Cuidados de larga duración en Europa.

Long-term care in Europe.

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RESUMEN

Los cuidados de larga duración son una rama de la seguridad social en busca de definición y reconocimiento estadístico, pero sobre todo político. Aunque arraigada en servicios como la atención residencial o los servicios de atención domiciliaria con una larga tradición histórica, sólo en las últimas décadas los estados de bienestar maduros, enfrentados al envejecimiento de sus poblaciones, se dan cuenta de su alcance y del reto que supone transformar la emergente variedad de servicios e iniciativas en una protección social adecuada disponible y asequible. Este artículo parte de las conclusiones de la investigación comparada europea de los años noventa para saltar a la situación actual y a las perspectivas de futuro. Ilustra que España en esta perspectiva europea se sitúa al margen con el tercio más bajo de los países europeos en cuanto a gasto en cuidados de larga duración y disponibilidad de servicios de cuidados de larga duración, pero duplicará su nivel de gasto en las próximas décadas. El estudio calcula un índice de solidaridad entre generaciones que ilustra que España podría hacerlo mejor a la hora de garantizar que el gasto social destinado a las personas mayores en el futuro evolucionará en consonancia con los ingresos del resto de la población. La propia Europa Social ha reconocido y estimulado recientemente y de forma sin precedentes el desarrollo de los cuidados de larga duración. Es un reto pero aún más una oportunidad desarrollar esta rama de la protección social también en España a un alto nivel, tanto más cuanto que reconoció ya tempranamente (2006) la necesidad de un seguro explícito para los cuidados de larga duración. Europa no es excusa para dudar.

PALABRAS CLAVE

Cuidados de larga duración, servicios de larga duración, Europa, envejecimiento, España.

ABSTRACT

Long-term care is a branch of social security in search of definition and statistical but especially political recognition. Although rooted in services as residential care or home care services with a long historical tradition, it is only in the last decades that mature welfare states, confronted with the ageing of their populations, realise the scope of it and the challenge to transform the emerging variety of services and initiatives in adequate available and affordable social protection. This article starts from the conclusions in European comparative research in the nineties to jump to the present situation and future prospects. It illustrates that Spain in this European perspective is situated at the margin with the lowest one third of the European countries in terms of spending for long-term care and availability of long-term care services but will double its level of spending in the coming decades. The study calculates an index of solidarity between generations that illustrate Spain could do better in guaranteeing social spending for the elderly in the future will evolve in line with the

income of the rest of the population. Social Europe itself recognized and stimulated recently and in an unprecedented way the development of long-term care. It is a challenge but even more an opportunity to develop this branch of social protection also in Spain at a high level, the more it recognized already early (2006) the need for an explicit insurance for long-term care. Europe is no excuse to hesitate.

KEYWORDS

Long-term care, long-term services, Europe, ageing, Spain.

1. INTRODUCTION: A COMPREHENSIVE VIEW OF SOCIAL PROTECTION FOR AN AGEING SOCIETY

The invitation by Prof. Gregorio Rodríguez Cabrero for this contribution goes back to more than thirty years of collaboration in European comparative research. The first collaboration was on 'services for the elderly' in twelve EU Member States at that time (Nijkamp, P., Pacolet, J., Spinnewyn, H., Vollering, A., Wilderom, C., Winters, S., 1990; Spinnewyn, H., Rodríguez Cabrero, G., 1990); the second on the 'state of the welfare state since 1992', afraid as we were at that time that the Maastricht treaty and European governance of public finances would hinder the further development of the welfare state (J. Pacolet (red.), 2006; Rodríguez Cabrero, G., 2006). In all those comparative projects I was eagerly listening to my fellow traveler through economics and social protection Gregorio to understand what was happening in Spain. It is a pleasure to give some of my European perspective in return.

I will go through that joint comparative past to jump quickly to the present situation, look further in the future and conclude with overwhelming and ambitious new European initiatives.

2. A BRANCH OF SOCIAL PROTECTION IN SEARCH FOR RECOGNITION

Let us give first our own synthesis of a definition of long-term care. Long-term care (LTC) is a branch of social security/social protection, in search of recognition, exhaustiveness and inclusion. It includes a set of in cash and in-kind benefits to support persons in need for physical, mental and social reasons (persons with handicap, illness, older persons), dependent for per-

sonal activities of daily living, but also for instrumental activities of daily living and for social inclusion and participation. It includes benefits as well for people living at home or in institutional settings (home care, community care, residential care) and supporting the dependent person, the informal carer but also taking care of the professional carer.

Saying that Europe is discovering lately the long-term is of course not correct. Our comparative research on services for the elderly, or other similar exercises, goes back to the nineties, among others in the European Year of Older People and Solidarity between Generations (1993), thirty years ago.

During all those years I had the impression that Europe was looking where to situate the long-term care. I remember a presentation at OECD to discuss if there was a need for separate statistics on long-term care, on top of health care. We should give credit to the legal experts in Europe that introduced very early in the MISSOC[1] tables a special comparative table on LTC. It is already from the very first Ageing Report of DG ECFIN in 2009 (European Commission), that they include within health the acute care and the chronic long-term care. Is it care related to health problems, or is it related to ageing, and is it health care or is it also non-medical care? That hesitation will continue, and perhaps adds to the complexity when we make a distinction between health care and long-term care, but there is not a contradiction. It is both. A good illustration for me was the terminology used at that time for the Dutch system that we met in our first report on services for the elderly. It was about 'exceptional health care cost', exceptional, because the costs could be high (for the individual) and can be of long duration, long-term, but they were qualified in one way or another also as related to health. The duration of the care need is relative also. It can be sometimes livelong for persons with handicaps, but we observe for instance in the sector of old age homes that the period of stay in an old-age home becomes shorter, because people are entering later in live, because they can stay longer at home, supported with home care. But that stay in the old age home becomes more intensive, so will become more costly, again with a need for explicit insurance.

The ageing of the population makes the need of non-medical care for dependent persons more visible and more urgent. It has however a long history in many societies, going back to homes for the elderly, public personal social services or community care services as district nursing. It has a pronounced development in many welfare state regimes for persons with a handicap and has been developed in many EU countries the last decades as a separate pillar of social protection, or within especially health insurance schemes or personal social services. It is also a field where complementarity and substitution is possible between informal care and professional care, especially in the home setting. The long-term care provides a large variety of in-kind benefits, classified as institutional care, semi-residential care, home care services, and in cash-be-

1. MISSOC - Mutual Information System on Social Protection

nefits. The latter is more or less to be treated as a voucher systems for in kind care, or as a compensation of additional costs, or as a payment for care. All kind of care leaves exist to allow the informal carer to take up care for the dependent person.

There are huge differences between Member States in development of those systems, in terms of places, services provided, number of users or beneficiaries, profile of those users, staffing, private and public financing. There is also a huge difference in the provision of those services, rooted again in history, with sometimes important public, mostly local providers, non-profit providers and finally also commercial providers, varying from individual solo-workers in home nursing to large multinational groups in old age homes.

Mature welfare states that responded to consecutive societal demands for those provisions show this variety. Although the long history, it was only recently that it was included in more explicit data-collection, describing the systems, their principles and more and more also the number of beneficiaries and its financing. But most of the time it remains hidden in statistics on personal social services, or health, or old age.

Long-term refers to a longer period that persons becoming dependent from those benefits. It makes it a large individual risk, hardly to support by many from their individual resources, but affordable at macro-level. The expectations are however high. They should be covering the complete spectrum, allowing autonomous choice in view of each individual situation. Payment for care and care allowances are only of relevance in there is a potential informal carer. Home care is relevant, and prioritized by all, when it is possible, but can become also expensive. Residential care is the ultimate setting, when no other alternatives are possible, but need to be then of high standards of quality and remain affordable for all.

The COVID crisis was a stress test for the resilience of many of those systems. Many failed in this test, because of the dramatic and extraordinary dimension. But for many observers, they also revealed the pre-existing weaknesses. Those weaknesses where sometimes related to the special needs of a pandemic, but others were general as lack of staffing, lack of financing, lack of quality, lack of concern for quality of life of the beneficiary, lack of autonomy, lack of integrated care.

