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ORIGINAL RESEARCH

Ageing at home: long-term care and the challenges of deinstitutionalisation in Spain

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Abstract

In this paper, we analyse the tensions in home-based care when carried out with fragmented and scant resources due to weak public policies, as is the case in Spain. The home-based care model places great strain on families, especially when situations of dependency worsen. It also overtaxes paid caregivers, who work in highly precarious conditions, and stretches the social and health systems, which cannot respond to the demand for resources, all of which have repercussions on family care. Long-term care provision is unequally structured on the basis of gender, class and ethnic/national origin. Our analysis is particularly relevant in light of political efforts to promote the deinstitutionalisation of long-term care by encouraging the ageing at home model and avoiding or delaying nursing home admissions. Without sufficient public resources, the deinstitutionalisation of long-term care will lead to a return of care provision to families. We address these issues within the context of the crisis of care and the contradictions between social reproduction and the changes in the logics of accumulation and dispossession of the capitalist system.

Keywords Elder care · Family care · Care workers · Gender and class · Deinstitutionalisation of long-term care · Social reproduction

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Introduction

Spain has one of the highest life expectancies in the world (85.7 years for women and 80.4 years for men, in 2022). Demographic forecasts confirm an incremental trend in ageing and predict that in 2035 a quarter of the Spanish population will be over 65 years of age. The population aged over 80 will increase significantly, and the rate of dependency will swell to 62.9%.[1] Greater longevity, which is a social success, comes with a rising need for long-term care. This issue is particularly important in Spain, where welfare policies are weak and the responsibility for care falls to families and especially to women.

Profound change within families is one of the aspects that will influence the future of long-term care. The lower availability of women to provide care because of their widespread entry into the workforce couples with low birth rates (1.16 children per woman, in 2022)[2] and smaller families, along with high work mobility, the divorce rate, and changes in intergenerational relations. Consideration must, then, be given to the social and political challenges involved in balancing long-term care with a rising demand for care for older people and fewer family members to provide it (Spijker et al. 2022). This imbalance, defined as a *crisis of care*, is exacerbated by a lack of public policies and the scant involvement of men in the provision of care (Benería 2008; Dowling 2022; Fraser 2016). The precarious employment of carers in the home, mostly immigrant women, has been a way of compensating these deficits. Gender, class, race, and foreign status emerge as factors of inequality in the social organisation of long-term care and form part of the globalised crisis of care (Colen 1995; Duffy 2007; Glenn 2010).

The COVID-19 crisis revealed the deficiency of the long-term care model and has forced a rethink. The consensus reached by institutions, expert knowledge, and international bodies is for a care model based on personalisation and the right to free choice. This option is advocated by the European Care Strategy (European Commission 2022), Lancet commission (Pot et al. 2023), and World Health Organization (2024). In Spain, these principles have been outlined in the *Estrategia estatal para un nuevo modelo de cuidados en la comunidad* (State strategy for a new model of care in the community) (Ministerio de Derechos Sociales, Consumo y Agenda 2030 2024). The key concept is deinstitutionalisation, which contemplates encouraging older people to remain at home and thus avoid, or delay, entering institutional care.

In a context of such demographic, social, and political complexity, it seems pertinent to analyse the current conditions of home-based care for older people, who are often affected by numerous physical and cognitive health issues. We start from the premise that, in Spain, current public social and healthcare services are insufficient and cannot meet the needs of long-term care in the home, in a context of a growing move towards the individualisation of risk and a retrenchment of the welfare system

[1] Spanish National Statistics Institute (INE, acronym in Spanish). Population projections: https://www.ine.es/dyngs/Prensa/PROP20242074.htm

[2] INE. Basic demographic indicators. https://www.ine.es/dyngs/INEbase/es/operacion.htm?c=Estadistica_C&cid=1254736177003&menu=ultiDatos&idp=1254735573002

(Pierson 1994, 2001; del Pino and Ramos 2018). This combines with the devaluation of social care, which is manifested in the transfer of vast amounts of work onto impoverished or migrant women who are employed by families, thereby enabling governments to make considerable savings in services provision (Anderson 2012a, b; Hochschild 2000; Parreñas 2015; Yeates 2008).

