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The diversity of care for elderly people with functional dependency in Barcelona

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There is an ever greater proportion of older people of advanced years and with functional dependency in Barcelona. The aim of this study is to analyse their characteristics and the established forms of care according to the different profiles. Data collected in the Barcelona Survey of People with Functional Dependency (EPSD) carried out in 2018 was used to do so. The results show that there are certain inequalities depending on individual characteristics (degree of dependency, gender and age), characteristics of the carers (an extremely feminised sector), characteristics of the household (forms of co-habitation and levels of income) and territorial characteristics (according to the income status of the neighbourhood). The results reveal a scenario that is far from ideal, requiring the serious consideration of public decision-makers with the aim of broadening the provision of services and benefits for this group.

Introduction

One of the major challenges facing advanced societies in the 21st century is how to manage the growing proportion of elderly people and the resulting increase in the number of people with functional dependency. In the last few decades, the pace of this process has accelerated in developed countries and the city of Barcelona is no exception. In 2018, 21.6% of the total population were aged 65 years and over and the proportion of the population aged 75 years and over is larger than the proportion aged between 65 and 74 years at 11.4% and 10.2%, respectively.

The dependency status is based on the activities that a person is unable to do or has difficulty doing and which, therefore, require some form of help to perform (Rogero, 2010). There are a number of aspects in which a person may find themselves with limited capabilities (psychological, social and physical), requiring the help of a third party to be able to perform various everyday activities in a normal way (Gázquez *et al.*, 2007). Dependency for reasons of health mainly affects older people, so ageing is one of the most relevant factors to determine the care needs of a population. The probability of a person becoming functionally dependent increases in line with age. According to data from the Department of Work, Social affairs and Families of the Government of Catalonia, 8.2% of the population of Barcelona had a legally recognised disability in 2016. The prevalence in the population under 16 years of age was 1.5%; in the age group 16-44 years it was 2.9%, in the age group 45 to 64 years the percentage was above the city average at 10.3%; in the

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age group 65-74 years it was 16.9%; and in the over-74s it was 21.5% Hence, according to an estimate by Cabrero and Cordoniú (2002), 90% of the volume of health and social resources consumed is usually concentrated in the last seven or eight years of life for those who become functionally dependent.

This scenario is a primary social, economic and political challenge on which a large part of the structure of our welfare state depends. The care and welfare of the growing population of elderly people with functional dependency is one of the major challenges for public administrations. The actions taken in this regard have and will have huge repercussions on the quality of life of those with functional dependency and their families, who will be forced to varying degrees to take charge of the care required (in terms of time and money).

Despite the alarm caused by this phenomenon, the outlook is not all bleak. Changes and advances in biomedicine, technologies, mobility and so on are being made in parallel to these demographic changes which are neutralising the increase and impact of dependency among the elderly population. Some authors report that the effect of a longer life expectancy is not so much reflected in an increase in the number of years of life spent in a situation of dependency as a delay in the age when problems and the need for help arises (Sarasa and Mestres, 2007). According to Mathers *et al.* (2015) there is a positive correlation between the increase in life expectancy and the increase in the number of years lived in good health.

This study is presented in this context of the new (and already present) social risks linked to demographic change, increased population ageing and growing numbers of people with functional dependency. It is an analysis of the characteristics of elderly people with functional dependency in Barcelona, the degree to which their needs are being met, and existing types of care and associated factors[3].

1. Factors associated with the type of care received by people with functional dependency.
People with functional dependency are not a homogeneous group. Beyond the existing association between age and the risk of being functionally dependent or not[4], this is a diverse group made up of people with FD and families and cohabitants with different socio-economic and demographic profiles. These characteristics can influence the forms of care received by people with functional dependency. Generally, three forms of care that tend not to be mutually exclusive can be identified. This group can be provided with care by family members or friends (either living with them or not), which is usually an unpaid occupation, despite the 2006 Dependency Law allowing non-professional care workers to receive remuneration for their commitment. Then there are the people who are in a financial position to access the private market and hire paid care services. This employment relationship can either be a formal one (the carer is registered with the social security system by the person or company paying them) or an informal one (paid employment without a contract). Last, people with functional dependency can be cared for by the public care services provided in each territory (in Barcelona the main service provider is the Home Care Service, SAD).

Different factors are at play in determining which care option, or combination of options, is chosen such as the characteristics of the person with functional dependency, the type of dependency, age (Gázquez *et al.*, 2011), gender (Kramer and Kipnis, 1995; Adams *et al.*, 2002) and ethnicity (Adams *et al.*, 2002). Other factors are the characteristics of the forms of cohabitation, family structures and the family or social support network, in addition to the available resources the family has for this end.

