Ageing & Society **22**, 2002, 669–687. © 2002 Cambridge University Press
DOI: 10.1017/S0144686X02008942 Printed in the United Kingdom

Nursing home vouchers in Spain: the Valencian experience

MARIA ANGELES TORTOSA* and RAFAEL GRANELL*

ABSTRACT
The main purpose of this paper is to evaluate the innovative nursing home voucher scheme that was introduced by the Valencia Autonomous Region of Spain in the early 1990s to implement targets laid down by the national plan for the development of older people's services. The article begins with a review of the evolution of Spanish social services, and especially the nursing home sector, and then summarises the genesis, objectives and characteristics of the voucher scheme. The main part of the paper reports a performance analysis and economic evaluation of the programme. On the basis of detailed information over four years, it is concluded that nursing home vouchers have contributed to the increased supply of publicly-financed rooms, have promoted equality of access to the service, and have increased user choice. It is also shown, however, that while vouchers can lead to an increase in the quality of inputs, they increase utilisation and expenditure. In the absence of the monitoring or reporting data that would be required, it is not possible to determine whether the scheme has increased efficiency, in the sense of improving the quality of life of frail older people at reasonable and containable cost.

KEY WORDS – older people, nursing homes, voucher schemes, quasi-markets, Spain.

Introduction

The state financing of nursing homes in Spain has customarily taken two forms: the direct provision of public sector homes, and subsidies to private and non-profit nursing homes. Nearly 10 years ago, however, the Valencia Autonomous Region decided to implement a financial instrument that had not previously been used in Spain: vouchers for individual users. The paper describes the origin, establishment and administration of this programme, and evaluates whether it has

* Department of Applied Economics, University of Valencia, Spain.

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

fulfilled the aims proposed in Spain's national plan, devolved to the regional government. The first section of the paper describes the characteristics of Spanish residential care provision for frail older people, and the second analyses the current problems of the Spanish nursing home sector and reviews the genesis, objectives and functioning of the Valencian voucher experience. The principal aim of the paper, however, is to evaluate the achievements of the scheme.

Social services in Spain

Spanish social care services developed later than in other European countries, principally because of the country's political history and social conditions. The main growth has been since the return to democracy in the early 1980s. The current Spanish constitution specifies rules for the formulation and implementation of social policy. Social care responsibilities are not only stipulated at the state level, but also for the 17 autonomous regions.[1] Furthermore, the social care legislation of the regions delegates powers to manage these services to the municipal local authorities. For this reason, there are considerable differences in social services among the various autonomous regions, and among local authorities in each region (Miguel 1998).

To mitigate the problems and deficiencies of the Spanish social care model, an agreement called the *Plan Concertado* was signed in 1988 between the Ministry of Social Services and the autonomous regions. The development of the plan helped to produce a consensus definition of the basic level of social protection that the state maintains, as well as agreements on a common statistical methodology for reporting care provision. To complete this work, a *National Gerontological Plan* was implemented in 1992, since when the autonomous regions have developed their own 'gerontological plans' for the development of older people's health and social care services. The national plan serves as a normative framework for the consistent development of various policies for older people, as for health care, pensions, social care, cultural and leisure activities, and transport. The gerontological plans of the autonomous regions follow the directives of the national plan.

The Spanish social care system recognises three suppliers of social services: the public sector (the state, the autonomous regions and the municipalities), private or for-profit companies, and non-profit organisations. Public sector social care has two levels: basic and specialised. The basic services are: information and advice, prevention and social integration, home care, and social housing. The specialised

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

second-level services work with specific groups such as children, older people, people with disabilities, and drug-addicts. Since the implementation of the national and regional gerontological plans, the supply of social services has increased in all three sectors of the mixed economy of care.

Recent decades have seen a substantial growth in Spain's older population. In 1994, 14.7 per cent of the Spanish population was 65 years of age or over, while in 1999 the share was 17.2 per cent (Institute of Migration and Social Services (IMSERSO) 1995, 1999). Current forecasts indicate an even higher rate of growth during the next three decades. The country's social services therefore need to be prepared for increasing demand from older people. The heterogeneity and organisational characteristics of Spanish social services have caused some serious problems, which are mostly unresolved, such as marked geographical variations in provision and poor co-ordination among the various administrations and providing agencies. To tackle these problems, Spanish regional and local government has increasingly stressed efficiency and user choice. Since the last evaluation of the *National Gerontological Plan*, the Ministry of Social Services is considering further changes to the framework for social services to tackle these problems, and it is contemplating revised regulations in the 2005 plan (Ministerio de Trabajo 1999).