3. VARIETY AND AVAILABILITY IN 1998

In 1998 we already wrote (Pacolet J., Bouten R. Lanoye H. & Versieck K., 1998, p. 67-68):

> *'For the services we were able to define, based on the systems present in each country, we found 8 categories of permanent residential and semi-residential services, 17 temporary residential and semi-residential services, and no less than 22 community services. This illustrates the fact that the last sector is the most diversified and has been the subject of the greatest amount of innovation during the last decade. However, social protection also includes more intangible aspects such as charters of rights for the elderly, the right of representation, the right of appeal, protection against fraud and misuse, the right of self-determination of care, and the right of determination of care by the family and advisory bodies. Informal care, which is the most important in quantity (4 to 5 times as important as formal care in number of hours) and of course in quality, is also becoming more and more formalised, a fact which leads to certain implications, such as the obligation to help, payment for care, and the care contract or care plans.'*

We remarked already at that time that the home care related services were the most innovative, showing the greatest variety. Was it a sign of its growth potential or its growth need? Our inventory, and it was the third time we tried to identify them, also revealed that in many countries those services were mentioned, as really existing, or emerging, but when we later on wanted to quantify the level of development, statistics became scarce, and the level of development was in a wide range. Those differences in development, jumping to today, remain the case.

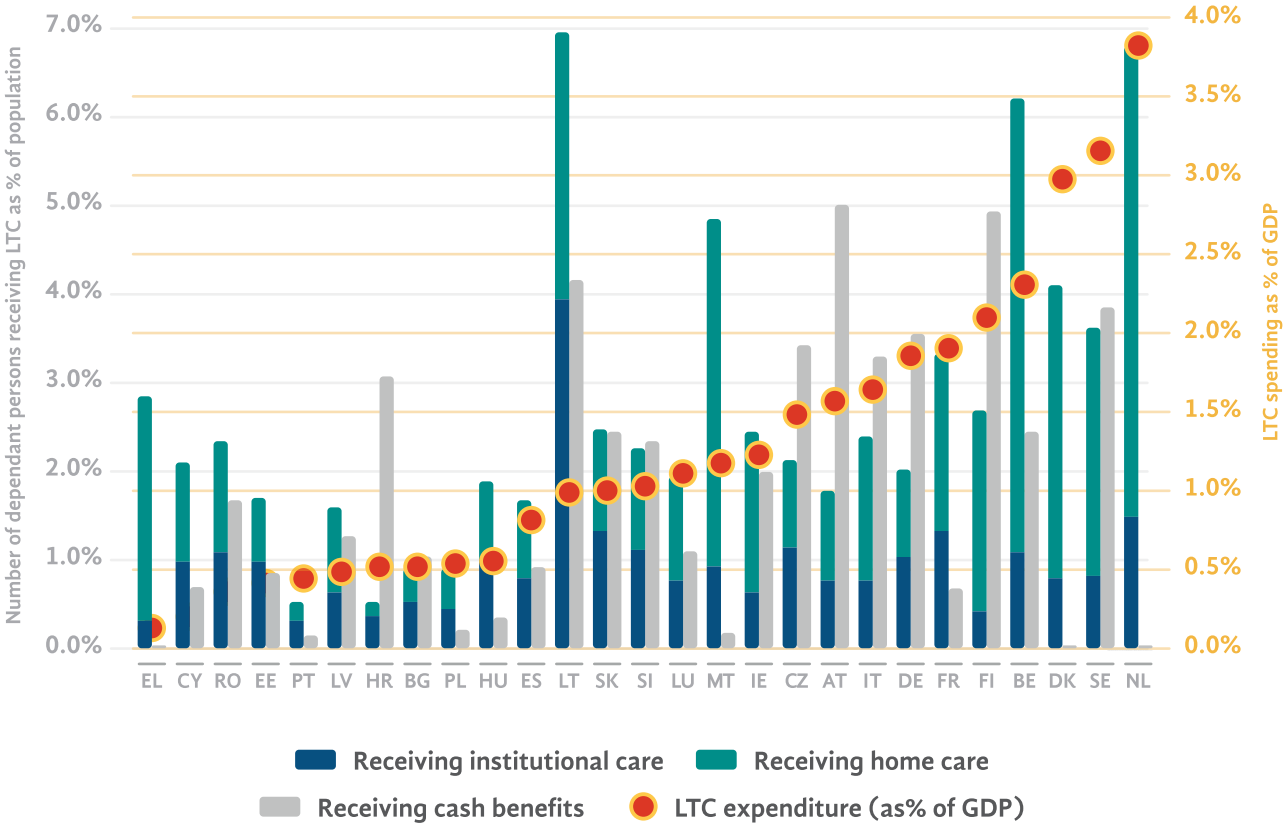
4. VARIETY AND AVAILABILITY OF THE LTC-SERVICES IN 2022

In the following two figures we show the huge differences that remain between the Member States in the public spending, as % of GDP, for LTC. At the higher end are Scandinavian countries as Finland, Denmark and Sweden, but also West-European countries as Belgium, Netherlands, and also France and Germany. Countries of the same region seems to converge to this higher level. At the lower end are as well Mediterranean countries, the lowest is Greece, and several new Member States. Spain is at the border with the lowest third of the 27 Member States, with a spending of some 1% of GDP. The graph provides at the same time the share of the population using the services of this LTC-system, either as share of the total population using home care, and the share of the population using residential care. On top of that, many countries provide also one or another care allowance, a cash benefit. Spain seems to provide the three types of the benefits, but all three for a relative limed share of the population: 0.9% of the population gets home care, 0.9% of the population gets residential care and somewhat more than 0.9% also gets a cash benefit. Especially the availability (or use) of home care seems to be at the lower side. For the right hand of Figure 1 with countries of higher spending levels, we see also a greater development and use of home care. We

see here a confirmation of the observation that we made in previous studies, that along the line of development of the LTC, the residential care comes first (and perhaps even the most needed for situations where the care is not more possible at home), and when the systems become mature, the spreading and diversity of home care and community care grows. This although also those home care services can have a long tradition.

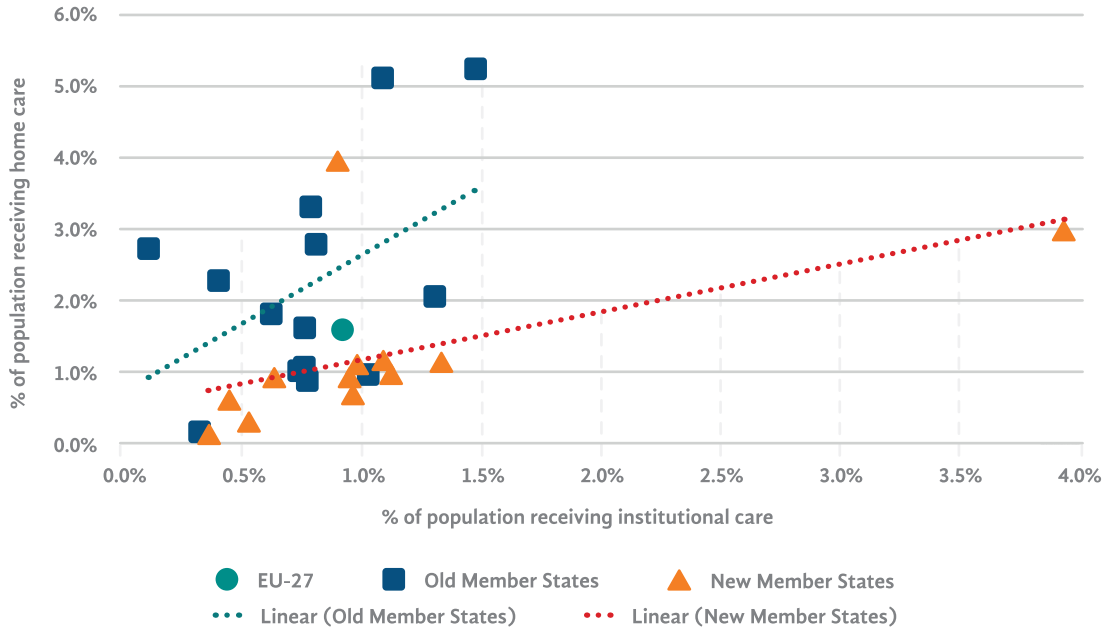
Figure 2 makes the difference between the countries and especially between the old and the new Member States more visible. For both groups of countries, when the system is developed, as well home care and residential care is developed. But the old Member states are more oriented already to home care (the trend line is oriented also to the vertical axes of use of home care), while the new Member States are still more oriented to residential care (the trend line is more oriented to the horizontal axes of use of residential care).