Types of care can also be conditioned by personal choices shaped by socialisation processes, the options offered by the official care system (public or private) and the degree of access the family has to these services. The welfare states in southern Europe is characterised by high levels of

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3 These studies do not include people with functional dependencies living in residences.
4. The number of people in Barcelona recognised as dependent was approximately 65,000 in 2018, 85% of which were 65 years old or over.

“familism” in terms of care responsibilities (Díe Olmos, Fantova and Mota, 2014). The public services provided and policies around care and dependency in these countries are usually less generous and comprehensive than in other European countries, meaning that families more often take on this responsibility. This circumstance cannot be taken out of the context of the cultural inheritance of this society in terms of who (the state or the family) should take responsibility for dependent people. As some studies have shown, a large proportion of the Spanish population still considers that it is the family’s duty to care for its members. According to data provided by the CIS on the attitudes and beliefs of Spanish people regarding who should care for dependent people (including elderly people, disabled people and people with a chronic illness) who cannot do basic everyday activities (going to the toilet, showering or dressing themselves) without assistance, more than half of those surveyed believed that the best option to organise this care is for the person to live with a family member, while approximately a fifth thought that they should live in a residential centre or home, and another fifth that they should live with a paid carer (CIS n.º 3009, 2014). Furthermore, a huge majority of the Spanish population agree or strongly agree that offspring have a duty to care for ill parents (90.5%), a figure that is much higher than in countries with continental and liberal welfare models (Germany 65.9% and the UK 41.9%, respectively), and considerably higher than in Scandinavian countries (Denmark, 25%)[5].

Nonetheless, irrespective of people’s beliefs, the evidence shows that the economic and human resources dependent people have at their disposal are fundamental to understanding forms of care. Some studies have shown that, depending on the economic level of the household, dependent people have a greater or lesser probability of being cared for by someone other than a family member (Kemper, 1992; Ayuso *et al.*, 2010). Other authors affirm that being cared for or not by family members or close acquaintances (neighbours, friends, etc.) varies depending on the network of family and friends the person with functional dependency has. Rogero (2009) reports that married people with functional dependency are more likely to receive care from the social services in an official setting due to the fact that their spouse acts as the link between the elderly person and the public system. Therefore, the presence or absence of support networks influences the choice of different care strategies. The paradigmatic case is a person with functional dependency living alone who is less likely to receive care from a family member (Rogero, 2009). However, it must also be kept in mind that care strategies depend to a large extent on the evolution of the existing public policies and services in the territories. The behaviour of both the elderly people in need of assistance and the family members who can take decisions about their care can vary depending on the public services offered, and irrespective of their own resources. However, as Eichler and Pfau-Effinger (2009) point out, elderly people may not take advantage of the “new” public care policies and services due to their tendency towards traditional forms of care based on family support. According to the authors, the main reason for this phenomenon is that elderly people and their families behave more in line with traditional care values in which priority is given to mutual support between spouses and their descendants. The second reason is that there are certain differences between the type of care a public service and a family can provide, making the option of family care more attractive for elderly people and their families.

The Survey of People with Functional Dependency (ESPD) was conducted in Barcelona in 2018 with the aim of understanding more fully the situation of people with functional dependency in the city and the associated factors that can influence opting for one care strategy or another. In the following section, we introduce the main features of this survey, and in the subsequent sections we present the results of the analysis focusing on the elderly people with functional dependency (FD) in Barcelona.

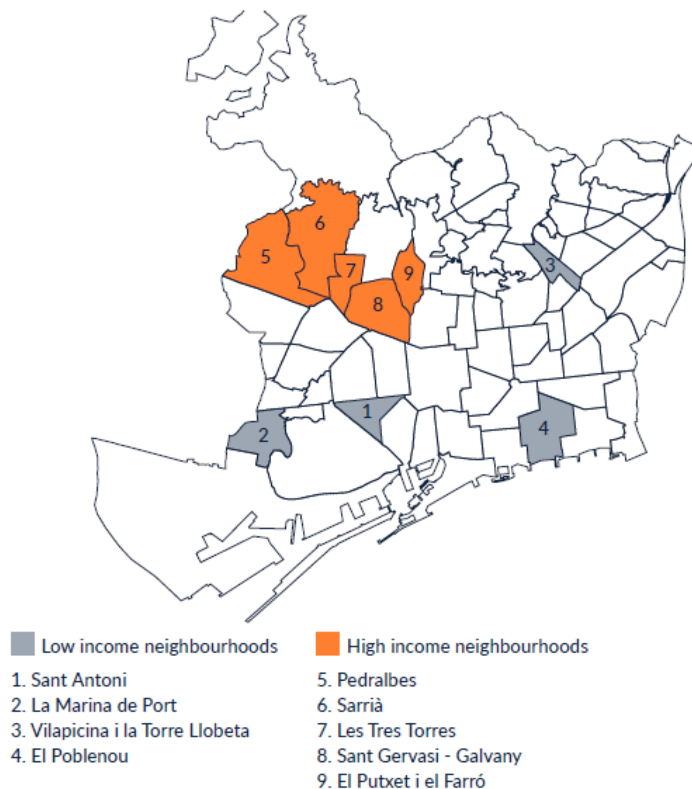
2. Barcelona Survey of People with Functional Dependency 2018 (EPSD2018)