Accordingly, we ponder the connection between current forms of duty, morality, and sentiments in family care, and the social reproduction logics of capitalism that does not value care but needs it to survive (Battacharya 2017; Weiss 2023). To that end, we analyse how the various actors in home-based long-term care interact, bearing in mind the crisis of care and the differential impact, depending on the various structural factors that condition care provision in the domestic sphere (social class, family makeup, and degree of dependency).

Thus, this article centres on the tensions of long-term care in the home. We understand that long-term care places a strain on families whose current organisation and structure make it difficult for them to provide care, particularly in worsening situations of dependency; that it also places a strain on paid women carers who work in precarious conditions (low salaries, intense timetables that make work/life balance difficult, emotional stress, and racialisation) and that it stretches social services, which cannot respond to the demand on resources and healthcare services, which are forced to find solutions to problems of a social nature. We believe it is important to consider these strains at a time when long-term care in the home is being advocated at a political level. This reflection is in line with placing the new approaches to long-term care in a broader scope of social and political logics and assessing their impact on home-based care provision. In this regard, we understand that if the present tensions affecting care provision in the domestic sphere are not taken into account, the strategy of deinstitutionalisation will reinforce the social and gender inequalities on which long-term care is currently based.

The political economy of home-based care

Analysis of care is particularly interesting for anthropology because it includes apparently contradictory trends. Care work is guided by moral standards and transmitted by kinship, and at the same time, it is commodified. On the other hand, it is associated with both family and private spheres, but also collectivised and politicised. The tensions between these two opposing trends offer an interesting framework of analysis.

Care as a family duty versus outsourced care

The initial trend (being outside work–capital relations) appears to contradict what has been one of the defining elements of the capitalist system: the commodification of all things (Wallerstein 1974). It has been shown that market logics have not penetrated all areas of life and society to the same extent and that transitions to capitalism are incomplete, unfinished, and multi-faceted. In the case of the family, it is

agreed that its preservation is useful for capitalism because it absorbs part of the social reproduction of taking responsibility for the care of its members (Fineman 2000; Gimenez 2018; Rapp 1978; Strathern 1992).

Feminist anthropology has made important contributions to the analysis of care in terms of its link with sexuality and kinship. Sexuality provides the language of biology to explain the differences between men and women, attributing women with an innate capacity for care, given their role in biological reproduction and in child-rearing (Caplan 1987; Ortner and Whitehead 1981). Yanagisako and Collier (1987) clearly showed that kinship is the social relationship by which human reproduction is regulated, and that people are distributed in a genealogical network on the basis of which they are attributed differentiated social roles. Since kinship is a system of cultural meanings (Schneider 1980), it provides a paradigm by which certain genealogical relationships are linked to moral obligation and affection, which are so important for care-related practices. This relationship between gender, sexuality, and kinship contributes to the division of labour between men and women being perceived as something based on natural and inevitable differences.

Moreover, gender and kinship have performative dimensions. The concept of *doing kinship* (Comas d'Argemir, Dolors and Soronellas, Montserrat 2019) should be added to that of *doing gender* (West and Zimmerman 1987, 2009): both concepts link gender and kinship to social practices and are therefore subject to changes in their cultural content. In turn, they interact with other forms of relations such as institutional and political frameworks that define what family is and is not, along with the obligations of its members (Donzelot 1977; Glenn 2010). Gender and kinship are the relations activated to provide home-based care (Carsten 2004; Comas d'Argemir, Dolors and Soronellas, Montserrat 2019; Drotbohm and Alber 2015; Heady 2012). Yet caring is not only based on kinship obligations but also produces and confirms them (Borneman 1997; Carsten 2000). Moral norms run through kinship-related obligations and are what Sahlins (2013) describes as the *mutuality of being*. It is the exercise of giving and reciprocity in its purest form, albeit with marked gender dimensions (Comas-d'Argemir 2017). Caring is also permeated with ethical dimensions (Gilligan 1982) and affection (Finch and Groves 1983), and its practices are embedded in larger institutional structures (Read and Thelen 2007).