Figure 1. Long-term care, % of beneficiaries of total population and total spending as % of GDP, 2022.



Source: Based on 2024 Ageing Report, see Pacolet, J., Wöss, J. and De Smedt, L. (2024).

Figure 2. Relation between development of residential and home care, 2022.



Source: Based on 2024 Ageing Report, see Pacolet, J., Wöss, J. and De Smedt, L. (2024).

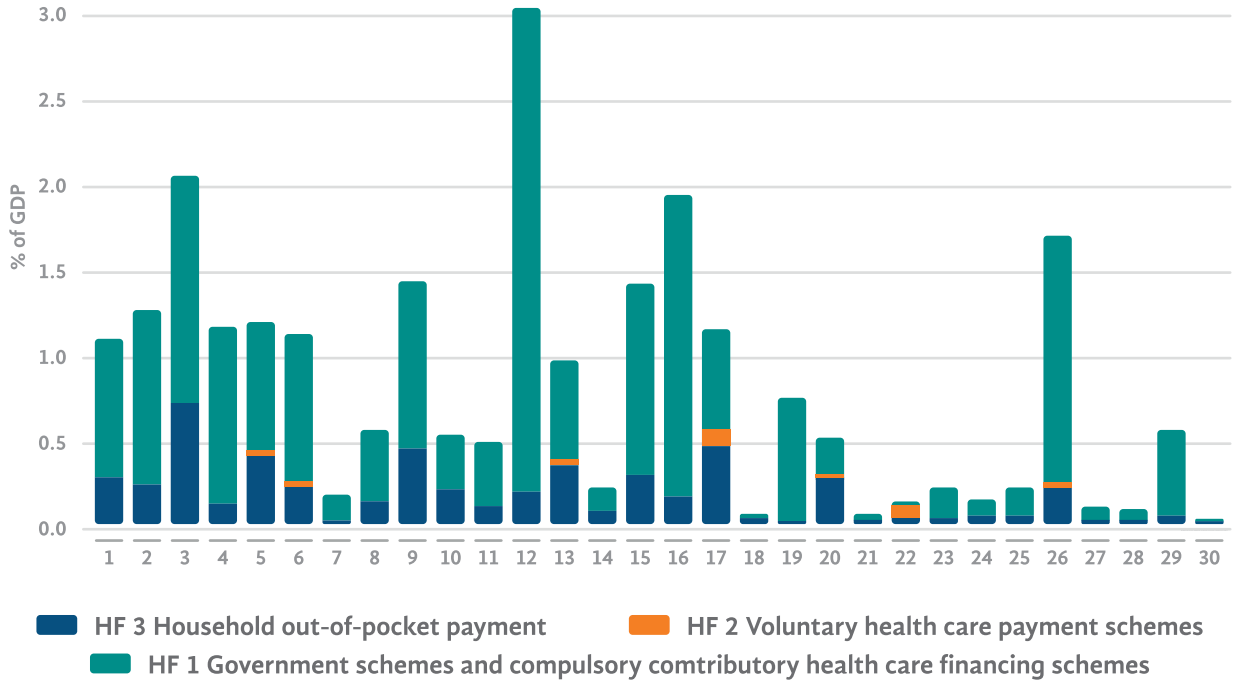
5. AFFORDABILITY IN 2022 AND THE NEED OF SOCIAL INSURANCE

The Ageing reports are focused on the sustainability of the public finances and bring in the picture the public spending for long-term care, financed by social contributions or general taxation. But to a greater or lesser extent, private spending can occur, as co-payment or out-of-pocket spending. On top of that private or occupational insurance might occur, as they exist in pension schemes and in the health care insurance. The SHA System of Health Accounts (Eurostat, Health care expenditure SHA 2011) provides information on as well the public spending, the copayment and finally also the occurrence of payments by private insurance. In following two graphs we compile a picture of that. The System of Health Accounts gives a picture of the health care and long-term care from two perspectives, who is providing care (HP Health care provider) and what is the function (HC Health care function). In Figure 3 we can bring from the providers side the residential long-term care providers in the picture. For Europe total spending is some 1% of GDP, for Spain it is slightly more than 0.5% of GDP. The share of household out-of-pocket payments seems to be limited although it is higher in some countries. Although those are the best comparative statistics that we might think of, they still have some weakness depending on how complete the spending figures are. For instance, we observed that in Belgium part of the out-of-pocket spending is not included because of they are considered as not a compensation for the care cost. We used the reasoning in Flanders that all out-of-pocket expenditures should be included, also when that cost

would cover also housing and catering costs De Smedt, L. & Pacolet, J. (2020). But such disputes may exist also in other countries. For all the countries almost no voluntary health care payment schemes can be observed, confirming the conclusions already in our first studies on long-term care, that there is limited room or interest for private insurance. The importance of the public scheme was also an important conclusion of the report of the High-Level Group on the future of social protection (see hereafter).

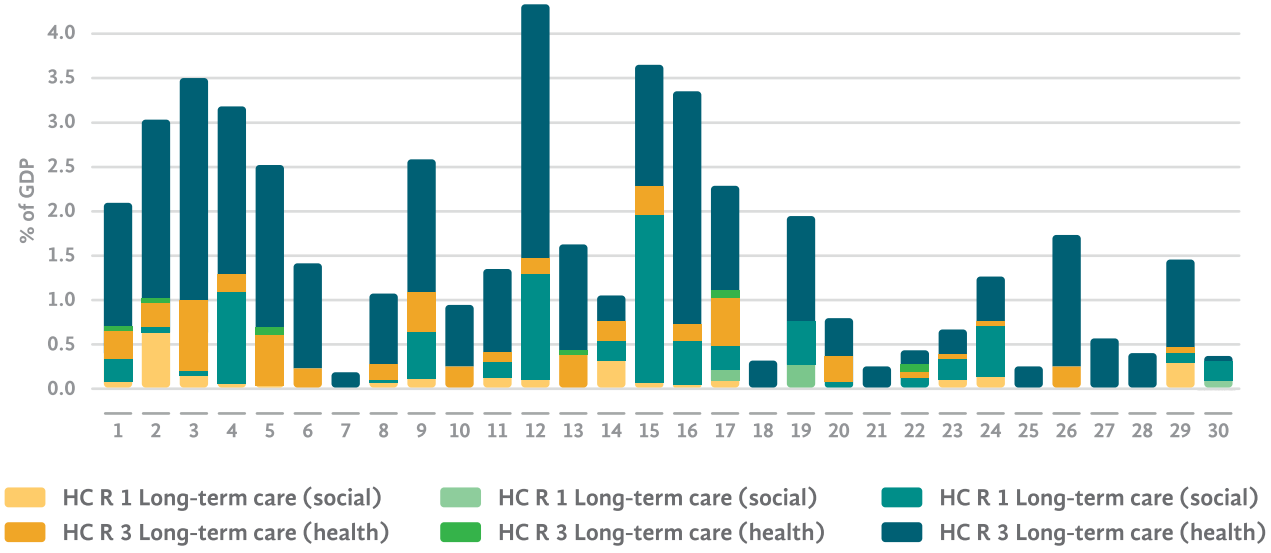
From other tables of this System of Health Accounts we use in Figure 4 as well long-term care included in health care (HC 3), as other care included in so called health care related social spending (HC R 1). Combining those two sources provides an overview of the total spending, health long-term care and social long-term care, in institutions, at home and in community settings. For EU 27 the total spending is some 2% of GDP, for Spain it is some 1% of the GDP, both implying almost the double of the spending in Figure 3. Most of the time the long-term care is included in health care but for countries like Denmark, the Netherlands and also UK there is a relative important part situated in social long-term care. The out-of-pocket expenditures are similar as in Figure 3 and again also the payments by voluntary insurance are hardly present.

Figure 3. Public and private spending for residential long-term care facilities (HP 2), % of GDP, 2021.



* Flanders: data concern 2016. UK: data concern 2019.
Source: Based on Eurostat, see Pacolet, J., Wöss, J. and De Smedt, L. (2024).

Figure 4. Public and private spending for health long-term care (HC 3) and social long-term care (HC R 1), % of GDP, 2021.



* Flanders: data concern 2016. UK: data concern 2019.
Source: Based on Eurostat [hlth_sha11_hchf], see Pacolet, J., Wöss, J. and De Smedt, L. (2024).