The Barcelona ESPD2018 is a survey addressed at people recognised as being functionally dependent. These can be users of the municipal Home Care Service (SAD) or people that receive economic benefits rather than the service (recognised under Law 39/2006). Neither the economic benefits nor the SAD make distinctions based on economic circumstances. In other words, neither

5. Data from the European Values Survey, 2008.

the quantity nor co-payment of the service is determined by the financial situation of the dependent person. However, they do depend on the degree of dependency recognised by the public administration. The sample is comprised of 613 subjects representative of both the low income neighbourhoods (four neighbourhoods with an average level of 84.3 points on the RFD (per capita disposable family income) index[6]) and the high income neighbourhoods (five neighbourhoods with an average RFD level of 199 points). The sample group of older people (55 years and over) represented 88.6% of the initial sample (n = 543; 74.6% women and 25.4% men). Thirteen cases were lost with the set of variables used in the different models, leaving a final sample of 530 individuals aged 55 years and over. This sample was comprised of 36.8% SAD users in low income neighbourhoods; 28.9% again from low income neighbourhoods who received economic benefits (CNP); 19.2% SAD users in high income neighbourhoods; and 15.1% again from high income neighbourhoods who received economic benefits. Regarding the degree of dependency, 42.2% of the people with FD had a recognised grade I dependency; 33.1% had grade II; 12% grade III; and 12.7% were still waiting to be assessed and assigned a grade, but were nonetheless already entitled to SAD or benefits.

Figure 1. Neighbourhoods included in the study



3. Profiles and forms of cohabitation among the elderly people with functional dependency

The data obtained from the ESPD2018 clearly show that the people with FD have different socio-economic and demographic profiles and varying degrees of dependency. To this effect, analysing this population in an aggregated way is not recommended. Taking these differences into account, some clear prevalences can be observed. The most frequent profile of a person with FD in Barcelona is usually a woman aged between 75 and 89 years with a dependency somewhere between grades I and II (Table 1).

6. The disposable family income index (RFD) estimates the average income or the economic capacity of Barcelona residents based on a series of indicators that enables a number to be assigned in relation to the average for the city, which is 100 (Calvo, 2007).

Table 1. Characteristics of the sample

	N	%
Typology		
SAD low income neighbourhoods	200	36.8
CNP low income neighbourhoods	157	28.9
SAD high income neighbourhoods	104	19.2
CNP high income neighbourhoods	82	15.1
Degree of dependency		
Grade I	229	42.2
Grade II	180	33.1
Grade III	65	12.0
Not recognised/NC	69	12.7
Gender of the person with FD		
Men	138	25.4
Women	405	74.6
Age		
55-74	102	18.8
75- 89	281	51.7
90 or over	160	29.5
Nationality of the person with FD		
Spanish	538	99.1
Foreign origin	5	0.9

Source: Compiled from the EPSD2018.
Functional dependency (FD) and non professional care (CNP).

One of the most important elements to understand the life circumstances of elderly people, and especially people with FD, is their cohabitation status. The support network and needs coverage to which people with some level of dependency can have access depends largely on whether or not they live with other people, and mainly family members[7]. Elderly people with FD usually have limited autonomy and often need help doing everyday tasks. People who do not have this help because they live alone are not only more unlikely to have their needs met, but their situation can also have a detrimental effect on their mental health due to an increased feeling of loneliness (Dean *et al.*, 1992). According to ESPD2018 data, 37.4% of people with FD who live alone have felt excluded from their immediate environment or have lacked company in the previous twelve months. Furthermore, according to the Duke-UNC-11 Functional Social Support Questionnaire (FSSQ)[8], people with FD who live alone are more likely to have low levels of social support (22.7%) than people who live with other people (6.6%).

