Care needs among the dependent population in Spain: an empirical approach

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Abstract

The objective of the present paper was to identify the profile and needs of social and healthcare users in Spain who required long-term care. To achieve this goal, an extensive empirical study was carried out in 2001 of a typical southern European region: the Valencia Autonomous Region in Spain. The method used was a questionnaire-based survey. The data collection instrument was a questionnaire comprising 119 questions grouped into seven sections: social and demographic data; clinical diagnosis and treatment; living environment; degree of dependence in activities of daily living (ADLs); cognitive state; social support; and the social, demographic and attendance data of the carer, if available. The sampling was carried out in two strata, i.e. social and healthcare: first, the authors randomly selected the centres and services as sampling points, and then they randomly selected the subjects. A total of 1265 people were interviewed. The results show different care profiles: users aged under 65 years were mostly mentally ill and/or drug users requiring short- and medium-term care from the health services, while those aged over 65 years had chronic illnesses for which they were actively receiving treatment, were functionally dependent for ADLs, and were normally receiving social care that basically provided company and resolved functional limitations.

Keywords: care needs, dependence, health care, long-term care, social care, social sustainability

Introduction

Welfare studies in different European countries have revealed similar social and economic problems (Gustafsson & Klevmarken 1989, Munday 1993, Munday & Ely 1996, Organisation for Economic Co-operation and Development 1996, 1998, Bonoli *et al.* 2000, Kautto *et al.* 2001). Hence, welfare problems such as the rise in the 'pensioner ratio' and the increase in demand for long-term care (Garcés 2000) are beginning to be perceived as supra-national issues. The common phenomenon of an ageing population in Europe signifies a major challenge for the financial systems (Economic Policy Committee 2001, 2002), and the social and healthcare systems of each country (Directorate-General for Economic and Financial Affairs 2002a,b).

Studies designed to quantify care needs make an important contribution to policy development, service planning and care provision. The present paper describes the results of a study carried out in 2001 in a typical Mediterranean region of Spain, the Valencia Autonomous Region. The purpose of this study was to assess the social and healthcare needs of patients using institutional facilities and care services.

Subjects and methods

There were 238 718 people in the Valencia Autonomous Region who were dependent on help in order to carry out activities of daily living (ADLs) (Garcés *et al.* 2002), representing 5.9% of the total population, a somewhat lower proportion than in Spain as a whole, for which

the figure is 7% (Instituto de Migraciones y Servicios Sociales 2000).

The sample was drawn from the main types of social and health services which are available in Valencia. Social services comprised institutional centres (such as nursing homes and homes for people with a mental illness or a learning disability), day centres (for elderly people and people with a mental illness) and home services (such as the home help service for elderly people).

The health services comprised hospital facilities, such as: hospitals for chronically ill and long-stay patients; short-stay medical units located in acute hospitals; units for psychiatric hospitalisation providing intensive treatment under a continuous care regime in acute hospitals; outpatients' services such as units for mental health, which care for people with mental health problems who are referred from primary care; units for addictive behaviour; and units for home hospitalisation providing specialised healthcare at home after hospital discharge.

Spain, like other Mediterranean countries, is a family-based society (Esping-Andersen 2000), and a high percentage of the dependent population is cared for in their own homes. The estimated number of people who received social and healthcare in the Valencia Autonomous Region in 2001 was 115 136, or 48% of the population of people with dependant needs (Garcés et al. 2002). Of these, 37 096 people used social services and 78 040 used health services. Note that the present study assesses the needs of people who use services, and that comparable information about people who are deemed dependent but do not use services is lacking.

Multistage stratified random sampling was used to select users from specific services in each stratum (i.e. social and healthcare). The healthcare system and the social services system in Spain have different legislation and administration. A number was assigned to each individual service and to each user, and then this information was used to produce a computer-generated list of randomly selected points and units.