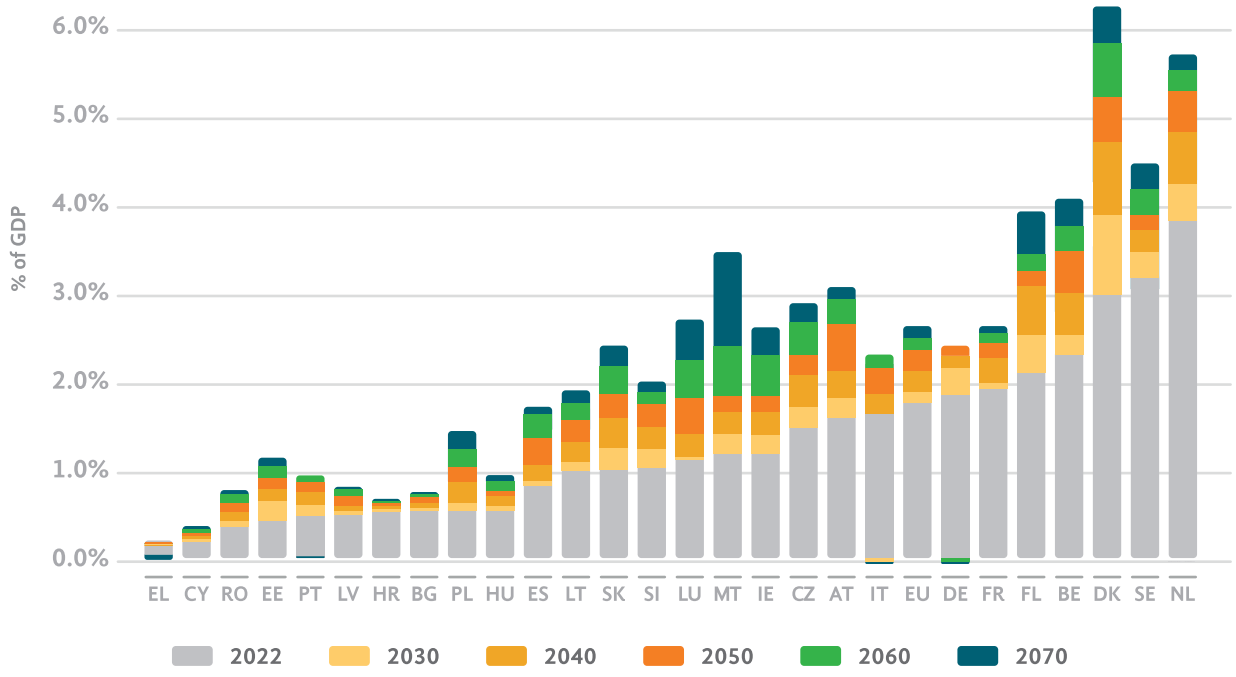
Insurance is needed. Even in market-oriented welfare state regimes as the USA or UK, private insurance schemes hardly surmounted. This confirms the role of explicit or more implicit social insurance schemes, financed by general taxation of by social contributions, with a higher or larger part of private copayment. When this copayment becomes too high, many times and especially in residential care, it becomes unaffordable. When beneficiaries need to tap on their own savings or even housing wealth, it again is an inadequate insurance against the risk of becoming dependent. When the schemes include too much income or means testing, it risks excluding part of the population, and changes from social security in social assistance. When becoming too selective, it risks reducing the willingness to pay for it.

In many of the more advanced welfare states, those services have been existing in the social services, most of the time of a local nature. In some others they were also explicitly or implicitly covered by the social security (as the AWBZ in the Netherlands, or the health insurance in Belgium). Sometimes after decades of discussion, as has been the case in the German 'Pflegeversichering', most of the newly created public long-term care insurance has been created along the lines of the social security: Germany in 1995, Luxembourg in 1999, a more limited additional long-term care insurance in the region Flanders (Belgium) in 2001, Spain in 2006 (Ley 39/2006, de Promoción de la Autonomía Personal y Atención a las personas en situación de dependencia), in France it is only in December 2021, also after a long debate, that a 'cinquième branche du régime général de la sécurité sociale relative à l'autonomie' has been launched.

6. FUTURE AVAILABILITY FROM NOW UNTIL 2070

The present level of development of LTC differs significantly between the Member states, as well in mix of provisions, availability, affordability and in the end public versus private financing. The convergence of today public spending would imply an increase of now sometimes less than 1% of GDP to already more than 3% in other countries, to become according to the scenarios of the Ageing Report more than 5% by 2070. But even in advanced systems of long-term care, there are demands for additional spending, that will push up this spending further. When only the present systems are extrapolated on the basis of demography, this would imply an increase for the EU 27 from 1.7 now to 2.6% of GDP according to the 2024 Ageing Report, and for Spain it would imply a doubling of its share of GDP spent on long-term care: from 0.8% of GDP in 2022 up to 1.7% by 2070 (see Figure 5). This is a substantial improvement, so the gap is getting smaller compared to for instance Germany, France and Italy whose projected evolution of the long-term care seems to be in some 'slump' compared to the evolution in the countries situated below and above them, in terms of spending for LTC. Figure 5 makes it also clear that at the left-hand side, those countries with at this moment low levels of spending, has no prospects for substantial increase. The further discussed European Recommendation on long-term care will form a real challenge to them.

Figure 5. Long-term care spending, % of GDP, projections 2024 Ageing Report for 2022- 2070.



Source: Based on 2024 Ageing Report, see Pacolet, J., Wöss, J. and De Smedt, L. (2024).

The question is if this future spending is sustainable? Or with other words 'can we afford to grow older'[2]. That is the central question of the DG ECFIN Ageing Reports. In the next section we provide our own reading of those reports, and the conclusion is: 'yes we can'.

7. ALTERNATIVE READING FOR SPAIN OF THE 2021 & 2024 AGEING REPORT

he Ageing Report brings the budgetary implications of the existing system of social protection in the picture[3]. It is prepared by DG ECFIN of the European Commission and the Economic Policy Committee (EPC), namely its Ageing Working Group (AWG).

The Ageing Report concentrates on the impact for public finances of the ageing population. Some read them as concentrating too much on sustainability (of public finances), and not so much on adequacy. So what. There is no social protection without a cost. The report provides essential information on the availability of social protection. And it provides macro-economic evidence for the present situation, and the future. Since the very beginning of the European flagship report on ageing, we were using the same statistics for our own reading and narrative (a.o. Pacolet, J., De Wispelaere, F., 2015).

Since the very first reports of the AWG became available (2009, 2012, 2015, 2018, 2021 and now 2024) we used the scenarios of the Ageing Report to make transparent the real impact of social protection of the pensioners for three major strands of social protection: pensions, health care and long-term care. We recently made those calculations for EU 27 and compared it with the Belgian situation (Pacolet, J., Wöss, J., De Smedt, L. and De Wispelaere, F. (2021). We make now the calculations also for Spain, based on as well the 2021 and 2024 Ageing Report[4]. The quintessence of the Ageing Report is starting from the present situation, making scenarios for the future on demography, economy, and social spending because of the greying of the population. The core of the ageing report is about the evolution of the share of public (or mandatory) expenditures for covering the cost of demographic change or ageing, as a share of GDP.

Our own reading of the ageing report starts from the observation that the complete report is in terms of yearly growth rates and relative shares of GDP, without any clear reference to the absolute level and evolution of GDP, GDP per capita and social spending in real terms for the elderly. That we try to solve.

2. Referring to Disney, R. (2003), Can we afford to grow older?
3. European Commission, DG ECFIN, 2009, 2012, 2015, 2018, 2021,2024 Ageing Report, Brussels.
4. In Pacolet, J., Wöss, J. and De Smedt, L. (2024), we made those calculations for 2021 and for 2024 for EU 27 and all 27 individual Member States.

We must pick that starting point from other sources and then start to use the information available in the ageing report, for our own further reading. In Table 1 we provide our reading of the information available in the 2021 and 2024 Ageing Report for Spain. We concentrate first on the right-hand side of Table 1, based on the 2024 Ageing Report.