The counterpoint to this powerful link of caring and family obligations is outsourcing them to other agents, which may be public and/or commercial services. Paying for someone to do domestic chores and provide care is nothing new: servants, wet-nurses, maids, and domestic employees, often from rural backgrounds, have participated in paid reproductive work throughout history (Wikander 2016). What is new is the magnitude of domestic employment, the greater ties to caring, and the internationalisation of care, which constitute a new world domestic order (Ehrenreich and Hochschild 2003).

Care work is a growing sector because of direct recruitment by families and an increase in care services, which may be public or private. Care jobs are underpaid, undervalued, and difficult to professionalise (Razavi and Staab 2010). These jobs are precarious, gendered, and racialised, endure deep-rooted discrimination, and are mainly carried out by migrant women (Coe 2019; Duffy 2007; Glenn 2010; Offenhenden 2017; Parreñas 2015). If we focus on home-based care, we should add that

women workers often have no legal residence and are part of the underground economy. These are working conditions that can be subject to exploitation because of a lack of rights and social protection; they can even be tantamount to slavery (Graeber 2006). It is paradoxical that the wellbeing and independence of the persons needing care come at the cost of women workers whose lives are undervalued. These workers can establish ties equivalent to kinship with the care recipient (Baldassar et al. 2017), as well as provide care through competence and affection to ensure the wellbeing of those they care for. Yet it is also true, as Buch (2018) points out, that this intensifies and conceals the inequality and structural marginalisation of care workers. The idea of sacrifice among women workers, who need these jobs to subsist and improve the lives of their own families, is an efficient mechanism by which to preserve and legitimise inequalities (Kussy and Comas-d'Argemir 2025).

These two contradictory trends (the persistence of the non-commodification of domestic and care work and the commodification of a part of it) are situated on another line of tension between the accumulation of capital and social reproduction, which we will examine below.

The political dimension of care: social reproduction

To understand the contradictions, tensions, and controversies in relation to care, specific family, and professional practices should be viewed in a broader perspective. The special importance that society attributes to the family within care provision, naturalising it as a support network, not only prevents caring from being viewed as a public matter but also conceals its centrality to social and political organisation and social belonging. Ginsburg and Rapp (1991) indicate that the local social arrangements within which reproductive relations are embedded may be viewed as inherently political and they request that a *global lens* be applied to research. The interests of states and other powerful—including international—institutions construct specific experiences at a local level. It is what Morgan and Roberts (2012), following Foucault, call *reproductive governance* (legislative controls, economic incentives, direct or indirect coercion, and moral requirements) and highlight the moral regimes that guide intimate behaviours, and ethical judgements. From this perspective care is not only domestic, intimate, and private, since it is embedded in economic and political processes, is situated in social inequalities, and can have global reach.

It is within the framework of the *global lens* that we can situate the transfer of physical and emotional care work from the global south to the global north. The international division of reproductive work (Anderson 2000; Ehrenreich and Hochschild 2003; Parreñas 2015) has been conceptualised as global care chains (Hochschild 2000), or as stratified social reproduction (Colen 1995), the latter revealing more clearly the power relations in domestic employment. There has been considerable analysis of migrant women's contribution to the welfare of host countries and to their enabling middle class women to join the workforce (Buch 2018; Glenn 2010), the determining factors behind emigration (Kussy and Serra Mingot 2023), the vacuum in care caused by these migrations in their places of

origin (Benería 2006), the difficulties of transnational families (Baldassar 2008; Parella 2003; Parreñas 2005) and the discriminatory experiences endured by racialised migrants (Coe 2019; Poblet 2024). A feature of these investigations is that they focus on flows between households, which effectively mask the other external agents and care services that interact in home-based care, along with the variety of family arrangements within the home (Kofman 2014).

