Evaluation of the Home Care Service in Catalonia: an analysis using mixed methods[1]

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ABSTRACT

The aim of this article is to present an evaluation of the Catalonia-wide Home Care Service (*Servei d'Ajuda a Domicili*, SAD, in Catalan), a complex public policy in which various agents and spheres of government intervene, and whose purpose is to provide personal support in the home to people who have issues with autonomy or who find themselves in situations of social vulnerability. The Home Care Service acquires a strategic relevance in the light of social changes and, in particular, the ageing population. Using mixed quantitative and qualitative methods, the evaluation analyses three key aspects of this policy with reference to its design and implementation. First, the coherence of the discourse and the policy is analysed; secondly, its implementation is examined, with a focus on the local variability of the coverage and intensity of service and the reasons behind this; and thirdly, an analysis is made of the changes in the uses of the Social Home Care Service as a result of the Dependency Law. The study highlights the complexity of the social policies which are implemented in different areas of Catalonia and the difficulties involved in addressing their design, application and, in particular, their evaluation.

KEYWORDS

Social policy; evaluation; social services; home care; long-term care; mixed methods.

INTRODUCTION

The evaluation of public policies is a planned activity which provides information and evidence to discern whether actions taken are really working. Starting from different analytical techniques and approaches, evaluation provides lessons and

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knowledge that can be used to improve policies and decision-making. For these reasons, efforts are made to incorporate evaluative practice into all levels of governance by means of strategies that motivate and drive evaluation until it is successfully institutionalised. In turn, the complementary nature of methodologies fosters a more rigorous approach, especially when an evaluation is made of social policies that represent a challenge due to their complexity and a constantly changing context.

The evaluation presented of the Home Care Service (HCS) is framed within this dual commitment: in the first instance, to take further steps to analyse and evaluate the social policies of the Autonomous Government of Catalonia (Generalitat de Catalunya) – policies which have an important territorial dimension, since in this case competences are shared with local bodies. Secondly, to move forward with mixed methodologies that complement and interrelate quantitative and qualitative methods, in order to gain a clearer and more accurate perspective of the reality under analysis.

The HCS aims to provide support in situations of need in the home environment and to boost autonomy and integration in the family and community environment. In view of the socio-demographic challenges, it is considered to be a strategic policy within the framework of a public care system, as well as an important social service on account of its scope and funding. Although the home care services are aimed at people of all ages, they have a key role to play in the light of demographic changes such as the ageing of the population and changes in family models and gender roles. Furthermore, it is defined as a preventative community resource which – by including professionals with different profiles in the service – is able to directly tackle isolated or ongoing situations where there is a need for support in the living area itself.

The HCS has more than one form: the service linked with Law 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care for Dependent Persons (LAPAD, in Catalan), known as the dependency HCS, and the social HCS. Many agents participate in this latter service, most notably the Catalan government, which plans and funds social services, and local entities which are also involved in planning and are responsible for management of the service. One important aspect of this service is its high degree of local variability, since it is implemented independently in each Basic Social Services Area (ABSS). Consequently, the HCS is a complex public policy with a coverage and intensity that remain insufficient in the face of citizens' increasingly diverse and growing needs.

This article presents the principal results of the evaluation of the HCS in Catalonia conducted between 2021 and 2022. The evaluation focuses on an analysis of the coherence of the policy, its territorial diversity, and the dynamics of its implementation. As a starting point, it considers the reflections and analyses of other studies of the HCS (among others, IERMB, 2020; DTASF, 2021; Generalitat de Catalunya and Avedis Donabedian Foundation, 2021d; Generalitat de Catalunya, 2022a; Generalitat de Catalunya, 2022b; and Barcelona Provincial Council, 2022a). We consider that this evaluation is of value in three respects:

- It is the first analytical study of the HCS that focuses on Catalonia as a whole. Although studies of high quality have been conducted in the past, all of these were descriptive or they focused on a specific region or area.
- This evaluation provides an insight into the social HCS, which has been studied relatively little in comparison with the dependency HCS.
- The evaluation uses mixed methods to gain a more exhaustive perspective of the reality of public policy. The qualitative part presents the predominant view of the HCS in the sector, drawing on the observations of various actors involved in the service, while the quantitative part searches for the factors that explain the high degree of territorial variability. The dialogue between the two methodologies is an added value for gaining evidence that may be useful when seeking to reappraise the HCS and initiate lines of action to improve the provision of the service.

The article is presented in four different parts: first, the main characteristics of the policy are outlined; next, a second section introduces the evaluation questions and the methodology of the study. Thirdly, the analysis and the results of the evaluation are presented prior to a final section devoted to challenges and recommendations for improving the policy.

1. THE CENTRAL ROLE OF THE HOME CARE SERVICE IN THE CARE SYSTEM

1.1. Context

In recent decades, the Member States of the European Union have launched a series of reforms of the care system aimed at making it sustainable. The reforms are a response to a triad of circumstances that endanger the sustainability of a care system which has been underfunded in the past (Navarro and Pazos Moran, 2020): the ageing population; the increased participation of women in the labour

market, leading to a decrease in the number of potential carers; and the squeeze on public spending which has predominated in European economies since the 2008 crisis (Albertini and Pavolini, 2015).

The reforms are taking place in three key areas of the care system: its funding – based on the logic of social insurance, universality or social welfare; its provision – direct or based on financial aid; and its degree of (de)institutionalisation – care in nursing homes or centres for dependent persons, or care at home – (Arriba González de Durana and Moreno Fuentes, 2009, Albertini and Pavolini, 2015; Floridi, Carrino and Glaser, 2021). Although European countries start from different points according to their welfare state model in the past, there would appear to be certain trends, such as universalism, which is growing, but limited by public funds; an increase in family responsibility; support in the private sector; decentralised management; and a growing importance of the person affected (Rodríguez-Cabrero, 2005).

It is in this context that home support emerges as one of the public policies whose reinforcement is of particular interest. Deinstitutionalisation is not only citizens' preferred option, but it is also considered to be a transition ‘towards a good life in the community’ (Spanish Ministry of Social Rights and Agenda 2030, 2023). Thus, the World Health Organisation (WHO) has declared the period 2021-2030 the Decade of Healthy Ageing, and it has endorsed a number of initiatives to improve the lives of elderly people which are also linked with the United Nations Sustainable Development Goals. Furthermore, the European Union has made a commitment to reinforce social protection policies, and the European Social Pillar explicitly acknowledges the right of everyone to accessible, high-quality long-term care, in particular, home and community services (European Commission, 2022). Within Spain, the Dependency Law was passed in 2006, and in 2023 a State Care Strategy and a Deinstitutionalisation Strategy have been developed (Ministry of Social Rights and Agenda 2030, 2023).