The nursing home sector

Throughout Spain, and particularly in the Valencia Region, the non-family residential care of older people has traditionally been supplied by non-profit institutions, mainly religious organisations. This panorama changed in the 1960s, when the public sector began to build large public nursing homes and to finance provision. After the transition to democracy, there was a great increase in demand that could not be absorbed by the public sector homes, and it was decided to provide subsidies to non-profit organisations. During the 1990s, however, another imperative has had rising importance – to contain the growth of expenditure. This has led the government to reform the management of various public sector institutions, and one approach that it has implemented is to contract private enterprises to provide 'complete management nursing homes'. So, in Spain and the Valencia Region, nursing home services are now offered by public, private and non-profit organisations, and some competition among them has been introduced (Kaufmann and Frías 1996).

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

TABLE 1. *The older population and the supply of nursing homes, Spain and the Autonomous Region of Valencia, 1994–97*

Attribute	Spain 1994	Spain 1999	Valencia Region 1999
Population (millions)	39.15	39.81	3.99
65 years and over (millions)	5.76	6.86	0.62
Percentage	14.7	17.2	15.4
Nursing homes			
Public sector	–	853	56
Private sector	–	2,849	187
Total	–	3,702	243
Places (rooms) in nursing homes			
Public sector	53,161	68,455	4,317
Percentage	32.5	35.2	31.8
Private sector[1]	110,177	126,197	9,268
Percentage	67.5	64.8	68.2
Total number of rooms	163,338	194,652	13,585
Rooms per 100 older people	2.83	2.84	2.20

Source: Institute of Migration and Social Services (IMSERSO) (1995, 1999, 2000).
Note: 1. Private sector nursing homes include non-profit organisation nursing homes.

In accordance with the 1992 *Gerontological Plan*, the regional governments set about its main objective, to increase the number of nursing home places. As Table 1 verifies, an increase did occur between 1994 and 1999, but because the number of older people has also grown, the proportion (2.8%) living in nursing homes did not change. In the Valencia Region, the percentage is only 2.2 per cent. This means that Spain, and even more the Valencia Region, are still far from the target of 3.5 per cent set by the national plan, and there is still considerable unmet demand (Aznar 1998; Defensor Del Pueblo 2000).

For the last few decades, the demand for nursing home places in Spain has exceeded supply. In the mid-1980s, around 100,000 older people were on waiting lists for a room in a public nursing home (National Institute of Social Services (INSERSO) 1987). In the Valencia Region, the figure in 1998 was 2,000 (Llorente 1999). If we remember that a nursing home is not the first preference of most older people with a care need, but is for home care, the unmet demand is of serious concern (Abellán 1997, 1999; De Miguel 1994). If it were possible to remain at home supported by domiciliary care, many older people would not apply for a place in a nursing home, but in most regions the home-care system is unable to meet the demand. As a result, people in need seek alternative care and apply for a nursing home place. As the demand continues to increase, several regional govern-

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

ments are improving their nursing home services, partly by implementing temporary (or respite) stays, and partly by giving financial help directly to private and non-profit suppliers and to older people themselves (IMSERSO 1999).

The origins of the voucher scheme

Before the introduction of the voucher scheme, the public financing of nursing homes in the Valencia Region had three elements: the direct provision of public nursing homes, subsidies to non-profit organisations, and financial agreements with private companies. The number of places was however insufficient to meet the demand, and so private and non-profit nursing homes expanded to fill the gap. Despite the additional places, a problem of equity or exclusion arose: some older people could neither find a place in a public sector home nor afford a room in a private nursing home. In an attempt to accommodate this group, regional and local governments first built new directly-managed homes, but found this option to be very expensive. Another idea was to place applicants in private and non-profit nursing homes, and it was therefore decided to subsidise some of their places. Even so, the supply of rooms did not rise as quickly as demand, with the consequence that there was an increase in the number of illegal (or unapproved) nursing homes (Llorente 1999). To remedy this situation, the Valencia Regional Government then introduced the voucher scheme (extending an approach that had successfully financed and expanded pre-school education in the City of Valencia) (Granell 2002). They had been made aware of the positive results of using vouchers for home-help services in Sweden (Nacka Kommun 2000), and of the nursing home quasi-voucher system in the United Kingdom from 1981 to 1993 (Hall and Eggers 1995).

Objectives and administration of the voucher scheme

Vouchers are internationally recognised as a financial instrument that creates some of the characteristics of a perfect or free market in what has come to be known as a quasi-market (Bartlett *et al.* 1994; Le Grand and Bartlett 1993; Calero 1998; Cullis and Jones 1997; Kane 1998). The main objectives of quasi-markets are to achieve efficiency and to increase user choice. According to Le Grand (1991), a service is more efficient (productive efficiency) when it reduces the costs of any given

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

quality or quantity of the service, and this can be brought about by the increased level of competition in a quasi-market. The Valencia Regional Government's aims in introducing nursing home vouchers were:

- To respect frail older people's preferences and facilitate their choice of nursing home.
- To enable applicants who had been denied a public nursing home place access to a room in a private nursing home.
- To provide those who could not afford a room in a private nursing home with supplementary finance to enable them to be admitted.