The intended sample size was 1300 users, 715 from health services and 585 from social services; and the actual sample size was 1265, 709 from health services and 556 from social services. The sampling fractions were 0.916% for healthcare and 1.577% for social care. The sample size is large enough to give a 95% confidence level for assessing fractions within ±4.1% of an observed overall percentage for the social stratum and ±3.7% for the healthcare stratum. The confidence intervals were based on fractions for subjects having a specific characteristic (p), or not having it ($q = 1 - p$). The present authors used $p = q = 0.5$.

The Social and Health Care Needs Questionnaire (SHCNQ) was developed specifically for the present study, and comprised 119 questions, some of which were answered by the person with needs and others by the carer. Seven sections are covered by the SHCNQ, including: social and demographic data; clinical diagnosis and treatment; living environment; functioning using the Barthel test (Mahoney 1965) and the Frenchay test (Bond et al. 1992); cognitive state using a Spanish adaptation of the Mini-Mental State Examination by Folstein et al. (1975) carried out by Lobo et al. (1979); social support, such as the presence or absence of a carer, and whether or not the user lives alone; and the social and demographic, and attendance data of the carer.

The SHCNQ was tested on randomly selected samples of people who used the social services ($n = 30$) and healthcare ($n = 30$) located in a single health area. These research participants did not form part of the main study. The pilot test detected minor problems in 19 of the 119 questions, and these were amended accordingly to produce a refined version of the SHCNQ.

The quality of field work by the five interviewers was monitored and reviewed closely by: providing several training sessions for interviewers; having written standardised rules for completion of the SHCNQ interview; ongoing supervision of interviews, including cross-checking agreement between interviewers and a supervisor or independent researcher regarding the interpretation of verbal responses and their transfer to the questionnaire; and monitoring fieldwork via regular phone calls with interviewers, and weekly coordination meetings. Cronbach's alpha coefficients ($n = 1265$) indicated high internal reliability: Barthel test = 0.96; Frenchay test = 0.89; Lobo test = 0.79; and living environment = 0.99.

When it was not possible to interview the randomly selected candidate, the person with the number immediately next to the number of the first choice candidate was interviewed. A carer completed the SHCNQ when the relative could not answer directly because of poor health. The response rate was very high at 97%. The non-respondents ($n = 35$) were those who were users of at-home services who were in poor health and without a carer ($n = 6$, home hospitalisation), those who were not at home ($n = 8$, social resources) or those who refused to participate ($n = 21$, social resources).

Results

The main results of the present study are given below. The tables show estimated numbers in the population, and the figures observed in the sample are weighted accordingly: 37 096/556 = 66.72 for the social stratum, and 78 040/709 = 110.07 for the healthcare stratum.

Social and demographic data

Table 1 shows that users of social services tended to be 3–4 years older on average than users of healthcare services. It also shows that there were more than twice as many female users in social services aged 65 years or over (71.4%) than male users (28.6%). Among those under 65 years, most users of social services were single (63.6%), as were most users of healthcare (43.6%). However, among those aged 65 years or over, the majority of social services users were widowed (54.9%), while the majority of healthcare users were married (57.6%). As regards education, the combination of being under 65 years of age and healthcare showed that 45.7% were educated to primary level and 24.8% to secondary level. In the other three combinations, most users had no education, with less than 10% being educated above primary level.

Table 2 gives a breakdown by gender and age of each type of facility studied. In social services, females tended to outnumber males except for centres for the chronic mentally ill (60.0% male) and residential homes for the disabled (59.1% male). In healthcare, units for mental health showed the largest percentage of females (61.3%), while units for addictive conduct had the largest percentage of males (81.2%).

Dependence in activities of daily life

Approximately 71.8% of healthcare users and 31.5% of social care users were independent in basic activities of daily living (BADLs) according to the Barthel test (Table 3). It is notable that at least twice as many social service users as healthcare users were mildly (33.4% versus 12.7%), moderately (13.7% versus 4.9%) or severely (21.4% versus 10.6%) dependent for BADLs. Dependence in BADLs is, above all, associated with elderly people of both sexes.