In this context, together with local agents and entities, the Catalan government's Department of Social Rights is drawing up a new home care model within the framework of the Strategic Social Services Plan 2022-2025 (Generalitat de Catalunya, 2021c). This new model of service in the home environment (SAED, in Catalan)[2], within which we find the Home Care Service (SAD, in Catalan),

[2] The social services Portfolio refers to the home care service within the framework of the services providing assistance in the home, among which the Support and Care Technologies Service is also included. Likewise, the 2022-2025 programme contract includes the SAD in the home environment care service (SAED), together with other services. Thus, the new SAED model seeks to integrate home care aimed at people that have social or autonomy needs with support and

stems from a process of reflection to achieve a model that is person-centred, with a focus on proximity, and flexible with respect to the needs of recipients. This is a home service aimed at people who have temporary or permanent relational or autonomy needs, and for whom social care in their own environment is the best option for their well-being and quality of life (Generalitat de Catalunya, 2021b). This concern is confirmed by the preparation of reports and studies focused on Catalonia, in which an analysis is made of the home care service and new lines of action are put forward.

Other recent studies also reflect this interest in home care services and highlight the challenges faced by the HCS in Catalonia. These studies include the study produced by the Barcelona Institute of Regional and Metropolitan Studies (2021) on the dependency HCS for the Metropolitan Area of Barcelona; the analysis of services in the home and community environment completed by Barcelona Provincial Council (2022a); and studies focused on evaluation (Rodríguez Cabrero and Marbán Gallego, 2022), such as the evaluation of experiences of home care and social and health integration made by the Autonomous Government of Catalonia and the Avedis Donabedian Foundation (2021d).

In seeking to combat situations of inequality and social fracture, the convergence between local and social agendas is proving key to generating new civic rights which remedy the shortcomings in care and its uneven distribution (Ubasart and Gomà, 2021). Thus, on a local scale, innovative experiences can be seen which are an expression of diversity and experimentation in response to demographic challenges, as demonstrated by various European cities (Rosetti and De Pablo, 2023). In the field of home care, Barcelona's new management model stands out, with its sharper community focus and improved quality of service and working conditions (Moreno-Colom, 2021; Martí and Rosetti, 2021).

The social and economic importance of the Home Care Service, together with the economic, demographic, and institutional challenges that affect the long-term care system, have led the Catalan government and local entities to show interest in evaluating its operation and results. This process of reflection also includes other key challenges such as comprehensive home care and the coordination of home services with other community and proximity policies. At a time of social crisis and increasing inequalities, it becomes more necessary than ever to evaluate the policies that seek to alleviate or reverse situations of exclusion.

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care technologies, support for relatives who provide care and other non-professional carers, the group of support products, and integrated social and health home care.

1.2. The Home Care Service

The HCS is one of the most important policies in the programme contract with local entities on account of its scope and the resources involved. The programme contract has been in operation since 2008 and it is the instrument of cooperation used by the Catalan government to fund the local entities. Generally, the Catalan government transfers 66% of the basic social services funding to the local entities. In 2022, this was a sum of 314 million euros. The 2022-2025 programme contract with the local entities is funded with a total of 1,385 million euros allocated to social policies, most notably social services such as the home care service and other social programmes aimed at infants, children and adolescents, the elderly, social inclusion and community action.

The HCS is a social service regulated by Spanish and Catalan regulations; its planning falls to the responsibility of the Catalan government, while its provision as a proximity service is managed locally, which has led to a high degree of territorial variability, one of the key elements of the analysis presented here. In 2021, the Catalan government's contribution to the HCS was 91 million euros, which represented 35% of its total contribution within the framework of the programme contract. This figure is increasing (it rose by some 30 million euros in 2022). The home care service attends approximately 70,000 people every year. In 2019, for example, it attended 67,751 people with a global budget of 172 million euros (Generalitat de Catalunya, 2021a).

Although the laws that regulate social services both across Spain and in Catalonia were mainly enacted in the 1980s, it was from the mid-1990s that the direct provision of the HCS was transferred to the basic social services areas (ABSS). It is important to mention that, although the powers of local governments have been reinforced, the funding situation continues to be limited, which has favoured the role of the autonomous governments (Adelantado, 2000). In principle, Spain funds one third of the basic social services provided, the autonomous communities put forward a similar sum, and the remainder is covered by the local entities (Pelegrí, 2010). When Royal Decree Law 20/2012 was passed, public spending cuts were made which had a serious impact on the care system for dependent persons and, consequently, home care services. It was not until 2021 that the Spain-wide Action Plan reverted this situation, and a

phase began in which funding was recovered, although the service remains under pressure due to waiting lists and people who are left unattended.

2. EVALUATION QUESTIONS AND METHODOLOGY

The HCS is a service which has existed since the 1980s, and like every social service, it has encountered changing needs, demographic circumstances and policies, especially with the introduction of Law 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care for Dependent Persons, to which it has had to adapt. In addition to this context of change, there is no specific regulatory framework for the deployment of the HCS. The social services Portfolio approved by Decree 142/2010 includes the HCS, but it does not establish its implementation. The result is a policy that currently shows certain variations between Basic Social Services Areas (ABSS), a situation which has already been documented in several studies (IERMB, 2020; Barcelona Provincial Council, 2022a, FEMP, 2015).

It is precisely this heterogeneity which prompts the evaluation of the implementation of the HCS. It should be emphasised that the territorial differences are not in themselves a source of concern, except when they lead to situations of inequality due to recipients' place of residence. Consequently, the evaluation of the HCS presented in this report takes these concerns as a starting point, focusing particularly on the transformation of the HCS, its lack of uniformity and the effects this has. For this purpose, the following evaluation questions are posed:

To what extent is the HCS a policy with internal coherence? Here, we start from the premise that a policy has an internal coherence when its theory of change is clear and it is therefore based on a hypothesis in which the results and impacts it is hoped to achieve are outlined. Although the analysis does not involve an evaluation of the design, in order to evaluate the implementation of the service, first of all the vision and the objectives that govern the policy must be understood; that is to say, the conceptual and discursive dimension of the public policy, which contains its fundaments and justification, and which conditions the entire process and content of the intervention. In the field work, the ‘internal coherence’ has been operationalised, enquiring about the origins and the development of the HCS, its objective, and the needs it is wished to address through its implementation.