The concept of *social care* allows a broad understanding of how societies organise care work, according to the various agents involved (family, state and the market), which has consolidated care as an academic category (differentiated from healthcare) and led to its conversion into a political one (Daly and Lewis 2000). The need to incorporate community care into this framework has resulted in the *welfare triangle* being replaced by the *care diamond* as a representation of the institutional architecture of care provision (Razavi 2007). Community care has been proven to be crucial for care in South America (Martínez-Buján and Vega Solís 2021) and in China (Trémon 2024), as has the important role of states in shaping public policies to deal with long-term care and the need to consider them in order to understand how home-based care is organised (Kofman 2014). The scope of commitment of these policies depends on the ideology of the welfare state and the role given to families in care provision (Anderson 2012a, b; Doyle and Timonen 2007).

In Europe, the development of long-term care policies has been stimulated, but there are significant differences between states (Bettio and Plantenga 2004; Spasova et al. 2018; Pacolet 2024). It is important to point out that, despite the differences between welfare regimes, in Europe families continue to be mainly responsible for the provision of care (European Institute for Gender Equality 2020; Rocard and Llena-Nozal 2022; Rodríguez-Cabrero 2019). In countries where welfare policies are not ample, family and intergenerational solidarity is necessary to resolve care provision. However, inequality is exacerbated in family resources, capacities, and time, as not everyone can gain access to market services (Saraceno 2010; Weiss 2022). In these conditions, hiring domestic workers is a low-cost solution, which also conforms to cultural perspectives of ageing at home (Bettio et al. 2006; Martínez-Buján 2011; Offenhenden and Bodoque-Puerta 2018).

These economic, social, and political dimensions are what makes it possible to associate care with social reproduction, placing it beyond the role of households, the initial focus of these reflections. Care creates, maintains and dissolves significant social links and, as such, is a constituent part of social organisation (Thelen 2015). It produces society in the strictest Maussian sense, as it generates ties, obligations, debt and reciprocity (Graeber 2011). Care, in this broader and holistic sense, is part of social reproduction.

Numerous works have explored the contradiction between the accumulation of capital and social reproduction, beginning with the writings of Karl Marx (2007; [1867]) and the debates generated to date. We will not enter here into these highly complex debates, but we do mention the contributions of Battacharya (2017), Fraser (2016), Gimenez (2018), Vogel (2013) and the synthesis by Weiss (2023). For care to be recognised as part of social reproduction, it must be disassociated

from the economic categories naturalised by capitalism, which make a conceptual separation between production and reproduction.

The contradiction between the accumulation of capital and social reproduction is an inherent feature of the capitalist system and is at the root of the crisis of care (Fraser 2016). Long-term care is, moreover, in constant crisis, not only because of existing demographic and social imbalances but also because of the social and cultural devaluation endured by reproductive work when it is directed at older people, who are considered unproductive (Federici 2021).

From this global perspective, regarding the social organisation of care and social reproduction, we can analyse the role of family and pragmatic solutions that reflect ideas, relations and moral principles around gender, work and care, as well as the factors that determine access to care services; hence, the important role of public policies. The home condenses the social–reproductive contradictions of capitalism and, as Weiss (2023) points out, family members assume the consequences of these contradictions as personal failures. We would add that the tension between expectations, wishes and rights between the actors involved in care emerges in this context. And that requires negotiation because injustices, inequalities, emotions and moral values are also under strain.

We believe that our theoretical contribution to the debates on care lies in showing the double articulation and different axes of tension that typify home-based care. First of all, the arrangements and practices that combine family-centred care, based on gender and kinship obligations, with care provision from public services, the market or the community, must be viewed as a whole (and not separately), according to the social organisation of care in specific contexts. Secondly, the tensions and contradictions that occur in home-based care are not only the product of internal logic but emerge from the crisis of care and the logics of social reproduction that have a global reach and a marked androcentric nature. It is in this broader framework that we must place the deficit of care, international migration, the precarious conditions of female carers and, ultimately, the devaluation of care and those who provide it.