Table 4 shows the breakdown according to the Frenchay test by strata, gender and age group. The great majority of social and healthcare users were moderately or severely dependent in instrumental activities of daily living (IADLs), i.e. 81.1% of healthcare users and 98.2% of social care users. Gender differences were not great. By age, there was a very high percentage of severe dependants in IADLs among people aged above 65 years (73.0%). Among those under 65 years, most were moderately dependent (55.0%).

Table 5 shows the breakdown according to the Lobo test by strata, gender and age group. More than two-thirds of healthcare users showed full cognitive ability (70.1%), while the situation was the reverse for social care users, with almost two-thirds showing cognitive failure (64.9%).

Table 1 Socio-demographic characteristics of users of social and health services aged under and over 65 years of age (total *n* = 115 136)*

Stratum	Mean age (± SD) (years)	Gender [n (%)]		Marital status [n (%)]					Education [n (%)]				
		Male	Female	Single	Married	Widowed	Separated	None	Primary	Secondary	Further	Other
Under 65 years													
Social services	45.5 ± 13.2	2 159 (45.1)	2 626 (54.9)	3 045 (63.6)	720 (15.1)	540 (11.3)	480 (10.0)	2 925 (61.1)	1 440 (30.1)	300 (6.2)	60 (1.3)	60 (1.3)
Healthcare	41.4 ± 13.0	26 834 (48.9)	28 028 (51.1)	23 910 (43.6)	20 815 (37.9)	3 659 (6.7)	6478 (11.8)	12 092 (22.1)	25 074 (45.7)	13 617 (24.8)	4019 (7.3)	60 (0.1)
Total	–	28 993 (48.6)	30 654 (51.4)	26 955 (45.2)	21 535 (36.1)	4 199 (7.0)	6958 (11.7)	15 017 (25.2)	26 514 (44.5)	13 917 (23.3)	4079 (6.8)	120 (0.2)
Over 65 years													
Social services	79.8 ± 7.0	9 229 (28.6)	23 082 (71.4)	4 743 (14.7)	8 383 (25.9)	17 751 (54.9)	1434 (4.5)	27 128 (84.0)	3 750 (11.6)	882 (2.7)	441 (1.4)	110 (0.3)
Healthcare	76.6 ± 7.3	11 250 (48.5)	11 928 (51.5)	1 213 (5.2)	13 346 (57.6)	8 233 (35.5)	386 (1.7)	17 938 (77.4)	3 530 (15.2)	1 434 (6.2)	276 (1.2)	0 (0.0)
Total	–	20 479 (36.9)	35 010 (63.1)	5 956 (10.7)	21 729 (39.2)	25 984 (46.8)	1820 (3.3)	45 066 (81.2)	7 280 (13.1)	2 316 (4.2)	717 (1.3)	110 (0.2)

* Source:'Poliwelfare' Research Unit, Universitat de València. Survey of Social and Health Care Needs in the Valencia Autonomous Region, 2001.

Table 2 Number of people by age and gender who use each type of facility or service (total n = 115 136)*