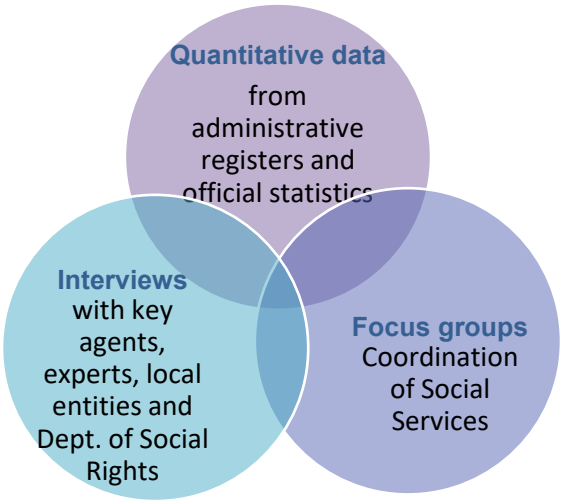
What degree of variability is there in the use of the HCS from one ABSS to another?
What factors correlate with the variability in the degree of coverage and intensity of each ABSS? What interpretation can be made of the existing variability? These three questions are posed in response to the concern that the HCS appears to be highly heterogeneous. Although a certain degree of variability is to be expected and is indeed desirable for the purpose of adapting to different territorial situations, part of this variability may be due to territorial, social, economic or political conditioning factors which should be corrected. For example, it might be the case that the HCS lacks impact in rural or low-income areas, despite the fact that the needs there are just as great, or that the allocation of the HCS is due to political negotiations or the wealth of the municipality. Our interest lies in determining what conditioning factors are relevant, for this will help us to understand whether the variability is purely due to criteria of supply and demand, or whether on the other hand it masks inequalities that must be corrected, this being the concern of the Department. The expectations harboured align with the concerns of the Department; that is to say, the variability is due to inequalities more than to differing needs. Account has been taken of those indicators for which statistical information was available with relation to the ABSS or which could be supplemented with data at municipal level. The results of the statistical analysis will be compared with the qualitative analysis.

What are the uses of the Social HCS and how is it related to the Dependency HCS? The Dependency Law has affected the development of the HCS and, to a certain extent, the operation of the Social HCS. Therefore, with this concern in mind, for the analysis as a whole a distinction has been drawn between the social HCS and the dependency HCS, there being a possibility that their dynamics are different, given that they are services of a different nature and aimed at different groups.

Different techniques – quantitative and qualitative – are considered in the evaluation, and their results are compared. Therefore, the strategy chosen in this evaluation is methodological triangulation, since both the aforementioned methodologies are oriented towards the same object of study and they bring greater knowledge and validity to the results obtained (Sanz, 2011). In the case of this study, the first question about the coherence of the policy has been analysed using qualitative methodology, whereas the following four questions have been analysed by triangulating the two methodologies.

As Figure 1 shows, the comparison looks for the findings from the different sources that coincide (triangulation of information), assuming that a hypothesis validated by various techniques or sources of information has more validity than a hypothesis that has only been compared using one channel of information. More extensive discussion of these matters can be found in the methodological annex.

Figure 1. Techniques used in the evaluation



Source: Own elaboration.

As sources of information, the qualitative analysis has drawn on the documentation of the programme, the various studies made, and the interviews with key informants. In a first phase, exploratory interviews were conducted with experts considered to be key agents in the design and implementation of the service (persons linked with research and local and Catalan government). In a second phase, different agents driving the HCS from local and Catalan government were interviewed. In addition, two focus groups were set up with managers of the basic social services areas in the HCS field. The criteria applied for their selection were size of municipality and some key social variables, with the aim of examining a wide range of realities. Thus, one focus group was formed with large municipalities (of more than 30,000 inhabitants and with their own ABSS) and another with smaller local or supralocal entities (see the methodological annex for more information).

With respect to the quantitative analysis, various sources of data have been used: in the analysis of the variables that influence the variability of intensity and coverage of the social HCS and the dependency HCS, use has been made of data from administrative registers (principally RUDEL, the Unified Register of Local Authority Data) and socio-demographic data obtained from official statistics compiled by Idescat (the Catalan Statistics Institute) and from transparency portals of the Catalan government.

The analysis has been made at ABSS level and on an annual basis with data from the period 2012-2019. All the ABSS are included in the analysis. The number of these has increased over the years, growing from 103 in 2012 to 105 in 2019. With respect to coverage and intensity, there are data on the number of people receiving the two types of HCS and the total number of hours for each ABSS from 2012 to 2019, itemised in groups according to age and gender.

On the basis of these data, the coverage of the service is defined as the percentage of the target population receiving the HCS, having established the target population as the total population of Catalonia, since the two types of HCS are available to all citizens. Additionally, data for people aged more than 65 are analysed (the law establishes coverage of 4% for this section of the population). The intensity of the HCS is defined as the average number of hours a week received by persons attended and it is measured as a fraction: total hours divided by the number of HCS recipients. In the same way, the measurements are at ABSS scale and they are taken for the social HCS, the dependency HCS and for both together.

Table 1. Variables of coverage and intensity of the service

Variables of coverage and intensity	Definition and measurement
Social HCS coverage	% of total population receiving the social/dependency HCS
Dependency HCS coverage	
Social HCS intensity	Number of hours a week of social/dependency HCS provided divided by the number of people covered
Dependency HCS intensity	

Source: Own elaboration.

Territorial variability factors

There are a number of different factors that can help us to understand the variability of the HCS from one ABSS to the next. On the one hand, there are factors of demand, that is to say, socio-demographic factors and factors linked with situations of social exclusion or inclusion that condition the need for the service. On the other hand, there are factors of supply – all those factors related with the provision and management of the HCS and other social services that complement or substitute these, in addition to local finances. All the factors are measured annually and for each ABSS. They are extracted from the following sources: Idescat (at municipal scale and by ABSS) and transparency portal and, in some cases such as the provision and management indicators, the source has been the Department of Social Rights itself.

With respect to the socio-demographic factors that may condition the demand for the service, people over the age of 65 have been included, in addition to people over the age of 75 who live alone, since this group is considered to be more likely to need the HCS. Furthermore, the percentage of the total population who have a disability has also been included, since these people are already included in the definition of dependency. In general, women have a longer life expectancy than men, and the majority of those requesting the HCS are women, so women aged over 65 from among the total population aged over 65 have also been considered. Finally, the migrant population from the Global South[3] has been included as the proxy of a group – migrants – who may be in need of the HCS, especially the social HCS, which is more focused on integration into the community environment.

Moreover, factors linked with situations of social exclusion or inclusion are included for all the population and, specifically, for children and adolescents who, a priori, should influence the use of the social HCS: when there is more social exclusion, there is a greater need for resources to assist with integration into the family and community environment. The variables included are part of the 19

[3] Idescat refers to the migrant population as ‘originating from developing countries’. Here, it has been deemed appropriate to use the terminology ‘migrant population from the global South’.

indicators that Idescat draws up at ABSS level related with the risk of social exclusion[4], such as the percentage of homes that receive rent and food subsidies, and – specifically for children and adolescents – the school attendance rate at 17 and case files on childhood risk. With respect to territory, the density of the ABSS in addition to the percentage of the population living in a mountainous area can have an influence on both the demand for the service and the supply that may exist, in the case of both the social and the dependency HCS.

With respect to provision factors, inclusion has been made of variables such as the existence of co-payment and the type of management, direct or indirect, which may affect the demand for both the social and the dependency HCS. Furthermore, other provision factors have been taken into account, such as the alternatives to the HCS, including resources offered to elderly people and people with a disability or functional diversity. Thus, inclusion is made of indicators on the existence of places and the percentage of elderly people or people with a disability in nursing homes and day centres, specialist care centres and occupational centres for people with a disability. Finally, consideration has been given to the financial situation of the local entity with three annual variables relating to the ABSS: total income, total expenditure calculated as the percentage of income allocated to the expenditure item of "social services and social promotion", and financial liabilities.