In short, the Valencia voucher system aimed to increase the applicants' choice, the supply of publicly-funded rooms, and equality of access, or the better matching of placements to needs. The target group are people of 60 or more years of age who live in the Valencia Region and need to enter a nursing home but have insufficient resources to do so. The scheme's administrative arrangements are relatively simple. Those accepted as eligible receive a monthly voucher that they give to the nursing home of their choice. With the monetary value of the voucher, their own contributions and, in some cases, additional family contributions, they pay the full fees. The nursing home sends the vouchers to the social welfare department of the Regional Government, the *Conselleria de Bienestar Social*, which reimburses the cash value.

In another attempt to improve the nursing home sector, the Regional Government has included temporary stays in the voucher scheme. Since January 2000, vouchers can be used for respite care or for short stays (maximum two months) to assist with temporary social or non-acute health care needs. The amount of the voucher (per month) is equivalent to the difference between the fees and the amount that the government assesses that the resident and his or her children can afford to pay (the assessment is based on the resident's and the children's income). The fees vary according to a schedule determined by the Valencia Government, and they depend on the 'needs' category of the resident. During the five years of experience with vouchers, there have been several changes in the fee scales (see Table 2).[2]

In 1996, only three categories of need for care (or levels of provided care) were specified, relating to older people who were 'independent', required 'semi-assistance', or required 'assistance'. The fees for the first and second types were the same. Since 1996, however, the Regional Government has created a 'high-dependency' category, because it was found that some who entered a nursing home as 'independent' later suffered a health problem which greatly increased their need for care. Another reason for the new category was increased

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

TABLE 2. *Stipulated fees per month, 1996–2000 (£ Sterling)*

Level of need	1996	1997	1998	1999	2000
Independent	360	400	440	440	460
Semi-assistance	360	–	500	500	528
Assistance	520	560	608	608	640
High-dependency	–	680	740	740	780

Source: Conselleria de Bienestar Social (Department of Social Welfare) 1996–2000. *Nursing Home Voucher Regulations*, Valencia Regional Government, Valencia.

demand from people with such conditions. The fees for each dependency or needs category has been recalculated every year, to reflect inflation and the cost of new equipment. No nursing homes participating in the voucher scheme can require their clients to pay more than the fees stipulated by the Regional Government.

The contributions of the residents and their children vary, as they are proportionate to their respective incomes. An applicant's contribution is identical to the fee they would pay if they entered a public sector nursing home without vouchers. It is set by the regional schedule, and rises with the income of the resident. At present, while the regulations governing vouchers specify four types of users, the official fees schedule specifies only two levels (an anomaly that requires urgent rectification). The contribution to be made by the children was set in 1997, and is indicated in Table 4: the amount varies by the number of members of people in the child's family household and their income per month. The children start to contribute if their *per capita* family income is higher than the official (poverty) level or threshold for means-tested benefits (£3,879 per year in 1999).

The scale of provision

Table 3 presents the number of private nursing homes in the Valencia Region that receive vouchers. In 1999, 77 nursing homes were participating, around 31.6 per cent of the total. While the voucher programme was originally designed for private sector and non-profit organisations, the Valencian Government has now introduced a pilot voucher scheme in one public sector nursing home. The other public sector homes continue with direct public financing, and competition, therefore, has not extended into this sector. The private nursing homes that receive vouchers are not obliged to offer all their rooms to voucher beneficiaries, and can reserve some rooms for privately paying clients.

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

TABLE 3. *Nursing homes accepting vouchers, Valencia 1998–1999*

Level of need of resident	1998	1999
Independent/assistance	62	74
High-dependency	11	12
Total	63	77

Source: Servicio Tercera Edad, Conselleria de Bienestar Social (Service for Elderly Care), Department of Social Welfare, Valencia Regional Government, Valencia.
Note: Private, non-profit and public sector homes are included.

TABLE 4. *Number of vouchers and their financial structure, 1996–1998*

	Number of beneficiaries		Room Cost	Average amount of voucher		Average user's contribution		Average children's contribution	
	No.	%[1]	£	£	%[2]	£	%[2]	£	%[2]
1996									
Independent	30	8.2	360	209	58.0	151	42.0	–	–
Semi-assistance	71	19.3	360	197	54.7	163	45.3	–	–
Assistance	267	72.5	520	346	66.6	174	33.4	–	–
High-dependency	–	–	–	–	–	–	–	–	–
Total	368	100	476	306	64.3	170	35.7	–	–
1997									
Independent	495	31.7	400	220	55.0	174	43.5	6	1.5
Semi-assistance	–	–	–	–	–	–	–	–	–
Assistance	1,016	65.0	560	363	64.9	188	33.5	9	1.6
High-dependency	53	3.3	680	474	69.6	190	27.9	17	2.5
Total	1,564	100.0	513	321	62.6	184	35.9	8	1.6
1998									
Independent	312	18.8	440	259	58.9	174	39.6	7	1.5
Semi-assistance	239	14.5	500	303	60.6	188	37.6	9	1.8
Assistance	902	54.6	608	407	66.9	191	31.5	10	1.6
High-dependency	199	12.1	740	521	70.4	197	26.7	22	2.9
Total	1,652	100.0	577	377	65.4	188	32.6	11	1.9

Source: Conselleria de Bienestar Social (Department of Social Welfare) 1996–2000. *Nursing Home Voucher Regulations*. Valencia Regional Government, Valencia.
Notes: 1. Percentage of all beneficiaries. 2. Value or cost per month; percentage of full fees.