| | Gender | | | | | |
| | Male | | Female | | Total | |
Type of resource	Number (%)	Mean age (± SD) (years)	Number (%)	Mean age (± SD) (years)	Number	Mean age (± SD) (years)
Social services						
Nursing home	4 686 (34.4)	76.5 ± 9.2	8 929 (65.6)	80.0 ± 8.0	13 615	78.8 ± 8.6
Specific centre for the chronic mentally ill	48 (60.0)	38.2 ± 5.6	32 (40.0)	35.8 ± 3.6	80	37.2 ± 5.1
Residential home for the disabled	625 (59.1)	40.7 ± 10.4	433 (40.9)	34.7 ± 9.1	1 058	38.2 ± 10.3
Centre for rehabilitation and social integration of the chronic mentally ill	141 (46.7)	36.1 ± 8.5	162 (53.3)	31.6 ± 8.7	303	33.7 ± 8.9
Day centre	178 (25.7)	70.7 ± 10.4	514 (74.3)	78.0 ± 6.6	692	76.1 ± 8.4
Phone assistance	650 (11.6)	79.2 ± 9.5	4 935 (88.4)	74.6 ± 10.0	5 585	75.1 ± 10.0
Home-help service	3 071 (30.7)	65.7 ± 21.4	6 935 (69.3)	74.3 ± 13.1	10 006	71.7 ± 16.6
Elderly care help	1 989 (34.5)	81.3 ± 5.3	3 768 (65.5)	83.5 ± 5.2	5 757	82.8 ± 5.4
Total	11 388 (30.7)	72.0 ± 16.8	25 708 (69.3)	76.8 ± 12.3	37 096	75.3 ± 14.1
Healthcare						
Short-stay medical units	6 389 (52.3)	68.8 ± 17.5	5 818 (47.7)	66.0 ± 20.0	12 207	67.5 ± 18.8
Hospitals for chronically ill and long-stay patient care	2 916 (52.4)	70.0 ± 12.8	2 645 (47.6)	75.0 ± 13.5	5 561	72.4 ± 13.4
Unit for psychiatric hospitalisation	2 270 (47.7)	37.8 ± 12.5	2 489 (52.3)	39.3 ± 13.9	4 759	38.6 ± 13.2
Unit for home hospitalisation	3 580 (50.2)	71.2 ± 15.0	3 548 (49.8)	73.2 ± 14.7	7 128	72.2 ± 14.9
Unit for mental health	14 880 (38.7)	41.2 ± 13.0	23 587 (61.3)	49.0 ± 15.9	38 467	46.0 ± 15.3
Units for addictive conduct	8 049 (81.2)	34.9 ± 7.9	1 869 (18.8)	33.9 ± 9.0	9 918	34.7 ± 8.2
Total	38 084 (48.8)	49.4 ± 19.9	39 956 (51.2)	54.15 ± 19.6	78 040	51.9 ± 19.9

* Source: 'Poliwelfare' Research Unit, Universitat de València. Survey of Social and Health Care Needs in the Valencia Autonomous Region, 2001.

Table 3 Levels of dependency as measured by the Barthel test (total n = 115 136)*

| | Level of dependence [n (%)] | | | | |
Variable	Independent	Slight dependence	Moderate dependence	Severe or total dependence	Total (n)
Social services					
Gender:					
male	4 043 (35.5)	3 672 (32.3)	927 (8.1)	2746 (24.1)	11 388
female	7 642 (29.7)	8 718 (33.9)	4155 (16.2)	5193 (20.2)	25 708
Age (years):					
< 65	2 300 (48.1)	927 (19.4)	408 (8.5)	1150 (24.0)	4 785
≥ 65	9 385 (29.0)	11 463 (35.5)	4674 (14.5)	6789 (21.0)	32 311
Subtotal	11 685 (31.5)	12 390 (33.4)	5082 (13.7)	7939 (21.4)	37 096
Healthcare					
Gender:					
male	28 094 (73.8)	3 201 (8.4)	2731 (7.2)	4058 (10.6)	38 084
female	27 939 (69.9)	6 710 (16.8)	1093 (2.7)	4214 (10.6)	39 956
Age (years):					
< 65	49 555 (90.3)	4 059 (7.4)	312 (0.6)	936 (1.7)	54 862
≥ 65	6 478 (27.9)	5 852 (25.2)	3512 (15.2)	7336 (31.7)	23 178
Subtotal	56 033 (71.8)	9 911 (12.7)	3824 (4.9)	8272 (10.6)	78 040

* NB Range of Barthel scores: independent = 20; slight dependence = 15–19; moderate dependence = 10–14; and severe or total dependence = 0–9.
Source: 'Poliwelfare' Research Unit, Universitat de València. Survey of Social and Health Care Needs in the Valencia Autonomous Region, 2001.