Ageing and caring in the home in Spain

Ageing at home, surrounded by family and the community of the town or neighbourhood where one has lived in adulthood continues to be an aspiration for most Spanish people. This wish should be interpreted both within the context of a surviving family model of care and the weakness of public policies in regulating and funding long-term care. This scant public involvement makes family, women in particular, the main pillar of support in caring for older people who have lost their autonomy (Rodríguez Rodríguez 2024). The complex nature of care, the shortage of public resources, the precarious employment of carers in the home, the economic capacity of families and the lack of coordination between the social and healthcare sectors all contribute to placing a strain on the conditions in which care is given in the domestic setting.

As for public policies, Law 39/2006, for the promotion of personal autonomy and care for dependent persons (LAPAD, acronym in Spanish) was a significant step towards recognising the universal right of persons to receive care, whether in institutions (day centres or care homes) or in their own home. Nevertheless, scant funding and cutbacks during the 2008 economic and financial crisis curtailed the rollout of these policies and has yet to be rectified (Deusdad et al. 2016; Rodríguez-Cabrero et al. 2022). In consequence, the public resources that the state devotes to long-term care are insufficient. It is also important to highlight that the care provision contemplated by the LAPAD is subject to co-payment, that is, a financial contribution by users. Thus, situations of dependency represent a significant burden for families, both in terms of work and finance.

The most widely used public benefit is financial aid for home care (PECEF, acronym in Spanish), despite it being earmarked as exceptional by the law. Insufficient care services have resulted in extensive recourse to this financial aid, which is assigned to family carers. Although the amount increases gradually, in accordance with the degree of dependency, it remains small, because co-payment is applied. The PECEF reinforces the family-centred and feminised nature of long-term care, as they contribute to reproducing inequalities of gender and social class. The most disadvantaged families incorporate the aid received into their budget and women step away from their working lives to provide care (Saraceno 2010).

Day centres, despite being a quality and useful complement to home-based care, are little used, owing to incompatibilities between benefits, and transport issues, particularly in rural areas. Public domiciliary care services, organised by local councils, provide personal care (getting out of bed, personal hygiene and dressing and accompaniment) and cleaning. It is a much appreciated and widely used service, though it is practically non-existent in rural areas. The number of hours assigned to a person depends on their degree of dependency, not on their needs. For those who are deemed as grade 2, for example, this can mean scarcely two or three hours a week. When there is a high level of dependency (grade 3), that figure can rise only to 20 h a week, although there are important differences between municipal districts. Considered women's work, it is known for its precarious nature and the difficulties of having full-time contracts because of the fragmented timetable (Roca-Escoda 2017; Roca-Escoda and Hernández-Cordero 2025).

As we can see, existing public services do not cover all care needs, which have led to the direct employment of women for home-based care (Martínez-Buján 2011). This also occurs in other Mediterranean countries, to the extent that the family-centred care model has now become one where a migrant provides care within the family (Bettio et al. (2006). Given the rise in demand for carers, foreign women are filling this gap in the labour market. Salaries and working conditions are very precarious and result in considerable savings in social costs, at the expense of high personal cost (Anderson 2012a, b). It is an activity that is barely acknowledged as work and, consequently, with full corresponding rights, a problem which was exacerbated during the pandemic (Bofill-Poch and Márquez 2020; Offenhenden and Bofill-Poch 2022). It is important to highlight the recent emergence of digital platforms offering women workers for home-based care, which contributes to the precariousness of an already precarious job (Martínez-Buján 2024).