The econometric analysis made is non-causal and exploratory[5]. Due to the fact that there are ABSS that use the social and dependency HCS interchangeably, the same variables have been used for the two models. Our interest lies in understanding the relationship between the aforementioned supply and demand factors and HCS coverage and intensity. There is access to panel data, that is to say, data for the same units of observation (ABSS) that are repeated over time, to be specific, annually during the period 2012-2019, and our interest lies in explaining the variability between ABSS.

With a transversal approach, the evaluation also analyses, insofar as is possible, the degree to which a gender perspective is incorporated into its design and development (De Quintana, 2021). Thus, both in the qualitative field work and in

[4] See https://www.idescat.cat/pub/?id=intpobr&n=8234&m=m

[5] In addition, analyses have been performed to test the robustness of the results. The purpose of these is to observe whether, when variations are made in the analyses, the results are sustained, that is to say, whether they are robust. The final report of the evaluation includes details on the estimation methods and identification strategy: https://ivalua.cat/ca/avaluacio/afers-socials-i-desigualtats/servei-dajuda-domicili-sad.

the quantitative approach, variables and elements of analysis have been incorporated in order to consider gender inequalities and the response of the service. In this respect, and for many reasons (recipients, female workers in the service, carers, etc.), including the gender perspective in this evaluation is key to providing evidence that will contribute to making proposals for the improvement of this public policy.

3. ANALYSIS OF THE HOME CARE SERVICE AND PRINCIPAL EVALUATION RESULTS

In this section, we present the principal analyses from this study which seek to respond to the evaluation questions. First, the conceptual and discursive dimension of the policy is explored and its design and internal coherence are analysed. Next, an examination is made of the variability that occurs in the use of the HCS between different areas of Catalonia and the variability between types of HCS. Thus, the analysis highlights the inequalities resulting from the high degree of local variability in access to the service, its quality and the lack of a gender perspective in its design and implementation. It also emphasises the weakness of the social HCS, which entails a blurring of its functions, and this may lead to the exclusion of groups that might need home support.

3.1. Absence of clear objectives and a theory of change underpinning the policy

This first analysis focuses on the theoretical fundaments of the policy and the definition of the problem, and therefore seeks to respond to the first evaluation question about the coherence and justification of the policy. We start from the consideration that the conceptual design of the policy conditions the entire intervention process and it may help to explain its implementation and the variability that exists.

The HCS is a public policy that generates consensus and acceptance on account of its strategic importance and the objectives it pursues in a context of social changes and demographic transition. However, as transpires from the qualitative analysis, ultimately the objectives are not sufficiently developed and defined. As a member of a focus group observes: “The generic concept with which we are in agreement is to keep people in their homes. It is hereafter that the differences begin". In simplified form, different approaches to the HCS coexist, one that sees

the service as a basic civic right that must be guaranteed and protected, and another which accentuates a policy of efficiency and streamlining of resources. The following are the observations of two experts interviewed from the field of research and local social services management:

> "It is no longer home care. The name should be changed to a person's right to be able to stay in the environment in which they have always lived".

> "All the reflections on this subject should go deeper. Regarding the question of dependency, the HCS should be useful for dependent people who receive home care, until the cost of the HCS becomes so high that it would be more effective and efficient to transfer them to a residential centre. Up until a few years ago, this was the reading of the situation. Should the HCS reduce institutionalisation as much as possible? It appeared that from the directives received, which were few and poorly composed, this was the discourse".

Therefore, there are two conceptions of the HCS that inevitably lead to different decisions about resources and implementation. In the case of the first conception, the person's wish and right to remain (or not to remain) in their home prevails over any economic decisions; with the second, it is the cost of the home care service compared with the cost of institutionalising the person that impacts the supply of the HCS, as well as the sustainability of this service in the future. In these approaches, a certain lack of precision may be observed in the discourse behind the home care services, which is not clear about the purpose of the service or when it would be best to direct the person towards other resources involving residential centres.

This issue emerges in the focus groups, where it is emphasised that the problem is linked more closely with implementation and, above all, with having suitable resources. Despite there being agreement on this matter, one of the focus groups referred to the contradictions between the definition and the imprecise objectives of the HCS. Several group members spoke of the incoherencies between the aims of the HCS and the actions and resources assigned, especially in the case of the social HCS.

Thus, with respect to the general objectives of the HCS, it is considered that they create a broad consensus (for example, with regard to a future model that is more community-focused and which adapts to new profiles and complex situations)

and that the problem would lie in specifying the objectives in order to be able achieve them, monitor them and evaluate the policy. Particular attention is drawn to the incoherencies that occur between administrations and, as a local administration professional notes, perspectives that are not shared and difficulties when faced by challenges such as comprehensive care:

> "Perspectives are not shared by different administrations and may be contradictory. The HCS has to go hand in hand with health and the coordination of long-term care. Now we are redoubling efforts. If we were capable of greater coordination, there would not be a need for so many people visiting the homes of the elderly. For years we have heard that this change has to happen, but it has not materialised. There are positive experiences, but they draw on the good intentions of the professionals".

In short, the existence of 'parallel' frameworks of interpretation make it difficult to draw up a theory of change that is explicit and agreed upon, and without this, the distribution of resources and the prioritisation of different groups cannot be executed coherently throughout Catalonia. Thus, certain problems are identified, such as the lack of definition of the target population, especially in the case of the social HCS; the difficulties encountered by a service to adapt to situations and new profiles, with a high degree of complexity; and incorporating more preventative and proactive work. Faced by the lack of clear objectives, the local entities and ABSS respond according to their priorities, their perspective of the service, and the resources available.

In reality, the lack of definition of the HCS is, to a large extent, the result of the complexity of the policy in which many actors with a decision-making capacity and shared responsibilities intervene, and this complexity leads to a high degree of local variability. Indeed, in the interviews and debates conducted, the local entities consider that the Catalan government should have a more proactive role and establish a common framework reached by consensus for a strategic considered policy. The focus groups are in agreement in this respect:

> "The role of the Department is important, but we also demand autonomy: on occasions, the Department makes proposals and it does so timidly, because these matters fall under the competence of each municipal council. Here, there must be a minimum agreement and the possibility of reaching the region just as we need to, especially in the case of small municipalities".

> “There are elements in the way that the HCS is defined that lead to many differences between local councils: there is no generic framework established by the Catalan government and each local council has gone its own way”.