We take the 2019 GDP figure from the European Economic Forecast Spring 2021 and the 2022 GDP from the European Economic Forecast Autumn 2023. We apply on that starting point the periodic real growth rates for GDP for the different subperiods mentioned in the statistical annexes of the 2021 & 2024 Ageing Report. This provides us with the total GDP in 2022, 2030, and 2070. The fourth column gives the index of GDP in 2070, compared with 2022 = 100. The figures based on the Ageing report 2021 are in prices of 2019. The same calculations are repeated on the 2024 Aging Report. There the nominal figures are Euro in prices of 2022. In annex 1 we illustrate the difference between both starting points of total GDP. The nominal difference is completely because of the price evolution. Compared in real terms, for instance both in prices of 2022, the level of GDP is almost identical in 2019 and 2022, illustrating the sharp decline of GDP in 2020 and the need of two more years to get back in 2022 at the level of 2019, the year before COVID. The growth scenario in 2024 Ageing report is somewhat less prosperous than in the 2021 Ageing Report, a report that include already some of the effect of COVID but was written before the war in Ukraine, and the energy crisis thereafter.

From then on, we can use the other figures from the 2021 or 2024 Ageing Report statistical annex for Spain. Be aware that these figures are projections, scenarios, 'analyse prospective', not forecasts. An illustration how fragile such prospective analyses are: the population in Belgium is in 2019 11.5 million; in 2022 it is 11.7 million; in the 2015 Ageing Report it was projected on 15.4 million in 2060; in the 2018 Ageing Report it became 13.9 million for 2070; in the 2021 Ageing Report it is 11.8 million in 2070 (almost the same as now) and three years later in the 2024 Ageing Report it is 12.7 million by 2070. As volatile even demographic projections can be, the more uncertain are economic scenarios. But projection after projection those scenarios are similar. Interesting here is to compare the several Ageing Reports and observe the differences of demography, economic growth and social spending. We do that further for Spain by comparing the results for 2024 with 2021. The main interest is, what is the evolution of the cost of ageing in Spain, and is it sustainable in terms of public finances, but also does it reveal adequate levels of social protection.

The table includes after GDP the total population of Spain. The population is in Spain by 2070 in those scenarios at the same level as today. With GDP and population, we can calculate the GDP per capita, an indicator so important for international comparison of the 'wealth' of a nation's population. The table includes further the share of the population above 65, evolving from now 20.2% to 33.1%. It is for this growing share of the population above 65, the pensioners of today

and of tomorrow, that we calculate social expenditures. The Ageing Report calculates those expenditures in a detailed and sophisticated way. It can hardly be done better, so let us use this information. The report calculates several alternative scenarios but in the baseline scenario social protection expenditures are expected to evolve in the hypothesis that the same level of protection will be provided in the future as of today, or as what is already legally decided now for the future.

Health care spending will evolve between now and 2070 from 5.9 to 7.1% of GDP, not such a large increase. But since the Spanish GDP per capita will almost double between now and 2070, the real spending on health care will double also. For the presently still very low level of spending for LTC, this will increase from 0.8% to 1.7% of GDP. It remains low when we compare in with some other Member States, as already can be seen in Figure 5. Nevertheless, when translated in real spending in euro per capita, it is almost a quadrupling. It becomes a 'fast growing industry' of care.

The most important for the total cost of ageing is the evolution of old age pensions and survivors' pensions. For a population above 65 evolving from 20 to 33% in the coming 50 years, the 2024 Ageing Report scenario for pensions expects spending to increase from 12% of GDP to 15.8%. This seems to be a fair share of the future national income. Total spending on pensions, health-care and LTC will evolve from 18.7% to 24.6% of GDP.

What is now the total social spending for the persons above 65, the retired persons? We can assume that pensions are indeed spending for the present and future pensioners. We make the same hypothesis for long-term care, although that is not completely correct since it includes also care for handicapped persons younger than 65. For health care we make the hypothesis that now only half of health care spending is for the population above 65, the rest is for the population below 65. By 2070 however we make the hypothesis that by then 75% of health spending will be for the persons above 65. Those stylized hypotheses are inspired by the situation in Belgium. When we further correct for the stylized share of the elderly in the total health care cost, the social spending evolves from 15.8% to 22.8%. When we spend in 2022 for some 20.2 % of the population above 65 some 15.8 % of GDP for pensions, health and LTC, that seems to be relatively balanced. But in 2070 it seems, under the hypothesis of the Ageing Report, and corrected in a stylized way, to become 22.8% of GDP spent on pensions, health and LTC, for 33% of a population above 65.

This % of public spending for the persons above 65 can be translated in real spending in euro per retired person, evolving from 22 026 euro to 35 377 euro, or index 161 in 2070, a total growth of 1.6 times the starting level. This must be compared with the evolution of the rest of GDP, net of the spending for the persons above 65, and to be divided by the population below 65, per capita, for any person from the newborn baby to the person just below 65. That income is 29 791 euro in 2022 and evolves to 59 279 euro in 2070, index 199, or a multiplication with 1.99,

a doubling in real terms of the income. Those two evolutions need to be compared with each other and illustrate how the spending for the pensioners is evolving in the same way as the income of the rest of the population, as it should be. We calculate finally the relation between those two evolutions, and that is the index 0.80. We call it an index of solidarity. When it is 1, it implies that the spending for the elderly is evolving exactly in the same way as the income of the rest of the population. It illustrates how most of the time pay-as-you-go systems of social protection guarantees that the social benefits follow the 'train de vie' (purchasing power) of the GDP. The more it is below 1, the spending for the elderly increases at a lower rhythm than the income available for the rest of the population. It could indicate, applying the present rules of eligibility, replacement rates, and rates of indexing, that there is rather a lack of adequacy, or should we call it an implicit lack of future solidarity and lack of generosity. Those figures reveal also how the present and future generations are better off. It compares the income for the present pensioners and the present population below 65 with the income of the future pensioners in 2070 and see how well the future generations their income is evolving. With an index of 0.80, this is relatively good but not perfect. It is just above the European average.

In Pacolet, J., Wöss, J., De Smedt, L. and De Wispelaere, F. (2021) we calculated the index for the EU 27. It resulted in an index of 0.76. We called it: 'Brussels, you have a problem'. In Pacolet, Wöss and De Smedt (2024) we calculate it again for 2024. The index remains the same, at 0.77, so 'Brussels still has a problem'. When the index is around 1, as it is the case in those studies for Belgium, it illustrates that the real social spending per elderly evolves in the future projections at the same speed as the rest of GDP per capita available for each person below 65. That should be the commitment of the welfare state for the future generations. Some would call it not sustainable, since this scenario implies that public spending for the elderly is indeed increasing when the share of the older population is increasing, as it should be. We would call it not social sustainable when it would not increase as such. And those saying it is not sustainable and a burden for the future younger generations, ignores that the income of the rest of the population is increasing also at the same rhythm or even faster.

We calculated this evolution for Spain also based on the 2021 Ageing Report (left-hand side of Table 1). There we come at an index of 0.56, implying a substantial decline in relative generosity of social spending for the pensioners. With this figure we should certainly say: Madrid you have an even more serious problem. Social spending was projected not to follow the general growth of the rest of the economy. The Ageing Report was not about budgetary orthodoxy, but it was projecting austerity. Policy makers should prevent it to become self-fulfilling prophecies. That happened in Spain. The index of solidarity based on the 2021 Ageing Report was dominated by

the evolution of expenditures for pensions. With an increase of the share of the population above 65 of 19.5% to 32% between 2019 and 2070, the spending for old age pensions and survivors was declining from 11.2% of GDP to 9.4% of GDP. It was illustrating a substantial declining generosity of the welfare state. The Ageing report 2021 itself calculated the evolution of the benefit ratio for pensions. For Spain it was reducing from 60 to 29, for Portugal from 59 to 32, for Italy from 61 to 45, for Greece from 65 to 43.5.

The Ageing report reproduces the rules of calculation of the pension rights applicable at the moment of reporting. But already at the moment of publication of the 2021 report we can read in the country report for Spain that the baseline scenario in the Ageing Report 2021 applied a system of indexing for pensions, the IRP Adjustment Pensions Index, that was already socially unsustainable. Already in October 2020 a revision of the Toledo Pact stated that the system of IRP lacked social and political support and recommended linking pension indexation to the consumer price index. The adaptation to this needed pension reform was already good for an increase for public pensions from 10.25 to 12.7% of GDP by 2070 or more than 2.5 percent point (Ministerio de Asuntos Económicos y Transformación Digital, Secretaría de Estado de Economía y Apoyo a la Empresa, Dirección General de Análisis Macroeconómico, 2021, p. 25). This more appropriate indexing was not included in the baseline scenario of the 2021 Ageing Report since it includes only rules legally in place. This dominates our low index of solidarity of 0.56. It also explains the difference with the hypotheses and calculations for 2024.