The COVID-19 crisis contributed to a re-evaluation of home-based care. Care homes were seriously affected by the virus, which resulted in the death of many residents. Before the pandemic and despite not having enough places to meet demand, care homes were already perceived as a last resort for cases of severe dependency. This negative consideration worsened with the pandemic, and some families decided to return to care provision in the home for fear of contagion but also to recuperate physical and emotional contact with their family members (Soronellas et al. 2022). Once the state of alarm was over, residential places were again occupied, despite the aforementioned reluctance (Comas-d'Argemir and Bofill-Poch 2022). The stresses and strains that lead to institutionalisation reflect the absence of resources for home-based care that can guarantee meeting the increasingly complex needs of older people.

It is in this context that the Spanish government put forward the *Estrategia estatal para un nuevo modelo de cuidados en la comunidad. Un proceso de desinstitucionalización (2024–2030)* [State strategy for a new model of care in the community. A process of deinstitutionalisation] (Ministerio de Derechos Sociales, Consumo y Agenda 2030, 2024), the aim of which was for the dependency care model to be based on personalised rights and a community approach. The objective of the strategy, which follows a human rights approach, is to avoid the risk of institutionalisation and to reserve care homes for situations of severe dependency. It is based on the following principles: a guarantee of the rights of persons needing care and support, and their families; respect for dignity and good treatment; independent living within the community; personalised care and support; freedom of choice and control over care and support; gender perspective; intersectionality; prevention of institutionalisation and universal and affordable access. This model places the individual at the heart of care practices and involves significant changes in the organisation of services and work cultures. The challenge is then to approach a change in model, bearing in mind existing organisational inertia, insufficient funding and the real difficulties that families face when seeking solutions to care needs in the home.

Methods

The data used in this article are qualitative and are taken from the research study "The long-term care model in transition: the impact of Covid-19 on family-based organisation of care" (CAREMODEL, funded by the Spanish Ministry for Science and Innovation, Ref: PID202-114887RB-C31), in which we set out to explore the way in which long-term care was being managed in the domestic sphere in the post-pandemic context.

To that end, we chose case studies as the methodological strategy, taking homes as observation units, which allowed for a deep understanding of the strategies rolled out in the domestic setting for organising and providing care for older people. For this paper, we worked with three of the 16 home-based care cases whose details were gathered in Catalonia between May 2022 and May 2024. "Care cases" refer to situations of care in the home that involve various agents of care: the family, (public or private) domiciliary care services, community support (friends, neighbours,

extended family and non-governmental organisations), and institutional support, such as day centres, community meal centres or home meal provision. The cases were selected according to socio-economic level, rural or urban residence and variability in the use of the resources available.

Research techniques included direct observation and in-depth interviews with persons linked to the caregiving context. Direct observation in the home enabled the researchers to describe the care settings and the organisation of long-term care, both in the home and beyond, and to accompany care recipients in their daily activities (shopping, visits to the doctor or day centre and walks). These observations were made over four days to a week, normally during daytime, although in some cases it was possible to remain on site for 24 h. Most of the in-depth interviews with persons engaged in long-term care were done during that time.

We have used the concept "mosaic of care resources" as an analytical category that allows us to gather information referring to families' strategic use of the resources within their reach to guarantee long-term care. Throughout the care process and with the changing needs and routines, different resources gradually appear in the mosaic as families confront the difficulties and limitations of their dedication to care. We define mosaics of care resources as the support and services utilised to provide home-based care for older people: informal support of kinship and community networks, recruitment of domestic help, public domiciliary care services, day centres, telecare and community meal centres (Chirinos et al. 2024). By focusing on mosaics, we have been able to record the diversity of the strategies and resources for long-term care adopted by families and their evident impact on how the process evolves. In some circumstances, care is collectivised, while in others it is withdrawn and returned to the family in full.

The interviews and observations were undertaken with the corresponding approval of the ethics committee for research and innovation of the Universitat Rovira Virgili (CEIPSA-2020-PR-0007). All participants were informed of the objectives, methodology and the use and preservation of the research data, for which they gave their explicit consent under a confidentiality agreement. To ensure compliance, we have used the same codes and pseudonyms to identify the cases included in this paper.