One feature that has caused concern is that few of the participating homes offered high dependency places (only 12 in 1999).

Table 4 presents information about the beneficiaries of vouchers. The first column shows the rise during the first three years in the number of recipients. Most of the vouchers were allocated to people with relatively high care needs, for around 70 per cent required 'assistance' or were 'highly dependent'. The columns to the right show the financial contribution of the vouchers. The value of the voucher (and therefore of the public finance contribution) is always the largest

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

component of the room cost. For each category of recipient, the average value of the voucher rose during 1996–98, but the average value of the vouchers has risen faster because the 'needs profile' has changed, with a steady increase in the percentage that are 'highly-dependent'.

Social care need is the most important eligibility criterion, but the amount of public funding is dependent on the applicant's income. The method used to calculate the value of the vouchers for each health status involves three variables: the care need, the applicant's income, and the income of the applicant's children adjusted for the number of their dependants. For a given care need, the most influential factor is the applicant's income. The average contribution of the residents increased slightly from 1996 to 1997, as a result of differences between the rate of inflation and the rate of increase of older people's income, and because the user's contribution is fixed by the regional regulations and has not been modified since 1993. While there is a positive relationship between the user's contribution and their level of care need or dependency, as a proportion of the fees the user's contribution decreases with increasing dependency. Public finance is therefore giving more support to older people with high dependency, one of the main objectives of the national plan.

The contributions by the resident's children to the costs were introduced in 1997 and have been controversial. For nearly 20 per cent of the voucher beneficiaries, one or more of their children are paying part of the costs (Table 4). Older people in need of care, who enter a public sector home, pay the same as in a private nursing home in the voucher scheme, but their children do not have to contribute anything. Most of the applicants' children believe that they should not have to contribute to the fees in a public sector scheme. In 1998, their contributions varied from 1.5 per cent (for 'independent' users) to 2.9 per cent (for the 'highly-dependent'). Although the percentages are small, only a few of the residents' children had a family household income higher than the means-tested threshold.

Evaluation of the scheme

Effects on choice

On the introduction of the voucher scheme, a potential resident was given two options: to apply for a room in one of the 56 public nursing homes, or to apply for a voucher to be spent at their choice of 77 participating private nursing homes. Applicants can select the nursing home closest to either their or their children's home, or choose one that

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

TABLE 5. *Performance indicators of the nursing home voucher scheme, 1996–1999*

Indicator	1996	1997	1998	1999
Application forms				
Received	759	1,913	2,948	3,999
Approved	368	1,564	1,652	2,529
Allocated rooms				
Private sector[1]	420	1,520	1,946	2,380
Public sector	100	100	100	100
Total	520	1,620	2,046	2,480
Regional government expenditure				
Per allocated place (£)	1,154	2,099	2,834	2,741
Total (£ million)	0.6	3.4	5.8	6.8
Increase in expenditure	1996–97	1997–98	1998–99	1996–99
Percentage	470	68	17	1,031

Source: Conselleria de Bienestar Social (Department of Social Welfare), Valencia Government and Asociación Empresarial de Residencias para la Tercera Edad y Servicios Sociales de la Comunidad Valenciana (AERTE) (Private Nursing Home and Social Services of Valencia Region Association), Valencia.
Note: 1. Includes non-profit nursing homes.

offers the most appropriate services for their needs. Unfortunately, no data are available about the reasons given for the choices.

To promote well-informed selection decisions, the Valencia Government provides information about the nursing home voucher scheme and the participating nursing homes with every application form. It has also organised and funded publicity campaigns. The private nursing homes have of course a vested interest in gaining new customers, so they also provide information brochures about their services and facilities, which include information about the voucher system (Asociación Empresarial de Residencias para la Tercera Edad y Servicios Sociales de la Comunidad Valenciana 2000). The success of the information dissemination is shown by the increase in the number of applicants over the first four years (Table 5).

The Valencia scheme anticipated the possibility of the users' choice being constrained by the nursing homes own admission criteria, and the participating organisations and homes have been obliged to admit any applicant when they have a vacancy. In practice, however, many homes have excess demand, and when filling single vacancies they are able to select applicants according to their criteria. The tendency would inevitably be to select those with the most optimal health status, gender, proximity and economic status. Some applicants have had to accept places in nursing homes that do not best suit their needs and preferences.