7. 68.2 % of the people with FD live with a family member. The most frequent profile is people who live with a husband/wife/partner (31.3 %), followed by those who live with a son or daughter (28.4 %).
8. The Duke-UNC-11 Functional Social Support Index (Broadhead *et al.,* 1988; Spanish edition in Bellón *et al.,* 1996) is based on a battery of eleven questions that use a Likert scale (from 1 = "much less than I would like" al 5 = "as much as I would like") to measure the degree of social support perceived in relative terms, of belonging to a communicative and affective group . In the final scale of 11 to 55 points, it is determined that low self-perceived social support is indicated below 24 points.

More than a quarter of the elderly people with FD analysed in Barcelona live alone (Table 2). There were no significant differences in terms of age groups and the different groups of neighbourhoods according to income. However, a certain association was observed between gender and not living with other people. Given that women have a longer life expectancy than their male partners and can therefore become widowed, the number of women who live alone is almost double the number of men in the same circumstance. Furthermore, the data show a very clear association between the cohabitation situation and the fact of being SAD users or not. 44.7% of the SAD users analysed live alone.

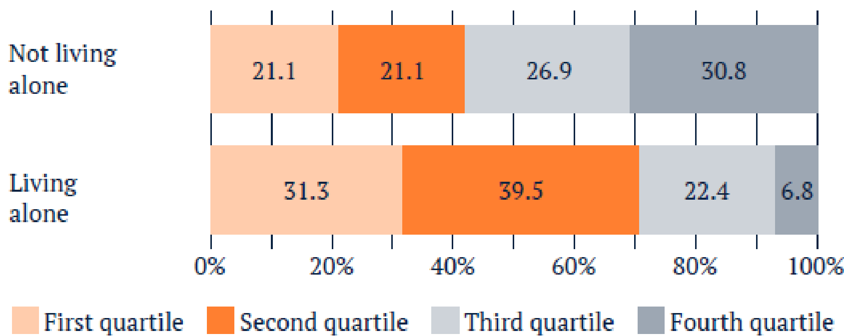
Table 2. Elderly people with FD living alone

	Living alone (%)
Total	27.6
Typology	
SAD	44.7
CNP	5.9
Neighbourhoods according to income	
Low income	27.7
High income	27.4
Gender of the person with FD	
Men	17.4
Women	31.1
Age groups	
55-74	26.5
75-89	29.5
90 or over	25.0

Source: Compiled from the EPSD2018.

There is a certain association between forms of cohabitation and the economic situation of the families. The number of people that make up a family unit is decisive in understanding their potential economic capacity. Households made up of fewer actively employed people (or more economically dependent people) are usually more likely to have lower incomes due to their reduced capacity to obtain income from the labour market. This phenomenon is given in certain cases. This association is found in households with elderly people with FD, mainly by means of the old age pensions. Of the people who live alone, there is a greater proportion with low incomes than with high incomes. According to the ESPD2018, only 6.8% of the people with FD who live alone are in the fourth income quartile (in other words, they have over 1,600 euros per month), while 70.7% are in the first two quartiles (below 1,065 euros per month). However, 30.8% of households made up of more than one person are in the fourth quartile and 42.2% are in the two lowest quartiles (Graph 1).

Graph 1. Percentage of elderly people with FD in the different income quartiles according to whether they live alone or with other people



Source: Compiled from the EPSD2018.

The first quartile is made up of households with an average income of less than 745 €/month; the second quartile between 745 and 1.065 €/month; the third quartile between 1.065 and 1.600 €/month; and the fourth quartile more than 1.600 €/month.

The relevance of income in households with elderly people with FD underlines the fact that, like in other households, income largely determines the purchasing power and life conditions of its members and, in a specific way, has a large influence on access to the different forms of care and the strategies set out for meeting the different levels of needs. The following section explains the associations produced in the different income profiles with forms of care, and due to other characteristics of the elderly people with FD in Barcelona.

4. Care strategies

The types of care people with FD receive depend on their individual characteristics (age, gender, degree of dependency), household characteristics (income and type of cohabitation), and even on the area where they live. The data show that elderly men with FD usually have more support from a family member (75.4%) than women (59%). On the other hand, women usually receive more help from the municipal social services (Table 3) As already pointed out, this difference is partly explained by women being at greater risk of living alone than men and, as can be seen in Table 4, by the very low proportion of people living alone having family support (just 10%).

The profile of the main carer depends largely on the cohabitation and economic situations of the people with FD and their family members. For 56.9%, the main carer is a family member; for 21.9% it is a paid carer (with or without a contract); and for 17.4% it is a person from the home help service provided by Barcelona City Council. It is basically people living alone with little or no family support whose main carer is a SAD employee.