The substantial changes that we notice between the 2021 and 2024 scenario are not only dominate by the change of the IRP indexing of pensions to CPI, but also several other pension reforms where adopted in 2021 and 2022 (Ministerio de Economía, Comercio y Empresa, Secretaría de Estado de Economía y Apoyo a la Empresa, Dirección General de Análisis Macroeconómico, December 2023, p. 32) and included in the calculations of 2024 Ageing Report. To be mentioned are the abolition of a sustainability factor SF that linked pensions to life expectancy from 67 years on, although already accepted in 2013 but never applied, and also measures to stimulate later retirement. The shift towards CPI indexing increases total pension spending from 11.7% to 14.9% and the abolition of SF results in a further increase to 16.6% by 2070 (Ageing Report 2024, Country Report Spain, p. 49)[5]. It resulted in an improvement of the future benefit ratio. The 2024 country report for Spain mentions: 'Compared to the 2021 Ageing Report, the decline of the old-age earnings related benefit ratio is remarkably lower (16 percent point in 2024 Ageing Report, 37 percent point in 2021 Ageing Report). The same applies to the old-age earnings related replacement rate (13 percent point in 2024 Ageing Report, 36 percent point in 2021 Ageing Report)' (Ageing Report 2024, Country Report Spain, p. 32).

5. This includes also invalidity pensions, that we do not include in our calculations of old age pensions in Table 1.

Our reading of the 2021 Ageing Report clearly illustrates that at that time the scenario's for the future were socially unsustainable because of the dramatic impact of poor indexing and other measures of retrenchment. They were also politically unsustainable and changed since then. This has become clear in the present calculations. They illustrate that at least for pensions the evolution of social spending is now better on track with the general evolution of disposable income for the rest of the population. Spending for health care and especially long-term care remains low, also for the future.

Table 1. Alternative reading of the 2021 and 2024 Ageing report Spain: Madrid there was indeed a problem in the 2021 Ageing Report.

	AWG 2021 (2019 prices)				AWG 2024 (2022 prices)			
	2019	2030	2070	index 2070	2022	2030	2070	index 2070
GDP (in billion euro)	1 245	1 481	2 590	208	1 346	1 477	2 449	182
Population (million)	47.1	48.8	47.0	100	47.7	49.3	47.7	100
Population elderly (million)	9.2	11.7	15.1	164	9.6	11.7	15.8	164
Health care spending as % of GDP	5.7	6.2	7.0	123	5.9	6.2	7.1	120
LTC-spending as % of GDP	0.7	0.9	1.5	205	0.8	0.9	1.7	208
Sum LTC + Health care	6.4	7.0	8.5	133	6.7	7.0	8.8	131
GDP/capita	26 412	30 358	55 054	208	28 223	29 941	51 361	182
Health care spending per capita in euro	1 504	1 875	3 868	257	1 668	1 848	3 653	219
LTC spending per capita in euro	194	259	830	427	229	257	868	379
Health & LTC spending per capita in euro	1 698	2 135	4 699	277	1 897	2 105	4 521	238
GDP - Health & LTC per capita, in euro	24 714	28 223	50 356	204	26 325	27 836	46 841	178
Old age and early pensions as % of GDP	9.0	9.4	8.1	90	9.7	11.0	13.8	143
Survivors' pensions as % of GDP	2.2	2.0	1.3	60	2.3	2.3	2.0	85
Total pensions-spending as % of GDP	11.2	11.3	9.4	84	12.0	13.3	15.8	132

	AWG 2021 (2019 prices)				AWG 2024 (2022 prices)			
	2019	2030	2070	index 2070	2022	2030	2070	index 2070
Total LTC, health and pensions, as % of GDP	17.6	18.4	17.9	102	18.7	20.4	24.6	131
Actual spending pensions per capita in euro	2 956	3 445	5 168	175	3 386	3 990	8 111	240
Pensions + LTC + Health care per capita in euro	4 654	5 580	9 866	212	5 283	6 094	12 632	239
GDP - LTC, health and pensions per capita in euro	21 758	24 778	45 188	208	22 939	23 846	38 730	169
Elderly population (65+) as % of total population	19.5	24.0	32.0	164	20.2	23.7	33.1	164
Social expenditures elderly per capita in euro	3 902	4 642	8 899	228	4 449	5 170	11 718	263
Social expenditure elderly as % of total	14.8	15.3	16.2	109	15.8	17.3	22.8	145
Social expenditure per pensioner in euro	20 003	19 308	27 790	139	22 026	21 807	35 377	161
Rest of GDP per capita in euro	22 510	25 716	46 155	205	23 774	24 770	39 643	167
Rest of GDP per person of rest population 65- in euro	27 966	33 855	67 899	243	29 791	32 468	59 279	199
Ratio trend benefits 65+ to income 65-: an index of solidarity				**0.57**				**0.81**

*Disability pensions are not included in total public pensions. When calculating the social protection costs for the 65+ we used the same stylized hypothesis for Spain, based on former evidence for Belgium, that now and in 2030 half of the health care cost is for the persons above 65, evolving to 75% by 2070. The long-term care cost is completely attributed to the elderly, ignoring the fact that part of it is also for younger disabled persons. We use the gross cost of pensions. The Ageing report also provides the net cost, taking into account the tax revenue on those pension benefits.

Source: Own calculations on the 2021 & 2024 Ageing report and the European Economic Forecast Spring 2021 and Autumn 2023 for respectively the GDP for Spain in 2019 and 2022, see annexes of Pacolet, J., Wöss, J. and De Smedt, L. (2024).

8. MUSGRAVE RULE

There will be a need for additional financing, especially when you expand the quality of social protection. The index we calculate illustrate how the rules of the social protection for the future are able to cope with those expectations. We recognize here the seminal textbook of Richard B.

Musgrave and Peggy B. Musgrave on public finances and social protection. Social insurance is a pact between generations and need to be organized so that the risks are shared equal between generations. They say: *'The social insurance system may be viewed as a social contract across generations. The working generation of today assumes the responsibility of supporting today's retirees, under the supposition that it in tum will be supported by the subsequent generation of workers. ...Retirees would be assured a per capita benefit equal to an agreed-upon percentage of per capita earnings (net of their social security contribution) of the working population. In this way, the risks of changes in population growth and productivity would be shared between workers and retirees in a fair fashion'* (Musgrave R. & Musgrave, P., Public Finance in Theory and Practice, p. 202-203).

This proposition holds for pensions but can be generalized to other expenditures as health and long-term care since they are so closely related with the age gradient. Our stylized representation and interpretation of the main statistics of the Ageing Report highlights if this is the case. For Spain the situation looks dramatic (especially for pensions) in the 2021 report. It improved for pensions in the present report. We hereafter will illustrate there is, under the influence of several European initiatives, a promise or potential to go forward also for health care and especially long-term care, one of the last strands of social security to be developed.

9. THE PERSPECTIVE OF SOCIAL PROGRESS

We illustrated already in the first part how long-term care is on its road of identification and recognition. We see at the same time the level of development is highly unequal. It is now that the needs for long-term care, when larger groups of the population are ageing, becomes more prominent. Sometimes some people doubt that social Europe is a reality (Höpner, M. (2018). Following initiatives illustrate that it is going to be developed further.

9.1 The European pillar of social rights (EPSR)

After a period of less European interest for social development, the Juncker Commission launched in 2014 the idea to establish a set of principles of social rights: the European pillar of social rights. It contains twenty principles of social rights, grouped in three chapters: I: Equal opportunities and access to the labour market; II Fair working conditions; III Social protection and inclusion.

The EPSR was solemnly declared on the 17th of November 2017 in Gothenburg (Sweden), supported by a unanimous group of European institutions, national authorities and social partners. The declaration placed the responsibility with all those stakeholders.

Remarkable was that from the very beginning the European Commission insisted on monitoring the steps forward by installing a set of indicators and a social scoreboard.

Remarkable was that the initiative was brought forward by the following Commission von der Leyen that introduced an Action plan and several related initiatives to put the EPSR into practice.