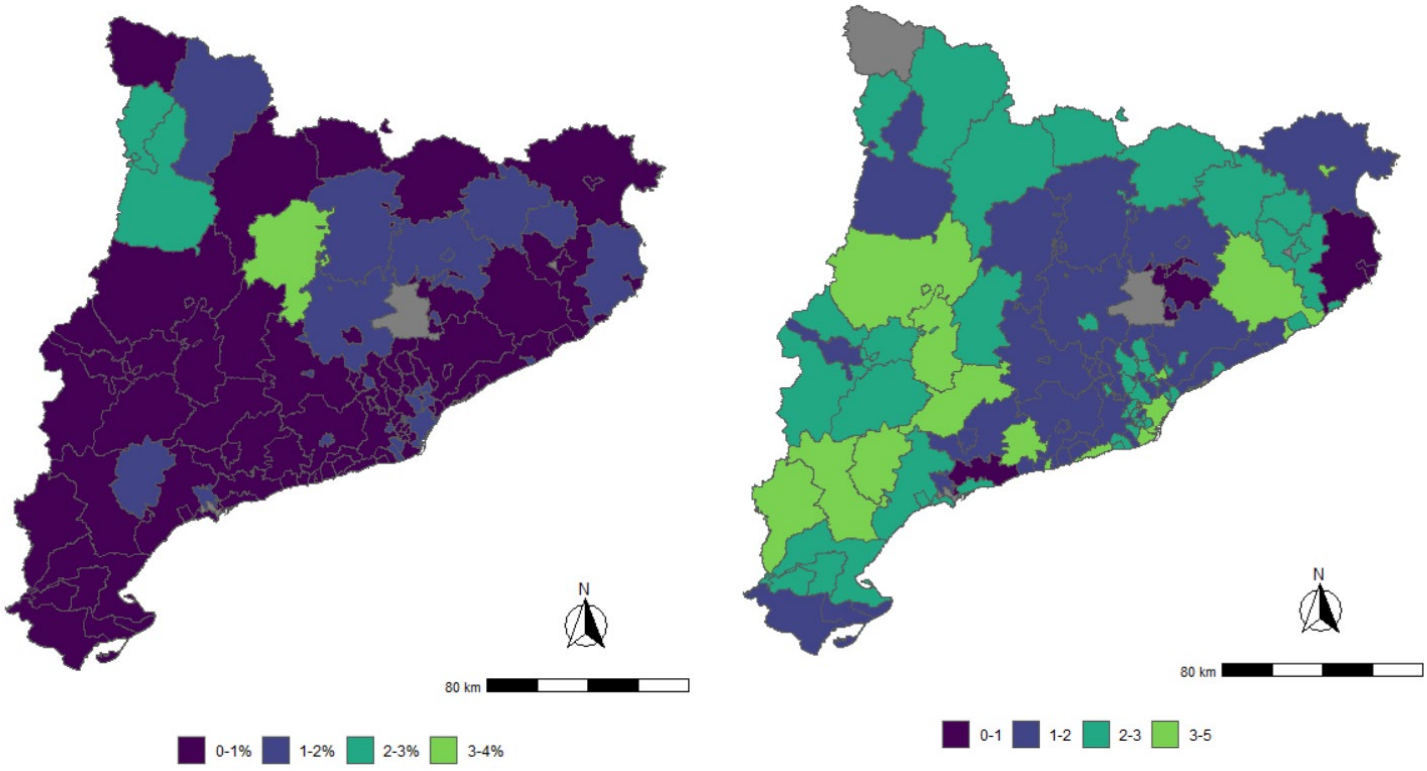
3.2. Territorial variability and inequalities

3.2.1. Magnitude of the variability

A first analysis reveals an uneven distribution of the coverage and intensity of the service. Overall, for both types of HCS, coverage reached a peak in 2016, one year after all the degrees established by the Dependency Law were incorporated. Nevertheless, whereas the dependency HCS has gradually increased since 2015, the opposite trend may be observed in the case of the social HCS, which has gradually decreased. With respect to the intensity of the service, the same pattern occurs; the intensity of the social HCS declines between 2015 and 2017 and recovers at the end of 2019. However, the average intensity of the dependency HCS – nearly 3 hours a week – is almost double that of the social HCS.

The relationship between the two variables – intensity and coverage – is fairly negative when they are applied to Catalonia, as the map shows. The ABSS with the highest coverage (these are situated in central Catalonia) are those with the lowest intensity of hours, and conversely, the ABSS with a higher intensity of service hours have a lower coverage (regions of Lleida, Tarragona and Penedès). However, there are some exceptions, such as the ABSS in Tarragonés, Vic, Palafrugell, Baix Empordà and the community of municipalities of la Plana, which show low coverage and intensity, whereas the Pyrenean region of Alta Ribagorça stands out for its high coverage and intensity.

Figure 2. Maps of ABSS according to coverage (percentage of population covered) and intensity (hours a week)



Source: Own elaboration

Furthermore, Law 12/2007 establishes that the HCS (without distinguishing between service types) should cover 4% of the population over 65. Data for 2012-2019 show that the average coverage is 3.48%, which comes close to this target. Nevertheless, only 32% of the ABSS exceed this threshold, representing 47% of the population over the age of 65. Regions that exceed 4% coverage include Alt Pirineu, Catalunya Central, Barcelona and Baix Empordà, while the regions of Lleida, Calafell, Baix Penedès, Blanes and Vall d'Aran have very low coverage. This diversity, also attributed to local autonomy, is confirmed by the interviews conducted with professionals working in local administration and the Catalan government:

> "There are municipalities in which the dependency HCS is focused more towards allowances linked with the service and the HCS budget

is allocated more to the social HCS. There are others in which the social HCS has a more residual role. There is a lack of uniformity".

"We don't know why a municipal council invests more hours and exceeds these and another council doesn't. There is a complete lack of knowledge, for no comparison and contrasting has taken place. It may be related to needs: due to the ratio of the population at risk, more resources must be assigned (…) or there may also be political factors. Some local councils always stick to the same budget and others increase and adjust it according to the needs".

3.2.2. Potential causes of the variability

There are various reasons for the variability described, which we will outline below. It should be noted that, here, the triangulation of quantitative and qualitative information has been key. While the quantitative analysis has thrown up some interesting correlations, the qualitative analysis has given us an in-depth understanding of what the numbers indicate. Therefore, the analysis is presented together in the paragraphs that follow.

Table 2 shows us that both the supply and the demand variables are of importance when seeking to explain the variability. In the case of demand, the most important factors are the percentage of people aged over 65 and the percentage of women. An increase of 1% in the percentage of people over the age of 65 is related with an increase in dependency HCS coverage of 8%. Although it does not particularly affect social HCS coverage, it does affect its intensity, since a 1% increase in this group is associated with an increase of 0.10 hours of care (some 6 minutes).

With respect to the percentage of women, this is associated with less coverage and intensity: a 1% increase in the number of women leads to a drop in intensity of approximately 0.26 hours (some 15 minutes). This result concurs with what HCS coordinators in different ABSS have to say about women that use the service, who are reluctant to be helped with cleaning, cooking and shopping for food, since they consider this *is not necessary* and that it is their duty as women to do these things. Furthermore, the coordinators interviewed observe that women around the age of 70 require a lower intensity of HCS use, given that they perform more domestic tasks on their own than men do in the same situation.