The degree of dependency is closely linked with the type of support a person with FD receives. The data show that a larger proportion of people with a higher degree of dependency tend to have family support. To this effect, those with a grade II or grade III dependency are 15% higher likely to have family support than those with a grade I dependency, while those with a grade I dependency are more likely to receive municipal social services care and support. Barring public services support, the rationale behind the data is that the higher the degree of dependency (which implies higher levels of everyday basic needs) the higher the proportion of support and care of all types the person receives (Table 3).

As mentioned previously, household income has an important direct effect on access to the different care options, given that it determines whether or not a person is able to access the official or unofficial care market. The ESPD2018 data confirm this hypothesis (Table 4) A higher percentage of people with FD living in higher income households have an unofficially paid carer (28.9% for families in the fourth quartile) or an officially paid carer (39.5% if we consider carers hired with or without provision under the Dependency Law and carers from private companies) than those with a lower income (the figures for the first quartile are 13.4% of people with FD with

unofficial carers and 19.7% with official carers). Although the cost of carers is sometimes met by members of the family who do not live with the person with FD, the relationship between the household income of the dependent person and the types of care is significant.

Table 3. Typology of carers according to the characteristics of the people with FD. their household and the neighbourhood where they live (%)

		Gender of the person with FD				Grade of dependency		
	Total	Men	Woman	SAD	CNP	I	II	III
Family	63.2	75.4	59.0	47.0	83.7	59.8	75.0	75.4
City Council Social Services Employee	48.8	42.0	51.1	86.2	1.3	54.6	36.1	21.5
Hired carer (with provision under the Dependency law)	8.3	5.8	9.1	2.0	16.3	5.2	12.2	16.9
Hired carer (without provision under the Dependency Law)	7.9	9.4	7.4	9.2	6.3	5.2	8.9	15.4
Unofficially paid carer	19.0	19.6	18.8	15.1	23.8	19.7	17.2	30.8
Carer from a private services or health company	6.6	3.6	7.7	7.6	5.4	6.1	7.8	7.7
Third sector volunteers (Cáritas, Amics de la Gent Gran)	1.1	1.4	1.0	1.0	1.3	0.4	1.7	1.5
Friend/neighbour (unpaid)	9.4	11.6	8.6	7.6	11.7	7.0	13.9	9.2
Others	1.7	2.9	1.2	1.3	2.1	1.7	1.1	3.1
No support	2.4	2.2	2.5	3.0	1.7	3.9	0.6	1.5

Source: Compiled from the EPSD2018
The columns add up to more than 100% because people can receive more than one type of support of different kinds

Table 4. Typology of carers according to characteristics of the household and the neighbourhood where the person with FD lives (%)

	Household income (quartiles)				Cohabitation			
	I	II	III	IV	Living alone	Living with other people	Low income neighbourhoods	High income neighbourhoods
Family	54.3	53.2	66.2	80.5	10.0	83.5	65.3	59.1
City Council Social Services Employee	60.6	57.6	49.3	28.9	76.7	38.2	52.7	41.4
Hired carer (with provision under the Dependency law)	5.5	2.2	8.8	17.2	2.7	10.4	7.6	9.7
Hired carer (without provision under the Dependency Law)	8.7	8.6	8.1	7.0	8.7	7.6	9.0	5.9
Unofficially paid carer	13.4	13.7	19.1	28.9	14.0	20.9	14.6	27.4
Carer from a private services or health company	5.5	4.3	4.4	11.7	5.3	7.1	1.4	16.7
Third sector volunteers (Cáritas, Amics de la Gent Gran)	0.0	0.7	2.2	1.6	0.7	1.3	0.6	2.2
Friend/neighbour (unpaid)	9.4	13.7	8.1	6.3	6.7	10.4	11.5	5.4
Others	3.1	0.7	0.0	3.1	1.3	1.8	2.0	1.1
No support	2.4	4.3	2.9	0.0	6.0	1.0	2.2	2.7

Source: Compiled from the EPSD2018
The columns add up to more than 100% because people can receive more than one type of support of different kinds

Another factor that can influence the type of care people with FD receive that has received less attention in previous studies is the influence of the territory. While some studies show the differences between the patterns and types of care received in rural and urban territories in other contexts (Herlitz, 1997), few have analysed the possible differences there may be within the same urban environment in what is supposed to be a blanket offer of public care services for dependent persons. There can be significant internal differences among the various urban territories which are not detected in aggregated care analyses. The large cities can have very unequal territories both because of their physical characteristics, urban design, communications (such as public transport), and so on, and because of other differences rooted in the profile of the population who live there, which can influence behaviour around the care of their residents.

