of care systems are underway based on strong cultural traditions, public policy design and the conservative conception of freedom of choice with regard to social benefits. He argues that these different social policies are being modified by a political process that socialises, familiarises and individualises the risk entailed by care and that the financial

crisis highlights the weakness and ambivalence of long-term care systems in Europe, where the family function of care persists in the majority of countries. The family develops its responsibility according to the social services of each country, the social class of its members and the social role of women.

How important cultural factors are can also be seen in the conceptual proposals on *ideal care* and *care culture*, since they enable an analysis of a symbolic dimension without losing sight of the institutional context and economic and political factors. Hochschild (2001) referred to *ideal care* as the option that is most appropriate for each society and the ideal is one that leaves ethical questions behind and constructs a social image around where, who and how care needs should be dealt with. Letablier (2007) introduced the idea of *care culture*, in which the collective representations surrounding responsibility for children and dependent adults are modelled on the values of each society. She explains that *care culture* is based on social values institutionalised by the state, legality and traditions of coexistence. Long-term care systems have deep national roots, so they are designed according to social and institutional history (Rodríguez Cabrero 2013). The two concepts, ideal care and care culture, allow us to capture the symbolic dimension and socio-cultural factors that underlie the relationships in responding to care needs.

We consider these factors to be especially important in the Spanish case, where the symbolic importance of the family is a key element for explaining existing social relationships regarding care. However, there are few studies on cultural factors of long-term care systems because the majority of research focuses on political, economic and legal factors. As Rodríguez Cabrero (2011) explains, in Spain the family has the legal responsibility of care but it also has the moral responsibility of care that is a constituent part of social culture. Moreover, as Saraceno (2010) suggests, the patterns of intergenerational solidarity depend not only on cultural norms but also on gender and social class. According to this author, cultural expectations and opportunity structures are gender-specific. As a consequence, women are directly affected by cultural expectations about caregiving across the intergenerational chain.

In addition to political and economic factors, we suggest that the social imagery of care creates an obstacle to the professionalisation of long-term care. From this perspective, we propose to analyse the cultural difficulties that exist in professionalising these services in Spain, in spite of the new regulatory framework in the shape of the LAPAD.

RESEARCH DESIGN

The analysed data make up part of the *PROFESOC project*, one of whose objectives is to clear the path and bring out the material, symbolic and cultural obstacles that remain in the Spanish social imagery when it comes to organising and professionalising long-term care services. We consider the qualitative nature of the methodological strategy for analysing the expectations, representations, preferences, requirements and discourses that formal and informal carers have in relation to the role they play in care. For this reason, detailed one-to-one interviews and focus groups were used as the most appropriate research technique. First, we limited the scope of analysis to women, given the female nature of both formal and informal care work. Second, out of our statistical exploration came one type of women employed as carers who were suitable for interviewing and another type of women carers within the family with different labour situation (employment, unemployment and inactive) who were suitable for the focus groups. The objective of the interviews was to capture the employees' working trajectory. Meanwhile the aim of the focus group was to get a glimpse of the influences of the collective imagery when faced with the same life situation in different material conditions.

The results were obtained by analysing the interviews and focus groups. The design format of the sample bore in mind the place where care is given (family home versus institution), and the type of working relationship (formal contract versus informal contract). As a base, the portfolio of long-term care services was used in the final selection of cases: home care workers, day care centre workers, residential care workers, and informal workers. Focus groups were defined depending on the typology created by the variables social class and age, following the conclusions of Saraceno (2010) on the impact of socio-economic status in the patterns of caregiving in familialism by default. We thought it is necessary to differentiate material conditions that women of 45 and over face when they are handed the care for a family member, broken down as working, middle and upper class. Throughout 2013, we conducted 25 interviews with caregivers (five for each profile) and six focus groups. During the fieldwork, we followed the snowball method for recording data. All the interviews and focus groups were recorded, transcribed literally, codified for discourse analysis and processed using Atlas.ti software. The discourse analysis is structured in two dimensions. The first one refers to the ideal of care, gender

identity, preferences for care and difficulties in carrying it out. In a second dimension the focus is on the contradictions between the ideal of care and specific practices.