Table 2. Variability regression models: supply and demand factors

	Social HCS coverage (1)	Social HCS intensity (2)	Dependency HCS coverage (3)	Dependency HCS intensity (4)
Demographic factors				
% population over 65	0.027	**0.101*** **	**0.080*** **	0.048
	(0.031)	(0.034)	(0.029)	(0.033)
% population over 75 on their own	0.014	-0.005	-0.014	0.033
	(0.019)	(0.024)	(0.015)	(0.031)
% women	-0.052	-0.081	-0.075	**-0.259*** **
	(0.097)	(0.103)	(0.089)	(0.100)
% population born in developing countries	-0.027	-0.004	-0.020	-0.042
	(0.017)	(0.028)	(0.016)	(0.027)
% people with a disability	0.046	-0.077	-0.085	0.060
	(0.050)	(0.050)	(0.054)	(0.072)
Social exclusion/inclusion factors				
School attendance rate at 17	0.002	0.0003	-0.005	0.009
	(0.004)	(0.008)	(0.004)	(0.009)
% homes that receive rent assistance	0.014	-0.050	-0.025	0.022
	(0.046)	(0.047)	(0.042)	(0.067)
% popu. that receive food assistance	0.004	-0.022	-0.016	0.005
	(0.013)	(0.021)	(0.015)	(0.020)
Case files on childhood risk (per 1,000 inhabitants)	-0.003	0.007	**-0.007** **	**0.015****
	(0.004)	(0.007)	(0.003)	(0.007)
Territorial factors				
Population density	-0.014	0.052	0.067	**0.180***
	(0.092)	(0.098)	(0.071)	(0.107)
% population in a mountainous area	0.125	**-0.900***	1.061	-1.288
	(0.461)	(0.513)	(0.357)	(0.820)
City-ABSS	0.315	0.006	**0.669***	-0.080
	(0.308)	(0.401)	(0.266)	(0.433)

Supply factors				
	Social HCS coverage (1)	**Social HCS intensity (2)**	**Dependency HCS coverage (3)**	**Dependency HCS intensity (4)**
Soc. HCS co-payment, NO/YES	0.126	0.112	0.125	0.108
	(0.113)	(0.162)	(0.085)	(0.153)
Total indirect management	-0.011	**0.302***	0.003	**0.488****
	(0.092)	(0.169)	(0.197)	(0.198)
Partial indirect management	**0.174***	0.211	0.049	0.262
	(0.085)	(0.167)	(0.197)	(0.181)
Nursing home places, NO/YES	-0.077	0.420	**-0.671****	**1.108***
	(0.384)	(0.390)	(0.374)	(0.599)
Disability nursing home places, NO/YES	0.065	0.069	0.092	0.248
	(0.166)	(0.186)	(0.166)	(0.217)
Specialist disability centre places NO/YES	-0.007	0.111	0.127	-0.121
	(0.069)	(0.106)	(0.086)	(0.165)
Places in occupational centres for people with disabilities NO/YES	-0.171	-0.097	**-0.198***	-0.185
	(0.162)	(0.217)	(0.116)	(0.155)
Municipal income at ABSS level, log.	0.060	0.030	0.043	0.101
	(0.128)	(0.111)	(0.090)	(0.136)
% income on social expenditure	0.091	2.729	**31.07*****	-3.125
	(1.000)	(1.904)	(1.000)	(1.984)
Financial liabilities as % of income	-0.319	-0.081	-0.354	-0.944
	(0.398)	(0.812)	(0.366)	(1.098)
Time fixed effects	yes	yes	yes	yes
Constant	0.100	3.303	2.853	10.666**
	(4.707)	(4.564)	(4.459)	(4.832)
Observations	477	452	473	456
Adjusted R^2	0.104	0.025	0.404	0.041
Note 1: the following transformation has been made for the coefficients in columns 1 and 3: exp(beta) – 1, since the dependent variable is in logarithms (with the exception of when the independent variables are also in logarithms; then, transformation is not needed and the coefficient is interpreted directly as elasticity). Therefore, the interpretation of the coefficients in these columns is as follows: an increase of one unit (or 1%) in the specific factor leads to an increase in coverage of the value of the coefficient x 100.				
Note 2: the coefficients with asterisks are statistically relevant, so they are the ones of interest to us. The more asterisks there are, the greater the statistical relevance, and the more important the factor is in explaining the variability in coverage and intensity. More specifically, the asterisks correspond to probability values of 10% (*), 5% (**) and 1% (***). The probability values tell us the probability of the result being different from zero, if the particular factor is in fact irrelevant (i.e. zero) when regression is performed. Consequently, the smaller the probability, the better (since the result is more reliable).				

Source: Own elaboration.

With respect to the supply factors, the quantitative analysis gives greatest relevance to the existence of alternatives to the HCS for elderly people, local finances, type of management, co-payment and the area being mountainous.

As for the alternatives to the HCS, the existence of nursing homes and occupational centres is associated with an average decrease in the dependency HCS coverage (67% and 20%, respectively). Conversely, the existence of nursing homes is associated with an increase in the weekly intensity of approximately one hour. The interpretation of this result acknowledges a substitution effect at work between residential centres and the dependency HCS service, and therefore, when there are more residential centres, more HCS hours can be provided to people outside these centres. At the same time, the dependency HCS coverage is also affected by the percentage of income allocated to social expenditure, which suggests a prioritisation of this type of HCS.

Indirect management (be it total or partial) is the model in more than 84% of the ABSS (average for the period analysed) and it is generally related with greater coverage and intensity. In the case of the social HCS, the quantitative analysis shows that coverage increases by 17% and its intensity by some 20 minutes a week (0.30 hours), in comparison with directly managed ABSS[6]. In the case of the dependency HCS, indirect management is associated with an increase in its weekly intensity of 30 minutes (0.49 hours). The interviews confirm this positive relationship between outsourcing and an increase in users and hours:

> "In our experience, the situation changes considerably according to the management model: moving from direct to indirect management, there is an immediate increase in the hours provided and the number of users".

> “When we begin to consider the management involved [in the HCS], is it efficient on our part? Companies that provide the home care service are beginning to appear. At the outset, there were different stances. Having your own staff entails higher quality: if I know the people, I can give them guidelines and train the family workers. But management on the part of the public administration is very inefficient”.

However, this increase in efficiency has costs associated with it. A concern emerges over the loss of control of the service that this involves and the difficulties of indirect management in areas where people are more spread out, since there are few provider companies that are prepared to manage the service.

[6] Although the accuracy of the estimators is low, the magnitude of the coefficients is maintained in other specifications (contact the authors to see the results).

A professional in the Department of Social Rights who is a coordinator of the HCS observes:

> “It is important that the local entity does not let go of the service. (...) The company must act as your eyes to alert you, but the local entity is responsible for the service. If another service has to be found, the company will not do this, it is the local entity that does it. This is why coordination is so important. Some information systems that will make the work easier are also needed. (...) Data is key to our coordination efforts”.