Moreover, the different city resident profiles in the various neighbourhoods can affect their social capital, support networks and behaviour regarding their use of social services. Some indicators show that the use or not of social services by potential beneficiaries may be down to the

neighbourhood and local community to which people belong. People with similar socio-economic profiles can make different use of some public services due to the possible associated level of stigma in each territory. This phenomenon can be more apparent depending on the type of neighbourhood and the social profiles of the people in one's immediate surroundings. For example, according to data provided by Barcelona City Council, there is a negative correlation between the RFD level of each neighbourhood and the degree of cover of the population identified as vulnerable both in terms of requesting benefits for minors in their care (Blasco and Todeschini, 2019) and the number of social services cases open concerning coverage of basic needs (based on data from Barcelona City Council Social Services) In other words, there are indications that in higher income neighbourhoods, people who are economically vulnerable tend to request fewer services and less municipal public support than people with the same profile living in lower income neighbourhoods.

Under this premise, Graph 2 shows that elderly people with FD living in higher income neighbourhoods are less likely to use the home help public services offered by Barcelona City Council[9], irrespective of the level of income of the households with people with FD. In fact, elderly people with FD living in Barcelona's high income neighbourhoods are 32% less likely to be SAD users than residents in areas with predominantly low incomes.

Graph 2. Probability of being a SAD user according to the type of neighbourhood

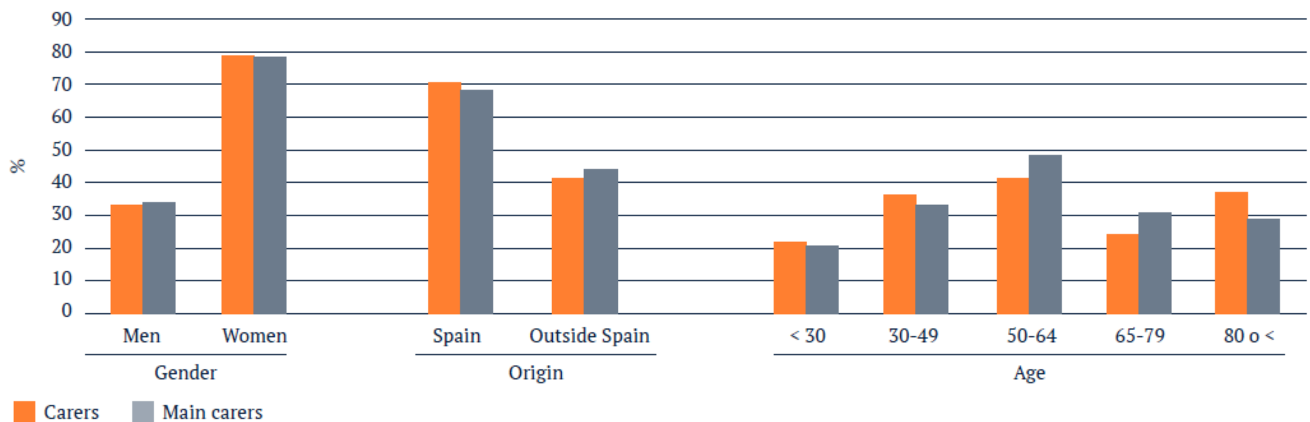
Source: Compiled from the EPSD2018.

5. Carer profiles

Some studies have shown that the action of caregiving has certain positive effects on the carers themselves (Nolan *et al.*, 1996), but there are a much greater number of studies that provide evidence of its potential negative effects (Larrañaga *et al.*, 2008). Some groups or social profiles may be more forced to take responsibility for this type of task, which represents a hugely important social inequality. Moreover, it is a specially significant sphere in terms of gender inequality. The data show that women account for almost 80% of the carers of elderly people with FD, and a similar percentage are these people's main carer (Graph 3).

9. The results of these probabilities are based on logistic regression models based on other variables such as household income, forms of cohabitation, degree of dependency, and the gender and age of the person with FD. The results are statistically significant ($p < 0.01$).

Graph 3. Characteristics of the carers and main carers of people with FD (%)



Source: Compiled from the EPSD2018.

As indicated in the previous section, there are unofficial (unpaid) and official carers. To this effect, both unofficial and official care is still basically a role carried out by women. In the group of paid carers the proportion of women is over 90%. It is basically a very feminised sector with a large proportion of people born outside Spain. More than 75% of the paid carers (both those paid officially and unofficially) were born in other countries, and approximately 50% of the public municipal employees were also of foreign origin.

Contrary to the situation with paid carers, the gender gap narrows if family carers are taken into account. The difference between men and women family carers is 13 percentage points. To this effect, the most frequent profiles of family carers of elderly people with FD are usually daughters (32%), male partners/husbands (21.2%), female partners/wives (19.2%), sons (18.2%) and mothers (13.5%).