RESULTS

The qualitative analysis suggests that the Spanish ideal of care 'at home with the family as main caregiver' is a problem for the professionalisation of services because the family remains as the central provider of care without specific skills, knowledge and abilities. Professional care workers and family caregivers reproduce this ideal built on the basis that for the dependent person is better stay at home than an institutional option such as residential care or day centre care. In the majority of cases, the family home care represents a female responsibility without professional support. It should be distinguished informal care provided by unpaid family members and paid care provided by carers hired in the informal labour market. However, the daily reality of the family home care involves some contradictions for the caregiver and the care receiver. On the one hand, women caregivers inside the family have a low quality of life given the hard tasks and rigid time of care. On the other hand, informal home care by immigrant women contracted involves bad working conditions for them and a lack of professionalisation of long term care.

The ideal care "at home with the family as the main caregiver"

Care is perceived as a female responsibility, so it is closely related to identity traits and way of being. The perception of care as something that eludes strict work logic reinforces the naturalisation of the skills and competences required to carry out the tasks. The interviews with care sector workers show that women are commonly considered to be predisposed to have these skills and competences given familiar responsibility or by naturalising their abilities as attributes linked to their gender, learned from its past experiences as women.

> *"And I tell you what, my experience came from my dad. I had to shower him. He got covered in poo, I had to wash him, I had to make him… Well, what are you going to do—just leave him? He's still a person. He's a person who can no longer control what he does, that's all" (home help worker)*

Following the conceptual proposal of Hochschild (2001) and Letablier (2007), we consider that in Spain the naturalisation of care shapes the expectations and representations of what is considered socially as a good level of attention. The level of expectation can become very high, to a point where standards of care often surpass existing professional job profiles. The professional caregiver is expected to adapt to the needs of the care

receiver with the same love and affection supposedly offered by the family. The naturalisation of these skills and competences regarding long-term care has led to a lack of confidence in the Spanish social services, which are perceived as the most welfare-bound and least professional branch of the whole welfare system and are believed to be completely unable to meet care receivers' personalised needs. That implies that the families consider that they do not have received a good professional care.

> *"If they wet themselves, for instance, they know they're going to change them at six o'clock, so they don't change them at 4 when it happened… they're all lined up and yes they do gym, they give them therapies, anything you want, but you can see them sitting in the chairs, just gazing into the void…" (focus group, working class)*

In this sense, families demand greater one-to-one care. That is, they expect the persons' individual characteristics to be taken into account as a guarantee of greater quality in what their long-term care offers. Family members often predict that the care receiver will adapt badly to the residential care in order to justify the option of keeping them at home. In the working class case, this option means take care for the dependent person at home without any professional support. Based on the specific nature of each case, family members construct arguments such as:

> *"My mum won't be fine. "He is special and only I know how to look after him". (Focus group, working class)*

> *"I mean, OK, some had physio, which helped them, you know, but, well… it was very sad. I just couldn't picture my mum sitting there." (Focus group, working class)*

The discourse on the distrust felt towards institutionalised care, in residential home, day care centre or professional home care is also built to suit the preferences and wishes of the dependents. Given the possibility of arrange the care in the institution, they are the first to speak up and make their wishes known about being cared for at home by a member of the family as the main caregiver

> *"Of course she does, it's really hard, because she wants to go home, to be in her own surroundings, with her boxes, her things, all her stuff, you know? And, of course, to be with her family…" (focus group, middle class)*

In the case of professional home care, workers recount the bad working conditions that prevent them from exercising their work professionally. These difficulties also influence the care receiver's preferences.

> *"The only thing they tell you is the name, the address and more or less the type of activity you have to do; maybe hygiene in bed, in the shower… There are times when they don't tell you about important*

problems in the family, whether there's been violence, abuse… Absolutely nothing. That's it… you have to find out little by little." (home care worker)

The difficulty in satisfying individual expectations in professional surroundings leads to the idea that the women of the family are the ones who are best placed to take on and carry out care duties. Even sector professionals reproduce this ideal, built on the basis of the ideal care model, as expressed in the idea of being cared for 'at home, with the family as the main caregiver'.