This, in turn, affects the quality of the service. The diagnosis made of the working conditions is very negative, and among other concerns, reference is made to low salaries, part-time work, excessive rotation, the lack of support and specialist training, little curricular prestige, occupational risks and no generational handover, which is also connected with the type of management. Consequently, professionals in the local entities and ABSS highlight professional recognition and an improvement in the working conditions as two key issues to be addressed if a HCS of higher quality is to be achieved:

> "As time goes by, less is known [about the management of the HCS], because it has been outsourced for some time. The entire provision of the service is an unknown to us. And companies and multinationals have grown which provide the service with many misgivings, (…) [Up until the approval of the new procurement act of 2019] these companies had evolved in Catalonia (…) which are very strong, powerful and capable of securing contracts".

> "Not enough value is attached to the role of the family workers, who must be trained and recognised. Their role must be reappraised. You can't just leave a fragile person with anyone (…): skills, competencies and training are required. This person opens the door to us and gives us something truly precious: trust. We enter their lives and we have to go all out, adopting a person-centred approach".

> "We are best at attending to dependency and disabilities, but we have many difficulties with complex profiles: mental health, drug addiction..., much will depend on the professional profile of the carer".

The accuracy of the quantitative results is low with respect to territorial and co-payment factors, although they appear to indicate that there is inequality in access to the service, due to both the rural-urban binomial (the ABSS in mountainous areas show negative coefficients in the intensity of the HCS) and co-payment, the predominant model in the ABSS and an important factor in the qualitative analysis. The people interviewed say that the situation in rural areas is becoming worse because, when there are no resources for the elderly, the best service that can be offered is the HCS, especially in villages with a high proportion of old people and where the majority do not wish to go into a nursing home. In this respect, it is considered that the configuration of the HCS and its funding is not equitable, and that account should be taken of these costs and difficulties of movement associated with rural areas.

As for co-payment, which is commonly found in most of the ABSS, this may create situations in which the people who need the HCS look for an alternative private service, or they decide to request the benefit linked to the service in the case of the dependency HCS. This is particularly the case when a public service is offered that does not accommodate the needs of the users.

> "When a person goes private, they can decide who attends them, at what time, etc. When you have a public service, you cannot decide".

Therefore, the results of the quantitative and qualitative analyses suggest that the global variability reflects inequalities on three levels. First, inequality in access to the service, especially due to the existence of co-payment and less supply in mountainous areas. Secondly, inequality in the quality of the service, which is related with the type of management. The analysis suggests that the reason why the service is outsourced in most of the ABSS is efficiency, although the costs of this can be found in the loss of control and, eventually, a loss of quality. Thirdly, there is gender inequality. Taking an approach with a gender perspective, we find a policy that is "blind" to gender. The proportion of women is very high, both as workers and as recipients of the service (70% of beneficiaries are women). Therefore, they are particularly affected by the precarious employment conditions, and the existing gender roles can lead to women not accepting some services and support that they believe they must "do" on their own.

3.3. Weakness and blurring of social home care functions

The division of the service between the social side and dependency, and the absence of a legal framework in the social HCS that is as strong as the framework

in the dependency HCS has moved the social HCS away from objectives that are more preventative, community-focused and socio-educational, and on the other hand, it has become increasingly linked with the ageing process. This can be seen in the quantitative analysis, which shows, on the one hand, that the social exclusion factors and the factors related with the socio-educational function are not significantly related with the variability of the social HCS from one ABSS to the next, and on the other hand, that the demographic factors, such as ageing, do indeed account for its intensity.

At the same time, in order to satisfactorily perform the more preventative and community-focused work, it is necessary to be familiar with the needs and profiles of those to be attended. However, as transpires from the interviews and focus groups, there is little knowledge of these needs, and this hampers the work of the social HCS.

> "There are others we don't reach and they are in need: they are hungry, cold, they have very low pensions, and we are unaware of this. They have problems as a result of what they have experienced in their lives. These people come to social services in very extreme situations. More preventative work and sensitisation initiatives are called for".

> “We can become aware of their needs, but a deeper insight is required and their needs are not always covered in their entirety. Very often some support is needed in the home; there are basic situations involving the infrastructure of the house. Therefore, we need to prioritise and apply a global focus to need, not only with regard to basic things, but to the environment in which they live."

> "We should make a thorough analysis of the HCS hours that are needed: how many people in each area need the service. We don't have this information, particularly in the case of the social HCS. Nor do we have a set of regulations telling us how many hours of care each person should receive: we only have this in the case of dependency".

Ultimately, the social HCS is irregularly deployed across Catalonia in consonance with the intentions of each local entity, and in many cases it is used for profiles of people with a lack of autonomy who are excluded or who are waiting to access assistance through the Dependency Law. The weakness of the social HCS is

also reflected in the smaller volume of funding: the dependency HCS almost doubles the cost per hour of the social HCS.

4. CONCLUSIONS AND FINAL REFLECTIONS

At present, the long-term care sector finds itself at the centre of debate in a context of pressure and socio-demographic changes. The organisation of care and, specifically, the design and management of public policies are the focus of proposals to achieve higher-quality care and to successfully overcome situations of vulnerability and inequality. The aim of the evaluation of the HCS is to gain more knowledge of this policy, in order to improve it in the future and, at the same time, offer evidence and reflections that will contribute to this open debate.

As a result of this evaluation, certain reflections and recommendations are of particular note. An initial conclusion to be drawn from the study is widely shared: the need to establish some common basic criteria for organising the HCS throughout Catalonia, with the aim that situations of inequality in both access to the service and the quality of the care do not recur. This also requires improving the design of the policy and how it is conceived, defining the objectives of the policy based on a theory of change that would offer specific guidelines and more precise orientation. Moreover, in a broader sense, there is a need to better define what the care consists of and explore how a more community-focused, preventative and participative approach may be applied in the field of social policies. The planning of the HCS should also be more closely linked with other social services and, in particular, it should advance the development of comprehensive social and health care.

While following these recommendations for the planning of the service, future scenarios should be considered, evaluating the coverage and intensity of the service according to the needs and priorities of each area based on a common framework of action. At the same time, as transpires from the interviews and debates conducted, there is no question that an improvement in the quality of the service goes hand in hand with better professional working conditions. It is important to achieve a consensus on a clear conceptualisation of the HCS, so that the activities, professional profiles and resources can be better defined and it becomes easier to introduce community-focused and participative approaches.

One of the priorities detected in this evaluation is the need to obtain an up-to-date diagnosis of needs, with a strategic perspective in the medium and long term. The demographic transition manifested by the ageing population will put pressure

on the care system due both to the number of people and to the wider range of more complex profiles that must be attended to. Gaining greater knowledge of the target population and their circumstances would help to redefine the HCS, especially with respect to its social facets and the profiles requiring care, which are not solely linked with situations of dependency.

In order to gain a good insight into the reality of what is happening and the public policies themselves, it is essential to have high-quality sources of information. On the one hand, strategic planning of the data and the redesign of this data is required. On the other hand, further steps must be taken to interconnect data between administrations and services. In short, the evaluation of public policies needs useful and accurate information systems that facilitate institutional intelligence and decision-making (Varela Merino, 2023) and, in this respect, services like the HCS need to extend and reinforce their sources of information.