Elderly people with FD can have more than one family carer. The responsibility undertaken by carers is not always the same, and it is worth taking into consideration who the person with the most responsibility is. The data show that the gender gap widens when the main family carer is taken into account. In this case, the difference between men and women widens to 31 percentage points (34.7% and 65.3%, respectively).

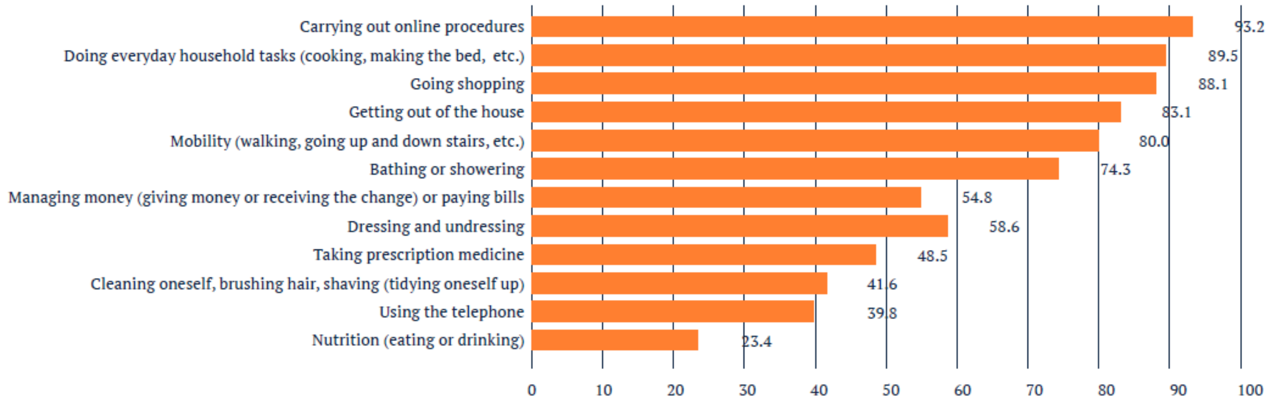
The age of the carer is a very important characteristic in terms of the possible negative effects that caregiving can have on the physical and mental health of carers. To this effect, the data show that 24.4% of main family carers are 80 years old or more. These people are usually the partner of the elderly person with FD. Becoming the main person responsible for the care of a person with difficulties carrying out everyday tasks is especially harmful for the health at this age, and these people run a high risk of suffering negative consequences.

6. Care needs and degree of coverage

The type of dependency people with FD have mean that there are different everyday activities that require the help of another person. These can be activities related to mobility (walking, going shopping, going up and down stairs, and so on), personal hygiene (showering, washing, cleaning oneself, etc.), household chores (cleaning, cooking, etc.), or even more basic activities such as feeding oneself. The data show that the main needs that elderly people with FD have are related to carrying out online procedures, mobility and doing routine household tasks (Graph 4).

The degree to which these needs are covered and the degree of satisfaction with the help received varies according to the type of difficulties the person has and according to the different profiles of the people with FD. According to the ESPD2018 data analysed, the everyday activities for which help is required that are least covered are those related to carrying out online procedures (for almost 20% of people this need is not met) and mobility (around 15%). Regarding the different

Graph 4. Elderly people with FD who have quite a lot or a lot of difficulty carrying out everyday



Source: Compiled from the EPSD2018.

profiles of elderly people with FD that have quite a lot or a lot of difficultly carrying out different everyday tasks, for all the activities analysed except for feeding oneself, those with a grade I dependency receive either occasional support or no support (less cover) more often than those with a higher degree of dependency (more cover). These results show that people with a higher degree of dependency or more difficulties doing everyday activities have more cover than those with lower degrees of dependency.

It was previously pointed out that people with FD from higher income families more often have family support and paid carers. The data also show that this group receive more support and care in terms of time. The ESPD 2018 not only allows us to know the dependent care coverage in terms of amount of time, but it also analyses who the person with FD is with at all times throughout an entire day (one week day and one at the weekend), including all the carers that are helping that person at any given time (similar to the time-use surveys). According to this data, people belonging to the fourth income quartile receive an average of 14.7 hours of care from a family member and 6.8 hours from a paid carer (sometimes simultaneously). People in the first income quartile, on the other hand, receive 9.1 and 3.4 hours, respectively. Regarding these profiles, there are no significant differences in the average time that care is received from SAD. In general, the difference in the number of hours of support and help received from all the profiles of carers throughout the day (taking into account that there are times when there is more than one carer present) is 7 hours: people in the first quartile receive help and care for an average of 12.8 hours per day (53.1% of the day) and people in the fourth quartile 19.8 hours (82.3% of the day).