"While they have been able to look after the person at home, they have kept them at home. Once they no longer could then they have put them into an institution… But, of course, while that individual can function and keep going, well, they stay at home…" (worker-manager, day care centre)

As a cause and consequence of this ideal care, the discourse from women caregivers in families shows the moral obligation and the feeling of guilt that goes with not fulfilling this responsibility. The majority internalise their care role to such an extent that it becomes an integral part of their identity. Their discourse raises little doubt about how this work is shared out between family members. They limit themselves to carrying out the role of daughters, wives and daughters-in-law when faced with care needs, which elude any type of planning and are regarded as a problem for the family, and only the family, to solve. But class differences stand out in the way the demand for personalised care is met. While working class women are the ones who can and must look after their family members' needs, for middle class women and even more for the upper classes, good management and task supervision always carried out in the home are what enables 'better care', understood as meeting the expectations of how the dependent wishes to be cared for. When is possible to hire private services, the family responsibility is quite similar to the trend in northern European countries with more resources and services for home care. These results are consistent with other researches that evidence how cultural expectations and opportunity structures are gender-specific. On the one hand, studies about Spanish case show the influence of gender, social class and ethnic on the caregiver profile according to his responsibilities and its impact on everyday life (Parella 2003; Sarasa 2007; Crespo & López 2008; Torns et al. 2015). On the other hand, European comparatives studies highlight that the impact of family responsibility in care differ on caregivers' resources and life chance across gender and social classes. The middle-class has more resources to buy care than the working-class for this reason the public care coverage is crucial for the impact the class differences on the care strategies (Saraceno 2010; Sarasa 2008). Saraceno (2010) argues that the intensity and

indispensability of the family role in care vary depending on the institutional framework, which in turn brings into play the gender and socio-economic inequalities among family carers.

Residential homes are often criticized, especially among the working class, where financial difficulties and a lack of knowledge about what resources are available are felt most. Conversely, the middle classes are the ones most predisposed towards institutionalisation in a residential home. This seems to be as much through the influence of financial capacity as the ability to look at the situation in a more rational, less emotional, way:

> *"In just one month, my father ended up in residential care because it's impossible at home. We needed lifts and a range of aspects. They've got all that in the residential home, so you can feel happier about it." (focus group, middle class)*

In any case, the ideal of being 'at home with the family as the main caregiver' is shared by the population in the study with no noticeable influence of socio-economic circumstances, especially in response to the care receiver's wishes. The family care providers justify this ideal due to the dependent personality:

> *"She's a mother from the old school, very domineering, one of those types who organise everything and everybody. Until she got her room in my house, she didn't stop nagging!" (focus group, middle class)*

As a consequence, long-term care remains relegated to the private or family sphere, more through a question of personal preference than because the public sector does not have enough places. Additionally, though the Spanish care regime suffers from a lack of resources, there are other reasons for preferring family care, especially among people influenced by a strong traditional social imagery who have never considered asking for such services from the public sector. It is a scenario that also considers that the expected standards of care will not be met in specialised institutions, though the LAPAD has universalised the right to care from public funding.

Apparently, taking on the responsibility of long-term care in the privacy of the family home responds to the ideal of being looked after 'at home, with the family as the main caregiver', and is the best option for the care receiver. A more detailed analysis of what this ideal means in reality basically points to the perception of the home as a space where the dependent's individuality and intimacy are respected. This is largely because such an option also enables them to maintain the decision-making power over how, when and what care tasks should be carried out. The private space is perceived as an element of control over care duties when compared with the public space of a residential home or a day care centre.