Table 4 Levels of dependency as measured by the Frenchay test (total *n* = 115 136)*

Variable	Level of dependence [*n* (%)]				Total (*n*)
	Independent	Slight dependence	Moderate dependence	Severe or total dependence	
Social services					
Gender:					
male	0 (0.0)	0 (0.0)	2 040 (17.9)	9 348 (82.1)	11 388
female	0 (0.0)	667 (2.6)	6 159 (24.0)	18 882 (73.4)	25 708
Age (years):					
< 65	0 (0.0)	482 (10.1)	1 224 (25.6)	3 079 (64.3)	4 785
≥ 65	0 (0.0)	185 (0.6)	6 975 (21.6)	25 151 (77.8)	32 311
Subtotal	0 (0.0)	667 (1.8)	8 199 (22.1)	28 230 (76.1)	37 096
Healthcare					
Gender:					
male	234 (0.6)	3 668 (9.6)	17 325 (45.5)	16 857 (44.3)	38 084
female	156 (0.4)	10 691 (26.7)	20 212 (50.6)	8 897 (22.3)	39 956
Age (years):					
< 65	390 (0.7)	12 486 (22.8)	31 606 (57.6)	10 380 (18.9)	54 862
≥ 65	0 (0.0)	1 873 (8.1)	5 931 (25.6)	15 374 (66.3)	23 178
Subtotal	390 (0.5)	14 359 (18.4)	37 537 (48.1)	25 754 (33.0)	78 040

* NB Range of Frenchay scores: independent = 60; slight dependence = 45–59; moderate dependence = 30–44; severe or total dependence = 0–29.
Source: 'Poliwelfare' Research Unit, Universitat de València. Survey of Social and Health Care Needs in the Valencia Autonomous Region, 2001.

Table 5 Levels of dependency as measured by the Lobo test on cognitive state (total *n* = 115 136)*

Variable	Cognitive failure [*n* (%)]		Total (*n*)
	No	Yes	
Social services			
Gender:			
male	4 971 (43.7)	6 417 (56.4)	11 388
female	8 050 (31.3)	17 658 (68.7)	25 708
Age (years):			
< 65	2 597 (54.3)	2 188 (45.7)	4 785
≥ 65	10 424 (32.3)	21 887 (67.7)	32 311
Subtotal	13 021 (35.1)	24 075 (64.9)	37 096
Healthcare			
Gender:			
male	29 109 (76.4)	8 975 (23.6)	38 084
female	25 597 (64.1)	14 359 (35.9)	39 956
Age (years):			
< 65	47 760 (87.1)	7 102 (12.9)	54 862
≥ 65	6 946 (30.0)	16 232 (70.0)	23 178
Subtotal	54 706 (70.1)	23 334 (29.9)	78 040

* NB Range of Lobo test scores: No cognitive failure: 28 or more; Cognitive failure: 27 or less.
Source: 'Poliwelfare' Research Unit, Universitat de València. Survey of Social and Health Care Needs in the Valencia Autonomous Region, 2001.

Amongst those over 65 years, the percentage of people with cognitive failure (68.7%) was four times the percentage of those under 65 (15.6%). Cognitive failure was mostly associated with women aged over 65 years, who represent half the social and healthcare users suffering this problem (50.0%).

Table 6 shows the characteristic values of the three tests for each type of centre or service. Combining the results of the Barthel, Frenchay and Lobo tests provided an overview of the autonomy of each kind of user. This enabled the differentiation of those needing personal and continuous care and vigilance from others who need home help only.

State of health

Table 7 shows that mental disorders were very frequent in social and healthcare users aged under 65 years. Chronic illnesses were also very widespread, in particular among social care users (84.6%), most of whom were elderly people with multiple illnesses. The other illness groups were much smaller and/or were related to users of very specific centres or services.

As regards the stage of the illness the patient was passing through at the time of the interview, more than 90% of social and healthcare users were under treatment for their condition, and only 2.5% were at the terminal stage.