Finally, incorporating a gender and intersectional perspective into the evaluations remains a theoretical and methodological challenge, an issue that is also related with including every voice in the process of creating knowledge. This becomes even more important in the field of social policies, since many of the target groups are in situations which hinder their participation. For this reason, evaluations must employ sensitivity and inclusiveness in articulating participation in this entire process, not least of those who use and receive the policies, establishing the most appropriate techniques and methods and innovating methodologies when this is necessary. In cases like the home care service, it is a challenge to rethink participation and the creation of knowledge while including people and groups in situations of vulnerability, and to continue to explore the possible effects of these public policies with a view to achieving greater social and gender equity.

METHODOLOGICAL ANNEX

The analysis of the Home Care Service has employed mixed quantitative and qualitative methods, in order to provide a more robust and rigorous response to the evaluation questions.

The **qualitative analysis** considered various sources of information: first, baseline studies on public policy, in addition to administrative documents. Secondly, exploratory semi-structured interviews were conducted with the aim of establishing the principal concepts and ideas linked with the service and gaining a temporal perspective of the long-range policy. People with responsibility in local entities and in the Catalan government were interviewed, in addition to an expert in the field of research. These systemic interviews also helped to identify other key informants and baseline experiences. Thirdly, based on the results of these first interviews, semi-structured scripts were drawn up for in-depth interviews with key policy informants: professionals working in local entities and the Catalan government with responsibility for the HCS.

Finally, two focus groups were organised for the purpose of gathering information and assessments from key figures with regard to the operation of the HCS, possible difficulties in its implementation, and proposals for improvement or change in the future. In addition to obtaining valuable qualitative information, the aim of the focus group was to contrast ideas and information from the various agents and, specifically, the main conclusions of the quantitative analysis. This contrasting has proved to be very important for understanding certain dynamics and causal relationships which emerged as significant in the quantitative analysis.

The focus groups were organised and defined in three stages:

a) Design: Two focus groups were set up to discuss the Home Care Service composed of 6-8 people chosen on the basis of criteria for obtaining a wide-ranging ABSS sample.
b) Formation and functioning of the group: After making prior contacts, two focus groups were established, with discussion to last one and half hours in each case. The groups were guided using an open script with the aim of contrasting the principal lines of research. Some of the most relevant results of the quantitative analysis were shown, in order to contrast their possible validity and find explanatory factors.

c) Analysis and interpretation of the results: transcriptions were made of the focus group discussions, and the information was organised by themes and according to the agreement or disagreement with which the key subjects were met.

As for the selection criteria for the participants in the focus groups, it was decided to organise two groups according to the population size of the Basic Social Services Areas. The provision of the HCS shows distinctive features depending on the characteristics of the municipality, in particular, the size of the population. One of the criteria for organising the focus groups was the population in the ABSS and the municipalities or municipality within these areas, and secondly, other variables were included to make as wide-ranging a selection as possible: basically, intensity and coverage of the HCS, while also taking account of other socio-demographic variables such as the age of the population. The first focus group was made up of small municipalities, and therefore these were all located in rural or mountainous areas with a low population density. The second focus group comprised large and medium-sized municipalities of differing characteristics.

The participants in the focus groups were ABSS coordinators with a range of job titles (HCS coordinator, head of social services, technical director or manager). In total, there are 105 ABSS and a very high ratio of women manage these, 83%, since only 18 are managed by men. 14 people – 13 women and 1 man – from local entities took part in the focus groups.

In total, 8 in-depth interviews were conducted between October and December 2021, and 2 focus groups met in January 2022, in which a total of 14 people participated. The program Atlas.ti was used to process the qualitative data, and the information was coded by subject areas related with the evaluation questions.

As for the **quantitative analysis**, the references have been the coverage and intensity variables of both types of home care service, and the socio-demographic, service and contextual data of the local entities which might explain the territorial variability of the HCS. So variables were collected – wherever possible, always at ABSS scale – which were linked with demand factors and supply factors, and the statistical program R was used to analyse these. All the factors were measured annually and for each ABSS.

The descriptives of the dependent variables are presented hereunder:

Variable	Definition	N	Mean	Standard deviation
% Social HCS coverage	% of total population receiving the social/dependency HCS	732	0.45	0.49
% Dependency HCS coverage		716	0.36	0.23
% HCS coverage in the over 65 age group	% of the over 65 age group who are social/dependency HCS recipients	801	3.48	2.14
Weekly Social HCS intensity (hours)	Number of hours of social/dependency HCS provision divided by the number of persons covered	681	1.61	0.85
Weekly Dependency HCS intensity (hours)		679	2.91	0.92

And these are the descriptives of the independent variables:

Variable	Definition	N	Mean	Standard deviation
Population aged 65 or more	Population aged 65 or more as a percentage of total population	831	17.56	3.16
Population aged 75 or more living alone	Population aged 75 or more and living alone as a percentage of total population	824	27.44	4.04
Women over 65	Women over 65 as a percentage of total population over 65	831	50.02	1.06
People with a disability	People with a disability as a percentage of total population	671	6.69	1.73
Immigration	People born in developing countries as a percentage of total population	824	11.64	5.25
Educational level	Population aged 17 at school according to place of residence, as a percentage of total population aged 17	824	81.75	7.21
Rent subsidies	Number of homes receiving a rent subsidy as a ratio of total homes	831	1.63	1.18
Food subsidies	Number of people receiving a food subsidy as a ratio of total population	824	3.88	2.70
Case files on childhood and adolescent risk	Number of case files on childhood and adolescent risk per 10,000 inhabitants	831	6.27	4.27
Co-payment	Existence of co-payment, NO/YES	812	0.72	0.45
Density	Population per km^2	831	2,544	4,007

Variable	Definition	N	Mean	Standard deviation
Mountainous area	% population in the ABSS living in a mountainous area	831	0.03	0.13
Nursing homes for the elderly	existence of places in nursing homes for the elderly, NO/YES	831	0.99	0.10
Day centres for the elderly	existence of places in day centres for the elderly, NO/YES	831	1.00	0.00
Residential centres or homes for people with a disability	existence of places in residential centres or homes for people with a disability, NO/YES	831	0.41	0.49
Specialist care centres for people with a disability (daytime)	existence of places in specialist care centres for people with a disability, NO/YES	831	0.33	0.47
Occupational centres for people with a disability	existence of places in occupational centres for people with a disability, NO/YES	831	0.75	0.43
Total income	Total income of the ABSS, in millions of euros	831	88.32	251.13
Social expenditure	% of income allocated to the expenditure item “social service and social promotion”	830	0.06	0.03
Financial liabilities	Financial liabilities as % of total income	825	0.10	0.05

The type of management of the service in the Basic Social Services Areas, outsourced or direct, according to the average in the period analysed (2012-2019):

Type of management	Percentage
Direct	8%
Total indirect	44%
Partial indirect	40%
No data available	8%
Total	**100%**

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