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

The increase in public funded places

The number of places in public sector nursing homes has been more or less constant over the last four years (4,317 in 1999) and, as said before, the Valencia Region is far from achieving the national plan target of 3.5 rooms per 100 older people. One effect of the voucher scheme has been however a substantial increase in the number of places in private sector nursing homes financed by public funds, to 2,380 in 1999 (Table 5). This is not, however, a net increase in provision, for many of the places were available to private payers before the vouchers were introduced. It is difficult to calculate the overall effect of the voucher scheme on the aggregate supply of nursing home places, for there have been simultaneous policy changes, such as direct subsidies to private sector homes and the construction of new public sector nursing homes.

Impact on equity of access

In order to evaluate the equity effects of the voucher scheme, we focus on two aspects: the conditions of access, and the amount of public support provided through the vouchers. Private sector nursing homes are notably diverse, and so place highly variable requirements on older people wishing to enter them, most importantly the level of their charges. The variability inevitably produces inequality of access: not unusually, those with higher incomes have more choice.

Since the introduction of the voucher scheme, both public and independently-managed nursing homes have more or less maintained the same fundamental access conditions as before: the resident still pays a high proportion of their income, and their eligibility and charges are determined by an assessment of their social and health care needs. Now, however, all the homes participating in the voucher scheme can only admit older people who fulfil the eligibility conditions set by the scheme's regulations, which are that residents must be at least 60 years of age, must be residents of the Autonomous Region of Valencia Region, and must have a social care need, which actually means that there is no possibility of adequate support from their family or other informal carers.

The potential resident's social and health care needs are separately assessed, and only these reports are used to categorise the individual and to allocate her/him to a type and cost of care (independent, semi-assisted, assisted or high-dependency). The assessments have no influence on whether a voucher is granted. In our opinion, although the assessment of 'social need' is well conducted, there should be more

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

TABLE 6. *The monthly value of the nursing home vouchers in 1999*

Applicant's income per month (£)	Care level and type of place			
	Independent	Semi-assisted	Assisted	High-dependency
160	312	372	480	612
260	228	288	396	528
360	138	198	306	438
460	48	108	216	348
560	0	8	116	248
660	0	0	14	146
760	0	0	0	42
Threshold point	502	560	665	800

Source: Estimated from data on room costs and number of vouchers.

attention paid to the physical and mental status of the applicant. If this were done, the voucher scheme could play a greater role in prioritising access for those with high social and health care needs. Only in 1997 was the category of highly-dependent people specifically recognised in the programme. Giving more weight to the physical and mental health status of the applicant in nursing home placements could also foster the care and support of less dependent older people in their own homes, by encouraging the development of domiciliary services.

Table 6 presents our estimates of the value of the voucher in relation to the applicant's income (without considering their children's contribution). In this model, the value of the voucher decreases as income rises, and above a certain level of income no voucher is granted and the resident pays the entire fee. In 1999, this threshold level of income was between £502 and £800 per month, depending on the intensity of care. The present schedule therefore favours people on low incomes.

Efficiency

One of the main objectives of quasi-markets is to increase efficiency through the introduction of competition. In the Valencia Region before the voucher scheme was introduced, nursing home services were provided by the three main sectors of the care economy. With vouchers people have more power to choose among the nursing homes, which should direct demand to the homes with lower charges, higher quality and better value for money. Whether the scheme has increased competitive selection is however difficult to verify. First, private and non-profit nursing homes were in competition before the voucher scheme was introduced. Secondly, public sector and 'complete-

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

management nursing homes' still receive direct subsidies from public budgets. Only one public sector nursing home has entered the voucher system and is competing for vouchers with the private and non-profit nursing homes. Arguably, therefore, the voucher scheme has left competition more or less unchanged. Nevertheless, it may have increased efficiency if it has increased the quality of the service or brought about lower costs.

A rise in quality may result from the tighter regulation of nursing home standards that accompanied the voucher scheme. In 1998, two kinds of standards were introduced that in principle encouraged higher service quality, about the number and qualifications of the staff, and about room specifications. The standards are, however, imprecise and inadequately regulated. The voucher scheme regulations only oblige the homes to offer 'suitable services' as well as occupational, rehabilitation and leisure activities. Both these and the general standards refer only to inputs and service provision. If 'quality' is accepted as a multi-dimensional concept involving inputs, provision and outcomes, and if it includes satisfying the wishes of users, professionals and relatives, the effect of the voucher scheme's regulations on the quality of the service has been limited (Olmeda 1991; Montoro 1999). It is now important, therefore, to strengthen the regulation and control of both provision and outcomes. Over the study period, there was no obligation on the providers to report the information that would enable this to be done.