Ethnographies of care in the home: tensions, disparities and deficiencies

Family care under strain

Florencia, now deceased, lost her autonomy in 2014, when she was 78 years old, after a complicated hip replacement operation. Her only son Juan and his wife Berta managed Florencia's care—though Berta dedicated more time—across the 30 kms that separated their places of residence. Florencia lived in a village of just 500 inhabitants in a rural area with very limited public and private social and healthcare resources. When she lost her mobility, her son and daughter-in-law agreed that she should stay in the village where she had spent most of her life.

With this objective in mind, they adapted the house so that Florencia could live on one floor. They also sought a carer who could spend the day with her and do the shopping and her personal hygiene, monitor her diabetes, medication and visits to the doctor, do the housework, prepare meals and supervise her diet and rest. Despite the difficulties of finding a carer, they eventually encountered the right person: Mariela, a Rumanian woman, had already been doing domestic chores for Florencia, so the family trusted her to assume responsibility for Florencia's care. Mariela lived in a town eight kilometres away. She would come in the morning and do everything required until after lunch, when she would leave Florencia having a nap. She would then return in the afternoon and stay until after dinner, when she would put Florencia to bed for the night. While Florencia was alone, she could count on telecare. At first, Mariela worked seven days a week, but after a few months, the family employed another carer for the weekends, a sub-Saharan woman who lived in the same village. Mariela had a part-time contract as a domestic worker, but the other half of her work was not covered by a contract. The weekend carer worked informally, without a contract.

At this point of the narrative, we can start to mention some of the tensions. The first relates to territorial location. Small towns are not availed of care services to assist the (over-)aged population mainly composed of women whose children live in metropolitan areas. There are no domiciliary care services, catering or day centres in rural areas or they are too far away to ensure ageing in one's own community setting. The second tension is one of the genders because the carers are women. Family-centred care, in this case the management of Florencia's care, is provided by the daughter-in-law rather than Florencia's son. Both deal with the carer, but Berta is responsible for negotiating working conditions, the limits of care, as well as handling emergencies and the unexpected. Gender and kinship are social categories used in the hierarchical distribution of care duties and, in this case, gender prevails over kinship. Women also provide paid care, and gender combines with another social dimension, foreign status, which is the third tension we referred to. When family members are not available, home-based care is only possible with the precarious and badly paid work of immigrant women. The breakdown of family-centred care as a welfare model has occurred in Spain in exchange for the internationalisation of reproductive work and the increasingly precarious lives of immigrant women. The commodification of home-based care reproduces and accentuates the hierarchies and inequalities inherent in family care.

When the pandemic was declared, in March 2020, Mariela informed Florencia's family that she would no longer visit her for fear of contagion and because of the restrictions on movement imposed by lockdown. The solution was for Florencia to be moved to her son's home, something Juan and Berta had previously tried to avoid, and which resulted in them spending practically all their savings. The daughter-in-law became the main carer. To lighten the load, a geriatric nursing assistant was hired from 8 to 9 a.m. She would wake Florencia, do her personal hygiene, dress her and prepare her breakfast. Also, for two hours a week, a domestic worker would take charge of the housework. Living in a larger town facilitated access to more resources and when the day centre reopened in February 2021, Florencia was able to attend. The family lived together for almost a year, which was very hard for Berta. When

we interviewed her in 2021, she emphasised how difficult sharing with her mother-in-law had been. Her dominant character and unacceptable behaviour made living together difficult. So much so, that the eldest daughter moved out to escape the complex situation. The family experienced that moment through considerable personal conflict: "Because she isn't a nice person. (…) I couldn't accept some things. She could be a little more considerate, bearing in mind she isn't in her own home". And Berta added: "It cannot be. What's happening in this house cannot be".

In the degree of dependency review in late 2021, Florencia was given the much awaited grade two, enabling her to be added to the waiting list for residential care. At the same time, her health deteriorated, and she was admitted to hospital from where she could not return to the family home because of insuperable architectural barriers. As a result, the family placed her in private residential care. A few months later, Florencia was given a place in a public care home, which was much closer to her village, and where the family believed she might find acquaintances because of its proximity to her home environment.