The people with SFD need continual assistance from a support person rather than intermittent support. The fact of being physically present is an important characteristic of the care these people receive, with the number of hours varying according to the degree of functional dependency. In the case of elderly people with grade III FD, 100% of this group need help every day and 93.8% need 24-hour care. Regarding those with grade II FD, 91.1% need care every day of the week and 51.1% of this group need 24-hour care. However, a total of 75% of the people with grade I FD also need help every day of the week and 27.1% need 24-hour care. The fact that people with higher degrees of dependency need care and monitoring throughout the whole day is understandable, given that these are people who have difficulties carrying out all types of everyday tasks. On the other hand, the fact that more than a quarter of those with lower degrees of recognised dependency declare that they need continual 24-hour care seven days a week is in some way counter-intuitive. These are profiles of people with FD who are understood not to need continual care and, based on this fact, they are usually assigned less time of SAD services or lower benefits to pay for non-professional care. These data are consistent with the profiles that declare that their needs are met to a lesser extent and have a lower degree of satisfaction with the support they receive. Double the number of people with a grade I FD consider as unsatisfactory the help they receive to meet their needs than people with a grade III FD (Table 5).

Table 5. Degree to which needs are considered to be met by the help received from other people according to characteristics (%)

	Totally	Partially	No
Total	60.0	26.8	13.1
Typology			
SAD	50.3	32.9	16.8
CNP	72.3	19.2	8.5
Neighbourhoods according to income			
Low income	57.4	29.1	13.4
High income	65.0	22.4	12.6
Household income			
First quartile	54.0	30.6	15.3
Second quartile	59.3	27.4	13.3
Third quartile	66.2	23.3	10.5
Fourth quartile	58.6	26.6	14.8
Degree of dependency			
Grade I	55.5	29.1	15.5
Grade II	65.4	22.9	11.7
Grade III	70.8	21.5	7.7

Source: Compiled from the EPSD2018.

7. Conclusion

The current and future population situation in Barcelona poses an unavoidable challenge if certain standards in terms of the quality of life of elderly people and people with FD and their families are to be maintained. The inverted demographic pyramid will peak in the following decades, which is when public administrations will be most challenged to respond to these demands with effective policies to manage the ageing functionally dependent population. As the ESPD2018 data show, a substantial proportion of this group lives alone (generally women) and has a limited or no social support network. In these cases, even though the home help services provided by Barcelona City Council are usually for a reduced number of hours, they are in effect vital for the welfare of these people whose needs tend to be covered to a lesser degree with the care they receive.

The city of Barcelona is a society predominantly based on familism, given that a person's level of welfare largely depends on each individual's family network. Family support and forms of cohabitation are essential for understanding the degree of coverage of needs and care strategies since these factors end up being more decisive than household resources. While there is no doubt that in households with more resources there is a greater presence of paid carers (both the official and the unofficial market), it is also true that these are the very households where family carers are more prevalent. The data show that lower income households with people with FD are more likely to be single-person households, which increases the likelihood of their receiving less family care. In short, higher income households with people with FD have more cover throughout the day thanks to the multiple care types they have[10], while households with fewer resources have reduced

10. The inequality between household income and care cover is even greater when taking elderly people with FD who are in old people's homes or other centres into account. These are overrepresented by high income households due to a lack of public places and their high cost.

access to the private market and family support, leaving them in a situation of greater risk of vulnerability.

Another factor shown by the ESPD2018 to be decisive in understanding the care strategies of the different profiles of elderly people with FD is the territory. Once again, it is pertinent to analyse the large cities in a disaggregated way due to the varying degrees of homogeneity of certain socio-economic profiles in specific areas. The city residents living in the different “Barcelonas” also have varying patterns of behaviour both in relation to their use of social services and care of elderly people that go beyond individual or household characteristics. Elderly people with FD that live in high income neighbourhoods are less drawn to using municipal social services than people with the same socio-economic and cohabitation profiles living in low income neighbourhoods.

In summary, this study reveals a situation of care for elderly people with FD that is far from ideal. The involvement of the different public administrations must be more decisive in providing home care services and benefits, which will also serve to “defamiliarise” the welfare of elderly people with FD. Any advancement in this direction must be aimed at improving the conditions of care of this group and reducing the inequality in care provision derived from having a lower income or a reduced or non-existent family or social support network. Improvements in public policies of this type would also impact positively on the health of family carers for whom the time and physical effort put into caring for elderly people with FD could be reduced. To this effect, the most vulnerable profile of family carers is currently women (caregiving influences their personal fulfilment and their availability to work/career path) and especially women of an advanced age, whose health can be seriously compromised.

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