Remarkable was that a branch of social security still in search of recognition, long-term care, became one of the principles. The European Pillar of Social Rights brought it forward as one the twenty principles, 'Principle 18. Everyone has the right to affordable long-term care services of good quality, in particular home care and community-based services'. It could be mirrored also by principle 17 on inclusion of people with disabilities, that refers to the right to income support that ensures living in dignity, services that enable those persons to participate in the labour market and in society, with a work environment adapted to their needs.

Those are not the only principles that reinforced the right of the population to adequate systems of social protection, including the ones of relevance for the older part of the population. But not only for them. Since adequate social protection for the elderly of today is also a guarantee for the social protection of the elderly of tomorrow, who today are the younger. As can be mentioned are the principles on adequate pensions, on access to social protection to all, on health care, on integration.

Box 1. Two of the twenty principles of the European Pillar of Social Rights.

17. Inclusion of people with disabilities

People with disabilities have the right to income support that ensures living in dignity, services that enable them to participate in the labour market and in society, and a work environment adapted to their needs.

18. Long-term care

Everyone has the right to affordable long-term care services of good quality, in particular home care and community-based services.

Source: European Commission (2023), *The European Pillar of Social Rights.*

There was in the beginning doubt that the EPSR would and could deliver what it promised. We did not share that doubt. We called it at the start an 'overwhelming ambition' (Pacolet, J., Op de Beeck, L., & De Wispelaere, F., 2018), and noticed afterwards that it was delivering (Pacolet, J., 2020).

The Action plan on the European pillar of social rights announced 'an initiative on Long-Term Care in 2022 to set a framework for policy reforms to guide the development of sustainable long-term care that ensures better access to quality services for those in need' (see hereafter).

9.2 Importance of residential care: forced deinstitutionalization versus freedom of choice

The principle 18 on long-term care comes in the EPSR just after principle 17 on inclusion of people with disabilities. For the debate on long-term care, it is sometimes unclear if the debate (and the empirical evidence) is referring to long-term care for the elderly only, or does it include also the long-term care for persons with disabilities. In theory and practice it should include both, although the care systems itself has long been developed along separate lines.

But we should avoid generalizations from the one part to the other part. An example is the disappointment we read of some (Moledo, A. & Couceiro Á., European Disability Forum (31st May 2022,) on the inclusion of the interest of persons with disability in the conclusions of the Conference on the Future of Europe (see hereafter). We read their following statement: *'Deinstitutionalisation—to ensure persons with disabilities live in the community and are not segregated in residential institutions—is a moral imperative as well as a legal obligation. EU funds must not be used to build or renovate these institutions, under any circumstances. Instead their closure must be pursued, even mandated, in favour of independent, humane alternatives: community-based support and services.'*

It reads as a "Götterdämmerung'. How could so much disappointment on the care system for persons with disabilities, lead to such strong disapproval of the need for also residential care?

On other occasions we have the impression that some read the 'principle 18' referring to priority for home care and care in the community (what is the same to our understanding), as if no further development of the residential care is needed, to bring it in line with demographic needs and present standards of accommodation and care. As learned by the evidence above, both home and residential care are needed, and most of the time also complementary with support for the informal carer. But residential care, where the dependency of the resident is also higher, requires also the most financing.

We highlighted in the beginning the diversity of services of relevance for long-term care, at home, in institutions, in kind and in cash. This is confirmed by the statistics provided since then, among others also in the Ageing Report of the AWG. My very first research on long-term care was on home

care. So this comes top of mind. And of course the priority of the population, and a preventive social policy, should put home care first. But at a certain moment this home care setting is not possible or desirable anymore, and then decent high quality transmural and later residential services will be needed. It is a comprehensive concept. And people know that perhaps better than pressure groups or policy makers.

9.3 It is the people's desire: support of the Conference on the future of Europe

The consultation of the European citizens in the 'Conference on the future of Europe' is giving us the perfect answer on a potential misinterpretation and misuse of the principle 18 of the Social Pillar. The measure 15.8 that they propose reads as follows: 'Guaranteeing appropriate social and health care to older persons. In doing so, it is important to address both community based as well as residential care. Equally, measures need to take account of both care receivers and care givers' (Conference on the Future of Europe, 2022, p. 59). We seldom read in one sentence such an exhaustive and up to date definition of long-term care. It not only integrates in one phrase health and social care but pleads for as well home care (community based) as residential care. It also asks for attention for as well the care receivers as the care givers. The latter can be understood as including the professional carer as well as the informal carer. Let us add to it that support for the informal carer is to a large extend also better provision of professional care.

9.4 Support of the High-Level Group on the future of social protection and of the welfare state

One of the action points to put the EPSR into practice was the installation of a High-level group of experts chaired by former European Commissioner for Employment, Social Affairs and Equal Opportunities Anna Diamantopoulou, to reflect on the future of the welfare state in Europe, confronted especially with the challenge of an ageing society. Those experts concluded that the long-term care was a social risk that should be covered by social protection, contributory of tax based, of high quality and affordable to all, so with a limited level of co-payments. At the same time those experts highlighted, so typical also for long-term care, the importance of high-quality services, enhancing well-being and capabilities (see Box 2). It resonates the importance of principle 17 of the EPSR that fosters inclusion, participation and autonomy ...for persons with handicap...of relevance also for the elderly. The HLG realizes very well that all this needs to be put in practice by national systems of social protection. The last sentence of the report reads (HLG, 2023, p. 87): *'A social Europe should support the political union of national welfare states that take the high road of fair and capacitating welfare provision and social protection for all'*.

Box 2. Two of the twenty-one recommendations of the High-Level Group on the future of social protection

E. Ensuring equitable and high-quality long-term care provision.

Given the increase in long-term care needs in ageing societies, Member States should reinforce the availability of high-quality care services, including ambulant, home-based and residential care, and ensure freedom of choice. Member States should ensure that services are accessible to all and are covered by social protection (contributory or tax-financed), with a reasonable ceiling on the co-payments that families need to make.

G. Ensuring inclusive service provision that enhances well-being and capabilities.

To provide effective, high-quality and comprehensive social services, Member States need to improve service provision at local level, foster co-production and professionalisation, and make the most of digitalisation opportunities. Member States should have quality standards and quality-assurance mechanisms for social services and apply them to both public and private providers. Member States should increase the involvement of non-profit and social economy organisations in the design and delivery of social services. The EU should foster more research and exchange of information on good practice to support innovations in the governance and provision of social services.

Source: High-Level Group on the future of social protection and of the welfare state (2023).

9.5 Recommendation on access to social protection

On 8 November 2019 the Council [of the European Union] adopted a recommendation on access to social protection for workers and self-employed. Again, the recommendation proves to be ambitious on (a) formal coverage; (b) effective coverage; (c) adequacy and (d) transparency. The ex-ante and planned monitoring guarantees a further soft pressure on further progress.

The guarantee everyone should be entitled to social protection, should be read with what the HLG highlighted, that this should also include an ambition to guarantee adequate financing, knowing there is no free lunch: 'No benefit without contribution, no spending without taxation' (HLG, 2023, p. 69). Remarkable is however that from the start, the branches of social protection are mentioned: (a) unemployment benefits; (b) sickness and healthcare benefits; (c) maternity and equivalent paternity benefits; (d) invalidity benefits; (e) old-age benefits and survivors' benefits; (f) benefits in respect of accidents at work and occupational diseases. Long-term care is missing.

While in the impact-analysis for this recommendation, some reference to long-term care can be found, and perhaps it is not included explicitly, since long-term care can be guaranteed under health care. In the report on how to monitor the implementation no single reference is made any more to LTC. The recommendation aims at social protection for all, but it should aim also at total social protection. By not referring to LTC, LTC risks being forgotten in policy concerns. On top of that the report on the implementation efforts, three years following the adoption of the Council Recommendation summarizes: *'The overall level of ambition in implementing the Recommendation varies significantly and, with a few exceptions, most Member States do not aim to address all existing gaps in access to social protection'*[6]*. Ambitions and realisations of ambitions are important guidelines but need to be critically monitored. And fortunately,* there is an additional Council Recommendation on LTC.

9.6 Recommendation on long-term care

The Action Plan for the EPSR announced a 'care plan' to promote and accommodate the care needs over the whole life course, from early childcare to long-term care for the dependent persons and the older persons (European Commission, 2022). It putted it further in action by launching a Council [of the European Unioxn] Recommendation on access to affordable high-quality long-term care.