To evaluate the quality effects, we have compared the main inputs in both the voucher scheme homes and the public sector nursing homes using data provided by the *Conselleria de Bienestar Social* on the facilities and services in 28 homes. Four groups of facilities are examined: health care, hotel services, leisure and social activities, and other[3] (See Table 7). The information shows that for each of the four groups, public nursing homes offer more facilities, which may be partly explained by their larger size. The voucher-scheme homes have a higher percentage of individual rooms and a lower percentage of shared rooms. There could be more personalised attention in private nursing homes, because the public sector homes were originally designed as centres for independent older people, and, characteristically, were large and had shared rooms.

Turning to the staffing, there are similar ratios of health and social care staff in both types of homes, although in the public sector homes there are more nurses but fewer doctors. The ratio of hotel and management employees is higher in the public institutions, and the ratio of all staff is slightly higher in the public sector homes. In

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

TABLE 7. *Average number of services and staff, Valencia nursing homes, 1999*

Amenity	Voucher scheme homes	Public sector homes
Facilities and services[1]		
Health care (maximum 7)	2.6	3.2
Hotel facilities (maximum 4)	2.8	3.0
Leisure and Social facilities (maximum 11)	4.4	5.7
Other facilities (maximum 6)	2.5	3.3
Total (maximum 28)	12.3	15.2
Room types and standards		
Square metres per 100 users	38.5	43.9
Number of rooms	53.1	91.6
Single rooms (percentage)	26	20
Double rooms (percentage)	62	76
Other rooms (percentage)	12	4
Staff per 100 residents		
Health and social care	40.2	39.6
Physicians	3.1	1.0
Nurses	3.2	5.3
Other health care specialists	1.0	0.9
Care assistants	30.8	30.1
Other social care	2.3	2.3
Hotel services or ancillary	1.6	4.1
Managers	0.8	1.8
Total	42.6	45.5

Source: Calculated from data supplied by the *Conselleria de Bienestar Social* (Department of Social Welfare) (2000).
Note: 1. *Medical facilities* are defined as medical unit, nursing unit, intensive care unit, oxygen unit, geriatric bath(s), rehabilitation room, and chiropody unit. *Hotel facilities* are defined as: residents' kitchen, dining room, cafeteria, and laundry. *Leisure and social facilities* are defined as: living room, television room, visiting room, library/reading room, occupational (hobbies) room, games room, chapel, swimming pool, gym, hairdresser, and multi-use room. *Other facilities* include: meeting room, assembly hall, garden, terraces, patio, consolation room (retreat), and store.

summary, although the private nursing homes in the voucher scheme have fewer facilities than those in the public sector, and although there are few differences in staffing, it is believed that the quality of the voucher homes has improved as a result of the regulations on staff and facilities.[4]

There have been serious administrative problems with the voucher system, namely extended delays in reimbursement by the Department of Social Welfare to the nursing homes. In 2000, several private nursing homes had difficulty paying their employees' salaries as well as the national social security contributions. For that reason, some homes decided to opt out of the voucher scheme. Since then, however, modified arrangements have been introduced, and in 2002 vouchers

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

TABLE 8. *Average monthly fees of the voucher scheme nursing homes, 1996–99 (£)*

Indicator	Residents' level of care			
	Independent	Semi-assisted	Assisted	High-dependency
Current prices 1996	422	429	468	500
Price deflator 1996–99	1.06	1.06	1.06	1.06
Real prices 1996	448	454	496	530
Current prices 1999	485	540	633	739
Increase 1996–99				
Percentage	8	19	28	39
Annual growth (%)	2.7	6.0	8.4	11.7

Source: Calculated from data provided in 2000 by the Asociación Empresarial de Residencias para la Tercera Edad y Servicios Sociales de la Comunidad Valenciana (AERTE) (Valencia Region Association of Private Nursing Homes and Social Services).

have been replaced by subsidies that are paid directly to the homes by the Department of Social Welfare. The residents do not receive actual vouchers, and the beneficiaries only have to agree to the transaction. The reform has meant that the homes now receive money promptly, and has encouraged homes to remain in the scheme.

Fees and costs

With respect to the reduction of costs, nursing homes entering the voucher scheme are obliged to fix a price that cannot be higher than the fees established by the scheme. This means that there will be an increase in efficiency only in those nursing homes whose prices were higher than the set maximum before the scheme was introduced. For nursing homes that previously charged below the new maximum, there is no incentive to charge below that level and efficiency is likely to have decreased. It would therefore be most effective to set the maximum fees to be charged by a home lower or no higher than the price they had been charging, otherwise it is possible that it would take the profit which may be gained from the higher permitted fees. One problem, of course, is that the Regional Government has insufficient information to make informed judgements about the level of charges that produce 'normal' or reasonable profits and the financial viability of a well run home.

The trends in average fees during the voucher scheme experience between 1996 and 1999 are presented in Table 8. We have compared the prices charged in the participating nursing homes before and after they entered the voucher programme in 1999 (deflating by the general consumer price index with a base in 1992 for the Valencia Region).