Another interesting characteristic relating to state of health is clinical complexity, which the present authors defined according to the procedures which each patient was receiving (Box 1). Table 8 shows the number and percentage of people with different levels of clinical complexity in each type of facility or service. As expected, it

Table 6 Characteristic levels for basic activities of daily living (BADLs), instrumental activities of daily living (IADLs) and cognitive state for each type of facility or service*

Type of resource	BADLs (Barthel)	IADLs (Frenchay)	Cognitive state (Mini-Examen Cognoscivito)
Nursing home	Slight	Severe	Cognitive failure
Specific centre for the chronic mentally ill	Independent	Severe	Cognitive conservation
Residential home for the disabled	Independent/slight	Moderate	Cognitive failure
Centre for rehabilitation and social integration of the chronic mentally ill	Independent	Moderate	Cognitive conservation
Day centre	Severe	Severe	Cognitive failure
Phone assistance	Independent	Moderate	Cognitive conservation/failure
Home-help service	Slight	Severe	Cognitive failure
Elderly care help	Slight	Severe	Cognitive failure
Short-term-stay medical units	Independent	Slight/Moderate/Severe	Cognitive conservation
Hospitals for chronically ill and long-stay patient care	Severe	Severe	Cognitive failure
Unit for psychiatric hospitalisation	Independent	Moderate	Cognitive conservation
Unit for home hospitalisation	Slight	Severe	Cognitive conservation/failure
Unit for mental health	Independent	Moderate	Cognitive conservation
Units for addictive conduct	Independent	Moderate	Cognitive conservation

* NB In facilities or services where more than one category appears in a test, the groups defined by these categories are very similar in their percentages.
Source: 'Poliwelfare' Research Unit, Universitat de València. Survey of Social and Health Care Needs in the Valencia Autonomous Region, 2001.

Box 1 Clinical complexity*

Patient needs	Clinical complexity
Enteral or parenteral feeding, assisted breathing or respiratory therapy – chest drain or transfusion.	High
Fluid therapy, respiratory or functional physiotherapy, chemotherapy, radiotherapy, biopsy, complex cures, ostomy or tracheotomy care, blood analysis, dialysis, or psychotherapy.	Medium
None of the above, but perhaps oxygen treatment or medication.	Low

* Source: 'Poliwelfare' Research Unit, Universitat de València, 2002.

was amongst healthcare users that there was a greater proportion of patients with high (72.4%) and medium (7.8%) clinical complexity.

Social support

For the purposes of the present study, a suitable home carer was considered to be a person aged under 75 years, either present or mentioned by the dependent person interviewed, who either belonged to the patient's nuclear family or had been employed to care for the patient for the necessary time, or at least for 6 months, at the patient's home or that of the carer. In the population studied, 71.0% of healthcare users, but only 39.1% of social care users, had a suitable carer.

Discussion

The present study shows that the characteristic profiles of social and healthcare patients in the Valencia

Autonomous Region, a typical southern European Mediterranean area, were the following:

- *Social care users*: A widow aged, on average, 77 years, uneducated, receiving a widow's pension, cared for at home or in a home for elderly people, and suffering multiple chronic illnesses for which active treatment is being received.
- *Healthcare users*: A man or woman aged, on average, 52 years, single or married, with primary education, working or disabled for work, suffering chronic mental or multiple illnesses for which active treatment is being received.

Care needs are different for men and women. Many more women use at-home and community resources, such as day centres, phone assistance, the home-help service and aid for the elderly. This seems to show that they can remain at home longer than men, perhaps because they have greater autonomy in basic domestic