While we observed in the present statistics on long-term care and the prospects for future development, huge difference between Member States and hardly a substantial improvement, the new Recommendation will substantially challenge the national systems of long-term care. The European initiative on LTC will imply further improvement of existing systems in some countries, and upward convergence of social protection of LTC in many other countries. It will imply even at shorter notice (2030) a further increase of public spending for LTC.

6. https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52023DC0043

The Recommendation starts from an ambitious definition of long-term care. It includes a range of services and assistance for people who, as a result of mental and/or physical frailty, disease and/or disability over an extended period of time, depend on support for daily living activities but also support for instrumental daily living activities. When referring to 'formal long-term care' it means long-term care provided by professional long-term care workers, which can take the form of home care, community-based or residential care. 'Community-based care' means formal long-term care provided and organized at community level, for example, in the form of adult day services or respite care. Box 3 provides some of the dimensions that needs to be put in practice. Member States are invited now (2023-2024) to make up a plan to implement this recommendation, and how it can meet the high-quality standards of the recommendation. If that is the case, it would substantially increase the level of spending for those countries where at present the level of development and spending is low. It would contribute to further upward social convergence. Also for Spain it would imply a serious further development of the long-term care already in place.

Box 3. Some important dimensions of the Recommendation on access to affordable high-quality long-term care

ADEQUACY, AVAILABILITY AND QUALITY

4. It is recommended that Member States ensure the adequacy of social protection for long-term care, in particular by ensuring that all people with long-term care needs have access to long-term care;

5. It is recommended that Member States continuously align the offer of long-term care services to long-term care needs, while providing a balanced mix of long-term care options and care settings to cater for different long-term care needs and supporting the freedom of choice, and participation in decision-making, of people in need of care, including by: (a) developing and/or improving home care and community-based care;

6. It is recommended that Member States ensure that high-quality criteria and standards are established for all long-term care settings, tailored to their characteristics and to apply them to all long-term care providers irrespective of their

legal status. To that effect, Member States are invited to ensure a national quality framework for long-term care;

CARERS

7. It is recommended that Member States support quality employment and fair working conditions in long-term care;

8. It is recommended that Member States, in collaboration, where relevant, with social partners, long-term care providers and other stakeholders, improve the professionalisation of care and address skills needs and worker shortages in long-term care;

9. It is recommended that Member States establish clear procedures to identify informal carers and support them in their caregiving activities;

GOVERNANCE, MONITORING AND REPORTING

10. It is recommended that Member States ensure sound policy governance in long-term care, including an effective coordination mechanism to design, deploy and monitor policy actions and investments in that area, evaluation of long-term care policies, and improving the consistency of long-term care policies with other relevant policies, including policies in the area of healthcare, employment, education and training, broader social protection and social inclusion, gender equality, rights of persons with disabilities and childrens' rights;

11. It is recommended that Member States communicate to the Commission, within 18 months from the adoption of this Recommendation, the set of measures taken or planned to implement it, building where relevant on existing national strategies or plans and taking into account national, regional and local circumstances;

Source: European Commission (2022), *Proposal for a Council Recommendation on access to affordable high-quality long-term care.*

10. STATE OF THE WELFARE STATE ANNO 2021

Monitoring the social convergence is what we did already since 1992 when we made a first report on the impact of the Economic governance of the Maastricht treaty on the welfare state. We repeated it since then every five years, to see if the welfare state is surviving this economic monitoring. It should not be a problem since budgetary orthodoxy is not the same as budgetary austerity. Our fellow traveler in this regular assessment of the state of the welfare state Gregorio Rodriguez Cabrero contributed also to the most recent assessment of the welfare state (Rodríguez Cabrero, G., 2021). We summarized his recent Spanish country report as follows. *'There is a decline in social investment in healthcare, long-term care, and programmes to tackle child poverty. Especially in long-term care the source of financing of the central administration has dropped considerable from almost 40% in 2009 to about 15% in 2019, while the importance of the autonomous communities and co-payment has increased, signalling the strong decentralisation of the welfare state. Furthermore, selective privatisation takes place in all public welfare services. There is a sustainability crisis in the public pension system, among others caused by the high unemployment rate. Spain has been hit particularly hard by the Covid-crisis. This has yielded certain initiatives to reconstruct long-term care such as injection of funds for social services and a plan to refinance long-term care and make the system sustainable, with a preference for living at home with support of community and home care services.'* (Pacolet, De Smedt, De Wispelaere, 2021).

It reveals a stop and go policy, as happens so often, but illustrating at the same time the potential for social progress is there. That is also our conclusion looking at Spain from a European perspective.

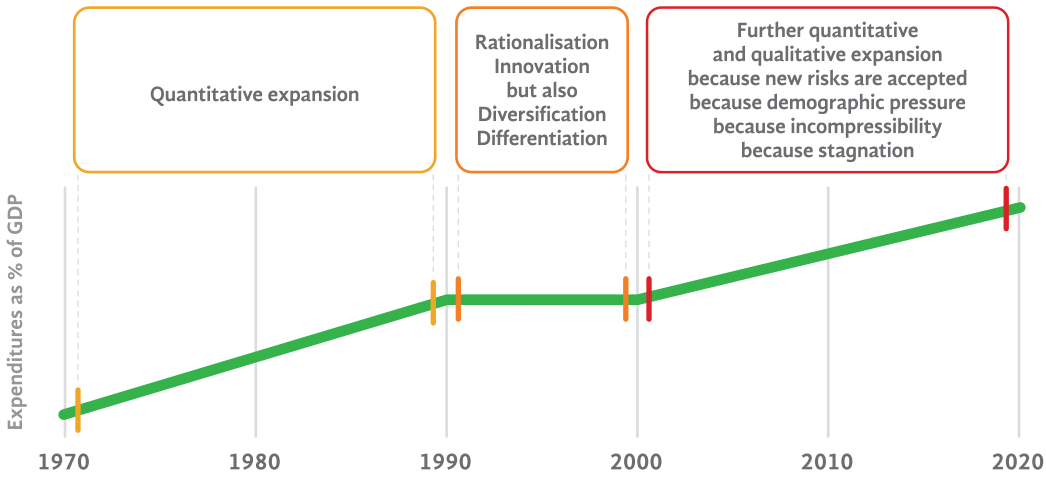
11. CONCLUSIONS

Already from the very beginning of our monitoring of the welfare state in the past, including the long-term care cost, we concluded Europe is following a common growth path of continued expansion in the past, with sometime periods of rationalization, sometimes rationing or retrenchment, and then again further expansion (see Figure 6).

Our reading of the information on the potential evolution in the future does not contradict this path of social progress. There is no alternative to accommodate for the needs of an ageing population that in Spain represents now 20 % of the total population and by 2070 will probably be 33% of the total population. We expect upward economic and social development. Europe is, inspired by the EPSR, pushing us further in this direction. The gap between political ambitions

and forward-looking analyses for Spain illustrates it can change quickly, and in the good direction of more adequate spending. Spain should take that high road also for the long-term care. According to the present applicable rules, the spending will increase from 0.8% in 2022 to 1.7% of GDP by 2070, or a doubling of the share. It is closing the gap with other more advanced countries. The instrument of for instance, even at an early stage (2006), an explicit long-term care insurance, is there. Social Europe is an opportunity to develop it further and should not be an excuse to hesitate.

Figure 6. Stylized profile of the development of the welfare state: a common European way of economic and social progress?



Source: Based on Pacolet J., Bouten R. Lanoye H. & Versieck K. (2000).

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ANNEX 1

Translation of GDP Spain in prices of 2019 in prices of 2022

Translating the GDP of 2019 in prices of 2019 in GDP in prices of 2022 reveals that between 2019 and 2022, there is on three years' time no real growth, as a consequence of the sharp decline in the COVID-year 2020 and the need of two years of growth to arrive back at the level of 2019. The growth scenario in the 2024 seems to be also somewhat less thriving than the 2021 growth scenario, ending up in the 2024 Ageing Report with a lower GDP in 2070 than was projected in 2021.

Table 2. Evolution of the starting point for GDP Spain in prices of 2019 and 2022.

		2019	2022	2070	Index 2070 (2019,2022 = 100)
Ageing Report 2021	GDP Spain, prices of 2019, in billion	1 245		2 590	208
Ageing Report 2021	GDP Spain, prices of 2022, in billion	1 347		2 801	208
Ageing Report 2024	GDP Spain, prices of 2022, in billion		1 346	2 449	182