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

There was a marked increase in prices during the period, and, furthermore, the rise was positively related to the level of dependency of the resident. Clearly, the intended reduction in fees has not been achieved. In our opinion, this could be the result of the stricter regulations on inputs (personnel and equipment), which imply new capital spending and higher running costs.

Of greater concern for the Valencia programme is how to control the increasing expenditure. As Table 5 shows, the Regional Government's spending on the vouchers increased by 1,301 per cent from 1996–99. Increased utilisation has been the principal cause, but there have also been rises in the *per capita* cost. Most users have come to see entry to a nursing home as an entitlement at a subsidised cost. Frail older people and their relatives have neither the incentive to look for cheaper nursing homes, nor the alternative of staying at home with home-care because such a service is not available. Little public money is spent in the Valencia Region on home-help programmes, home adaptations, or direct payments to informal carers. Under the scheme, the users do not bear the cost and have increased choice, and the regulations have produced rising quality standards. The net effect has been to increase the cost to public funds. In our opinion, the voucher system has stimulated demand, and its prospects are for ever-increasing expenditure.

It is interesting to note that the experience of the United Kingdom nursing home quasi-voucher scheme during the 1980s had the same result, for providers had no incentive to keep their prices down and raised the prices to the maximum level permitted by the regulations. Because the British government was unable to contain the growth of expenditure, the scheme was discontinued in 1993.

Conclusions

The Spanish *Gerontological Plan* demanded modernisation of the nursing home sector and an increase in the number of places. Several of the country's autonomous regions have used traditional methods to achieve these aims, namely more public provision and increased subsidies. The government of the Autonomous Region of Valencia Region, however, implemented an innovative nursing home voucher scheme. The main objectives were to increase users' choice, to reduce waiting lists, and to achieve greater equity of access (or matching of allocations to needs). The introduction of the voucher scheme was also designed to achieve the usual objective of quasi-markets to increase productive efficiency.

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

Our evaluation of the Valencian experience is that there has been an increase in user choice, although this is limited when demand exceeds supply. Moreover, there has been a needed increase in the supply of publicly-financed nursing home places. A common criticism of quasi-markets is that they have perverse effects on access, because the homes admit the least demanding and costly users that the rules permit, *i.e.* there is 'cream skimming'. The graded levels of care and monetary values of the vouchers in the Valencia scheme have substantially avoided this effect, and equity of access in the system has been promoted because those with low income benefit most.

A voucher scheme may in principle lead to an increase in the quality of inputs through the stricter regulations and minimum standards, but we have been unable to establish whether there have been increases in the quality of the care, in the daily activities of the residents, or in the quality-of-life outcomes, largely because there are no relevant data or indicators. As far as the Regional Government is concerned, the most apparent result has been rapidly increasing expenditure (the same effect as in the United Kingdom's partially comparable scheme). Clearly, the final effect of the Valencia nursing home voucher scheme on the quality of life of frail older people and on efficiency in meeting their needs is yet to be determined.

The considerable pressure that the voucher scheme is putting on the Regional Government's funds must be seriously reconsidered. Our most important recommendation, partly based on the British experience, is that if the Valencia Government decides to continue with the programme, it must set limits to the budget. The financial problems should, however, encourage it to rethink the policy and approach to the support of frail older people in need of care, and specifically to examine the alternative of domiciliary care. If home-care programmes received more public support, the demand for nursing home places would decrease. At the same time, more older people would be enabled to remain at home, one of the main aims of the Spanish *Gerontological Plan*.

NOTES

1 The Kingdom of Spain has a federal national government and 17 Autonomous Regions, the governments of which have varying responsibilities and powers. A useful guide to the country's federal government arrangements is available (Ross 1997).
2 The amounts have been converted to pounds Sterling at £1 equals 250 pesetas.
3 The facilities under each heading are listed in the note that accompanies Table 7.

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

4 We wished to verify Knapp's (1984) suggestion that the effect on the quality of care is related to the degree of dependency and varies by the type of nursing home, but the information to test the relationships were unavailable.

REFERENCES

Abellán, A. 1997. El alojamiento colectivo de personas mayores (Collective homes for older people). *Revista de Gerontología*, **7**, 114–6.

Abellán, A. 1999. Problemas de vivienda y riesgo de institucionalización. (Home problems and risk of institutionalisation). *Revista Multidisciplinar de Gerontología*, **9**, 4, 253–7.

Asociación Empresarial de Residencias para la Tercera Edad y Servicios Sociales de la Comunidad Valenciana (Association of Private Nursing Homes and Social Services in the Valencia Region) (AERTE) 2000. *Guía de Residencias Privadas para Mayores de la Comunidad Valenciana* (*Guide to Private Nursing Homes in the Valencia Region*). AERTE, Valencia.

Aznar, M. 1998. Los servicios sociales públicos para mayores: balance y prospectiva (Public social care for older people: review and prospects). *Documentación Social*, **112**, 65–85.