Table 7 Number of people suffering illness for each type of facility or service*

Type of resource	Type of illness [n (%)]						
	Mental disorder	Chronic illness	Acute illness	Degenerative illness	Cancer-related illness	HIV/AIDS	Congenital illness
Social services							
Nursing home	5 160 (37.9)	12 322 (90.5)	3 540 (26.0)	4 370 (32.1)	831 (6.1)	0 (0.0)	0 (0.0)
Specific centre for the chronic mentally ill	80 (100.0)	32 (40.0)	16 (20.0)	0 (0.0)	8 (10.0)	16 (20.0)	0 (0.0)
Residential home for the disabled	1 058 (100.0)	432 (40.8)	48 (4.5)	0 (0.0)	0 (0.0)	0 (0.0)	48 (4.5)
Centre for rehabilitation and social integration of the chronic mentally ill	303 (100.0)	80 (26.4)	10 (3.3)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Day centre	580 (83.8)	620 (89.6)	180 (26.0)	340 (49.1)	20 (2.9)	0 (0.0)	20 (2.9)
Phone assistance	519 (9.3)	4 680 (83.8)	1 173 (21.0)	910 (16.3)	128 (2.3)	0 (0.0)	0 (0.0)
Home-help service	2 822 (28.2)	8 225 (82.2)	1 171 (11.7)	2 001 (20.0)	590 (5.9)	0 (0.0)	350 (3.5)
Elderly care help	1 681 (29.2)	4 934 (85.7)	524 (9.1)	628 (10.9)	104 (1.8)	0 (0.0)	0 (0.0)
Subtotal	12 242 (33.0)	31 383 (84.6)	6 714 (18.1)	8 272 (22.3)	1669 (4.5)	0 (0.0)	408 (1.1)
Healthcare							
Short-term-stay medical units	1 831 (15.0)	7 190 (58.9)	7 532 (61.7)	793 (6.5)	2173 (17.8)	0 (0.0)	110 (0.9)
Hospitals for chronically ill and long-stay patient care	1 168 (21.0)	5 188 (93.3)	1 563 (28.1)	1 318 (23.7)	751 (13.5)	61 (1.1)	28 (0.5)
Unit for psychiatric hospitalisation	4 759 (100.0)	1 018 (21.4)	657 (13.8)	0 (0.0)	0 (0.0)	71 (1.5)	0 (0.0)
Unit for home hospitalisation	1 055 (14.8)	5 988 (84.0)	3 650 (51.2)	798 (11.2)	2466 (34.6)	64 (0.9)	36 (0.5)
Unit for mental health	38 467 (100.0)	9 309 (24.2)	3 731 (9.7)	2 500 (6.5)	615 (1.6)	0 (0.0)	0 (0.0)
Unit for addictive conduct	9 759 (98.4)	7 032 (70.9)	426 (4.3)	149 (1.5)	0 (0.0)	2440 (24.6)	149 (1.5)
Subtotal	56 813 (72.8)	35 898 (46.0)	17 715 (22.7)	5 619 (7.2)	6087 (7.8)	2653 (3.4)	312 (0.4)
Total	69 312 (60.2)	67 124 (58.3)	24 409 (21.2)	13 816 (12.0)	7829 (6.8)	2648 (2.3)	691 (0.6)

* Source: 'Poliwelfare' Research Unit, Universitat de València. Survey of Social and Health Care Needs in the Valencia Autonomous Region, 2001.

Table 8 Breakdown of clinical complexity for each type of facility or service (total n = 115 136)*

Type of resource	Clinical complexity			Total
	Low	Medium	High	
Social services				
Nursing home	7 897 (58.0)	5 623 (41.3)	95 (0.7)	13 615
Specific centre for the chronic mentally ill	0 (0.0)	80 (100.0)	0 (0.0)	80
Residential home for the disabled	1 009 (95.4)	49 (4.6)	0 (0.0)	1 058
Centre for rehabilitation and social integration of the chronic mentally ill	121 (40.0)	182 (60.0)	0 (0.0)	303
Day centre	277 (40.0)	415 (60.0)	0 (0.0)	692
Phone assistance	4 675 (83.7)	782 (14.0)	128 (2.3)	5 585
Home-help service	7 645 (76.4)	2 121 (21.2)	240 (2.4)	10 006
Elderly care help	5 440 (94.5)	317 (5.5)	0 (0.0)	5 757
Total	27 064 (73.0)	9 569 (25.8)	463 (1.2)	37 096
Healthcare				
Short-term-stay medical units	1 489 (12.2)	8 203 (67.2)	2515 (20.6)	12 207
Hospitals for chronically ill and long-stay patient care	1 713 (30.8)	2 525 (45.4)	1323 (23.8)	5 561
Unit for psychiatric hospitalisation	1 832 (38.5)	2 855 (60.0)	72 (1.5)	4 759
Unit for home hospitalisation	870 (12.2)	4 227 (59.3)	2031 (28.5)	7 128
Unit for mental health	8 694 (22.6)	29 773 (77.4)	0 (0.0)	38 467
Units for addictive conduct	863 (8.7)	8 906 (89.8)	149 (1.5)	9 918
Total	15 461 (19.8)	56 489 (72.4)	6090 (7.8)	78 040