> *"... And at home they are in charge. You do what they want for them and if you don't do what they want, its 'I don't want you, you can go away'. But in the homes it's different, because you are in charge. They pay me to do this and this is what I have to do. One way or another, I try to do what has to be done. If you smell bad I have to shower you, I'm sorry. In their homes they are the kings ..."* (residential care worker)

Contradictions of family home care

The ideal of family home care hides other daily realities that transcend the care receivers' wellbeing. The principal one is the struggle that this care entails for the main caregiver in the family who, while offering wellbeing to the dependent, loses quality of life.

> *"I know it's really hard, it's hard. She's my mother and I'm sorry to say it but a person in this state can't be looked after at home. I mean, you just don't have a life. No life at all..." (focus group, working class)*

On this point the social reality of long-term care in Spain would tie in with the theoretical proposals that put forward the dual nature of care as an activity where work and love cannot be separated out from one another (Graham 1983; Thomas 1993). In practice, the conceptual tension of the care dichotomy, "work versus love", brings everyday suffering for the women who are carers, especially when they are working class without resources to hire professional support.

However, long-term home care can be carried out with outside support, whether through home care services or using public sector money to hire workers internally (despite of the fact that the law forbids it), mostly immigrant women. With the living space under control, it becomes easier to delegate some of the care duties to third parties from outside the family. There thus arises a contradiction between the defence of the family home as the care ideal and the reality of care which, once the material conditions are right, leads people to easily follow the commodification route.

> *"Well, of course it's a big problem. I don't want to take her to a home. But if someone can come to the house, so I can be around..." (focus group, working class)*

Once the space is under control, the profile of the person undertaking the care does not arouse as many objections as that of professionals working in residential care. Proof of this lies in the informal nature of the jobs in long-term care services that are carried out at home. As stated above, this informality is characteristic of the care regimes found in Mediterranean countries, where family resources are combined with the female immigrant workforce (Parella, 2003). The low level of qualifications required from people who carry out home

care under informal working conditions is justified by naturalising their abilities as attributes linked to their gender and ethnicity.

"South American women are so patient… and Philippine women are, too' (Focus group, middle class)

In contrast to the workers at institutions, for those women—mostly immigrants—who work informally in people's homes there is no expectation of special accreditation in order to get a job. The low level of training requirements contrasts sharply with the number of duties they carry out and the types of decision they have to make. With multiple demands on their time, they have to be able to do all the domestic work (cleaning, cooking, ironing… running the house), as well as knowing how to look after the person who is ill, being attentive to their needs and offering very personalised care. The pressure these women feel from working in a situation of absolute submission, and the need to deal—and put up with—all manner of eventualities in order to keep their jobs, forces them to learn as they go along. They thus learn new skills that are expected of them by the dependents and their families. They use any new opportunity to learn new abilities:

> *"I really wanted to do it and when I went to the hospital, to the Carmeta, for example, on the first job of the day I asked the nurse 'How do I do this?' I said to her: 'Show me how to change the sanitary pads, how to change their position', and she showed me… how to change their position by putting the leg like this, the arm like that and add a little 'click'" (immigrant home help)*

The recruitment of immigrant women under an informal working arrangement means that the control of the domestic space is imposed on the standards of care demanded of specialist institutions. Therefore, the ideal of 'at home, with the family as the main caregiver' means that whoever does care work must perform beyond their capacity or professional training. The discourse of caregivers, whether hired or one of the family, justifies this contradiction when it naturalises long-term care as a female responsibility more closely related to identity and a way of being than to a set of learnt skills and competences. Furthermore, linking these care tasks with invisible female work clearly naturalises the capabilities needed to perform them. This ends up in a situation where the profession knowledge associated with a job is not valued and vital knowledge for creating the dependent's wellbeing is ignored or even hidden. This is a problem that the workers themselves are very aware of and, particularly among those who work the longest hours and are expected to submit to all type of demands, there is a consensus that they do an important but undervalued job.