Bartlett, W., Propper, C., Wilson, D. and Le Grand, J. 1994. *Quasi-Markets in the Welfare State: The Emerging Findings*. School for Advanced Urban Studies, University of Bristol, Bristol.

Calero, J. 1998. *Una Evaluación de los Cuasimercados como Instrumento para la Reforma del Sector Público* (*An Evaluation of Quasi-Markets as an Instrument for Reforming the Public Sector*). Fundación BBV, Bilbao.

Cullis, J. G. and Jones, P. R. 1997. Los cuasimercados desde la perspectiva de la elección pública (Quasi-markets from a public choice perspective). *Hacienda Pública Española*, **140**, 1, 39–52.

Defensor del Pueblo 2000. *La Atención Sociosanitaria en España: Perspectiva Gerontológica y Otros Aspectos Conexos* (*Social and Health Care in Spain: The Gerontological Perspective and Related Subjects*). Oficina Defensor del Pueblo, Madrid.

De Miguel, A. 1994. *La Sociedad Española 1993–94* (*Spanish Society 1993–94*). Alianza, Madrid.

Granell, R. 2002. Education vouchers in Spain: the Valencian experience. *Education Economics*, **2**, forthcoming.

Hall, J. and Eggers, W. D. 1995. Health and social services in the post-welfare state: are vouchers the answer? Policy Study 192. *Reason Public Policy Institute*, Available at http:/www.rppi.org

IMSERSO (Institute of Migration and Social Services) 1995. *Guía Directorio de Centros para Personas Mayores*. (*Nursing Homes Guide*). IMSERSO, Madrid.

IMSERSO 1999. *Datos Estadísticos*. (*Statistical Data*). IMSERSO, Madrid.

IMSERSO 2000. *Las Personas Mayores y las Residencias*. (*Older People and Nursing Homes*). IMSERSO, Madrid.

IMSERSO, Scientific and Social Research Centre and Universidad Autónoma Madrid 2000. *Las Personas Mayores en España: Informe 2000*. (*Older People in Spain in 2000*). IMSERSO and Universidad Autónoma Madrid, Madrid.

Kane, R. L. 1998. Assuring quality in nursing home care. *Journal of the American Geriatrics Society*, **46**, 232–7.

Kaufmann, A. E. and Frías, R. 1996. Residencias: lo público y lo privado (Nursing homes: private and public). *Revista Española de Investigaciones Sociológicas*, **73**, 81–104.

Knapp, M. 1984. *Economics of Social Care*. Macmillan, London.

Le Grand, J. 1991. Quasi-markets and social policy. *Economic Journal*, **101**, 1256–67.

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press

Le Grand, J. and Bartlett, W. 1993. *Quasi-Markets and Social Policy*. Macmillan, London.

Llorente, J. J. 1999. Las personas mayores en el País Valencia: aspectos de sociología crítica (Older people in the Valencia region: critical sociology perspectives). 20th May 1999. Available at www.ctv.es/users/jjllorente.

Miguel, J. A. 1998. Balance de las políticas sociales con los mayores en España. Los planos gerontológicos: análisis y perspectivas. (A review of the social policies for older people in Spain. Gerontological plans: analysis and perspectives). *Documentación Social*, **112**, 175–93.

Ministerio de Trabajo y Asuntos Sociales 1999. *Informe de Valoración del Plan Gerontológico Estatal, 1992–1997* (Assessment Report of the National Gerontological Plan, 1992–97). IMSERSO, Madrid.

Montoro, J. 1999. Factores determinantes de la calidad del cuidado asistencial institucional a personas mayores y/o con discapacidad. (Factors influencing the quality of care in nursing homes for elderly or disabled people). *Papers* (Barcelona), **57**, 89–112.

Nacka Kommun 2000. The home-help services voucher. In *Directory of Services*. Municipal Authority of Nacka, Nacka, Sweden.

National Institute of Social Services (INSERSO) 1987. *Guía de Centros de la Tercera Edad*. (*Nursing Homes Guide*). INSERSO, Madrid.

Olmeda, M. 1991. Cantidad, cualidad y calidad de la enseñanza universitaria: una distinción útil. (The quantity, intensity and quality of university teaching: a useful differentiation). In *Actas del I Congreso Internacional sobre la Calidad de la Enseñanza Universitaria*. Institute of Educational Sciences, University of Cádiz, Cádiz, Spain, 370–9.

Ross, C. J. 1997. *Contemporary Spain*. Arnold, London.

Accepted 10 June 2002

Address for correspondence:
Maria Angeles Tortosa, Departamento de Economía Aplicada, Edificio Departamental Oriental, Universidad de Valencia, Avda Los Naranjos s/n, 46022 Valencia, Spain.
e-mail: Angeles.Tortosa@uv.es

https://doi.org/10.1017/S0144686X02008942 Published online by Cambridge University Press