* Source: 'Poliwelfare' Research Unit, Universitat de València. Survey of Social and Health Care Needs in the Valencia Autonomous Region, 2001.

tasks and receive greater social support. Nevertheless, at younger ages, there are more women than men using units for mental health, evidencing a greater demand for care for slight mental disorders (neuroses) among women, either because of a greater incidence of this type of illness among women or a lower level of resistance in acknowledging its existence by men. The situation is the other way round amongst users of units for addictive conduct, most of whom are men.

As regards dependence on another person, the great majority of the social and healthcare population show slight dependence in BADLs, but are more dependent in IADLs. This is the basic characteristic of the survey population: dependence in IADLs of 98% and 81% amongst social care and healthcare users, respectively.

The highest degree of severe dependency is to be found in the group aged 65 years and over, especially among users of social resources for the elderly (e.g. nursing homes and day centres), and in the healthcare stratum, among patients using home hospitalisation services and those in hospitals for chronic patients.

Cognitive failure is another source of dependence on others. This problem is fundamentally associated with elderly people, especially in women aged over 65 years, who represent over half the people suffering from this problem in the survey population.

Analysis of state of health indicates that mental and/or chronic disorders together affected virtually everyone in the survey population. The large, and growing, numbers of young people using resources for the mentally ill indicate their special care needs. In fact, the mean ages of users in units of mental heath and units for psychiatric hospitalisation are less than 40 and 50 years, respectively. If such patients are not supported by their families, then they require very long-term care.

Chronic illnesses mainly affect people over 65 years of age who tend to suffer multiple illnesses. In many cases, these patients can be treated at home if a suitable carer and resources are available.

The great majority of social and healthcare users are in the active therapy stage, with fairly low levels of clinical complexity amongst social care users and average levels amongst healthcare users. This suggests the possibility of referring healthcare patients from hospitals to home nursing care in the more complex cases, or to outpatient services in combination with home social care in less complex ones. The present authors are currently studying this possibility for enhancing system efficiency and will shortly offer their results.

If patients are to have reasonable quality of life in care outside hospitals, they must have social and family support, and in cases of dependence or fragile health, a carer is required. In the population studied, the present

authors found a lack of sufficient carers for 60.9% of social services users. This poses a problem for the implementation of alternative care scenarios at home.

Most of the survey population aged under 65 years (54 862 out of a total of 59 647) receive healthcare services. A high percentage of them have a mental illness and/or drug-related illness. Such pathologies reduce their independence for IADLs, but do not affect BADLs (except in the case of terminal patients). They can be treated in the short and medium term in specific out-patient healthcare facilities.

Social facilities serve more than half of those aged above 65 years (32 311 out of a total of 55 489). Most of these individuals receive active treatment for many chronic illnesses and are dependent for IADLs. Most of their needs can be met by home and/or community services.

If the needs of this group are not met, the demand for institutional facilities increases. Many of these patients could remain in their own homes if:

- the home was adapted and the relevant technical aids were installed;
- carer training programmes were carried out, offering professional, trained staff to patients lacking a carer; and
- family carer aid programmes were extended (e.g. with carer substitution, rest periods and psychological support).

In this way, many requests for institutionalisation and the high risk of family carer rejection could be avoided. Social and health services could then focus on home and community services, which are much cheaper and more satisfactory from the point of view of users' quality of life.

The present report has been used in the debate on an appropriate social and healthcare policy to meet the specific needs of the dependent population, and on new administrative structures for this purpose, such as a Valencian Agency for Dependent People.

Acknowledgements

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