"Sometimes they say 'I pay you, so you'll do what I say. You have to keep telling yourself, and valuing what you do because if you wait for someone else to tell you you're doing a good job… I don't know. I don't think members of the family have any idea of the things we end up doing here for their relatives." (Residential care worker)

DISCUSSION AND CONCLUSION

This paper takes as its starting point the growing importance of long-term care in the European context and uses the evidence from that situation to present the Spanish case. The size and intensity of the phenomenon introduces into the equation new needs, which outstrip the capacity of current welfare systems and social policies. One of the academic discussion is about levels of familialism in each county according to the public support and social policies, strategies to care management, individual preferences and social impacts by gender, class and generation (Keck & Saraceno 2010; Bettio & Verashchagina 2012).

The paper has focused on the Spanish case and the difficulties of professionalising the long-term care system. Specifically, it has asked the question why—despite the existence of the LAPAD, a new regulatory framework that recognises dependent care services as a subjective right with new benefits—family and informal labour persist in the organisation of long-term care. To answer this question, we have argued that, in order to understand and explain the complexity of this care system, we need to consider the political, economic and socio-cultural factors. From a legislative point of view, the introduction of the LAPAD in 2006 placed Spain promised significant changes in terms of social rights linked to dependence, but the economic and socio-cultural context places obstacles in the path to achieving the objectives laid down by the law.

First, the eruption of the financial crisis in 2007 prevented the law's implementation as initially envisaged. Second, the use of the new benefits and the population's preferences make it plain that the family is still important in the social organisation of long-term care (EDAD 2008; SAAD 2012; Durán 2012). Faced with this evidence, the study presented herein suggests a starting point for the hypothesis that, in Spain, the socio-cultural factors that hinge on the notion of 'ideal care' represent an important hurdle for the professionalisation of long-term care services to overcome.

Qualitative analysis shows that the Spanish system is set up in line with the care ideal expressed as 'at home, with the family as the main caregiver'. The consensus of opinion on this scenario is shared by a majority of people, whether dependents themselves, family members, care professionals or institutions dedicated to long-

term care. This ideal sets up the family home as meeting the standards and values arising from the symbolic importance of family and home in opposition to the institution (residential care, day care centre or professional home care). The home is preferred as a privileged space that allows the preservation of intimacy and maintenance of the ability and power to take decisions. In addition, it picks out women in the family as being the main caregivers, turning them into the only ones capable of assuring personal and affectionate treatment. Everything points, then, to the pre-eminent scenario in which care receivers see entering specialised care homes as a loss of privacy and decision-making power, hand-in-glove with impersonal and serialised treatment. In home formal care, the bad employment conditions of workers and the limited number of hours of services could explain the few preferences for this option. The grouping of these elements gives a good account of the effectiveness of familialism in the Spanish context, despite the regulatory steps that have been taken in another direction. The discourse of care workers, whether professionals or family members, backs up this familialist socio-cultural substratum which forms the foundations for the whole of Spanish society. We should also highlight that the professionalisation of long-term care comes up against obstacles, which are largely explained by the emphasis on gender and ethnicity and by their location at the heart of the family. The results obtained thus enable us to suggest that Spanish society's notion of ideal care is an obstacle to the professionalisation of the long-term care system, despite the regulatory framework that the LAPAD was supposed to promulgate over and above the current context of crisis. There is a tension between legal regulation, economic context and moral obligation.

This conclusion allows us to add some reflections on other studies. Krüger and Jiménez (2013) claim that the LAPAD has not brought about a change in care services because, fundamentally, Spanish familialism still persists, according to the terminology of Leitner (2003) and Saraceno (2010). Nevertheless, Krüger and Jiménez (2013) predict that optional familialism may be a long-term political option that will replace supported familialism. By contrast, the qualitative analysis presented in this paper suggests that the ideal of 'at home, with the family' is an obstacle to achieving a scenario of optional familialism because the cultural tradition of the family as the main caregiver persists. With regard to the care gap, one of the main political questions is about the role of the family as a complement or substitute of long-term care services. During the last few years the emphasis placed on care by family members has increased in European countries. However, as Glenn explains:

"If we take seriously the notion that caring is a public social responsibility, we also need to examine critically the conception of the family as the institution of the first resort for caring" (2000:89).

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