In addition to those already mentioned, we pinpoint other tensions around ageing at home. One such tension derives from the home environment and its unsuitability as a place for ageing and care provision. Another factor that can cause considerable strain, as in the case we present here, are the relations in care provision. Caring and ageing under this conditions cause stress and conflict between carers and care recipients. Care can be needed over long periods, which can cause tiredness, along with the perception of imbalance and inequality between the persons distributing the care, whether family members or paid carers (Tolkacheva et al. 2014). Conflict and personal tension are very present in care relations, though they may not emerge in the narratives of those participating, who usually focus on love, mutuality and personal dedication. What also appears is the tension provoked by a dependency assessment system that is extremely slow to acknowledge real dependency has insufficient resources and overstretches a family's capacity to provide care at home (Montserrat 2015). The final strain is the family's decision about when to place their relative in assisted living facilities. In this case, the hospital functions as a transition space between one's own home and residential care, in the same way that worsening physical health acts as the moral justification that smooths the path for admission to residential care.

The home is, then, a care setting in which the family takes on a leading role, albeit while constantly interacting with the other components of the mosaic of care resources, including those provided by the market, an issue that we will explore further.

Paid home-based care work: the strain of the precarious

The case of Paco, an 80-year-old with Alzheimer's disease, who lives on the outskirts of Barcelona, is paradigmatic of the complex mosaics of care resources that families must construct in order to ensure long-term care in the home in a context of weak public policies. A mosaic, moreover, that gradually changes according to how the situation of dependency evolves and to the availability of resources.

Around 10 years ago, Paco's family—first his wife, who alerted their children—began to notice that "something was happening", "he was strange" and "disorientated". After several consultations, he was eventually diagnosed with Alzheimer's disease. María, his 80-year-old wife, initially took charge of Paco's care. When the situation deteriorated, the family decided to hire a carer for two afternoons a week, to give María a break and so that Paco had company and could go for a walk. This is how María explained it: "I hired him so that we could go out for a walk. If not we wouldn't have gone out at all (…)—you have to get him up, dress him, and feed him. If I have to go out and last the whole day, it's a heavy burden; that is the honest truth" (María, 80 years old, wife, family carer).

Ángel is Paco's carer and is an exceptional case, as few men take on paid care work. The 2008 economic and financial crisis and ensuing destruction of employment in male-predominant sectors favoured the entry of some men to this employment sector (Bodoque-Puerta et al. 2019). It was at that time that Ángel changed direction in his work. After a period of training through the employment service, he began working in a care home, before changing to domiciliary work, which allowed for more personalised care. This appraisal is shared by other women workers interviewed. After witnessing the tough working conditions in care homes (due to chronic lack of staff and intense and standardised work), they preferred to move into domiciliary care work. However, they also point out the difficulties of travelling from one household to another in a short time, particularly because services are usually concentrated into specific time bands in the morning and evening. Highly flexible contracts are a reality across this sector, which adds to the difficulty of being able to work full-time. This forces many workers to hold down more than one job. In fact, this is Ángel's situation. He combines working for a domiciliary service company with private jobs, among them at Paco's house, where he has been informally employed for years. Over time, not only has he increased the number of days he offers domiciliary services but also the caring activities he provides, which now include personal hygiene and psychomotor activities. In 2018, Paco's worsening condition and María's growing burden led to the family's decision to use a day centre in the mornings, following the recommendation of the family doctor. For a long time, the family costed this service. Although Paco had been assessed as grade two dependent, it was not until 2020 that he began to receive benefits from the LAPAD.

The mosaic of care resources is completed by a domestic worker who carries out cleaning chores twice a week. This worker is the daughter-in-law of Mercedes who had worked at Paco and María's house since 1976. Mercedes, a poorly educated woman from Andalucía, lives near the couple's home and, even though she is now retired, goes there on the afternoons that Ángel does not. She spends three hours with Paco "just in case he gets up and falls over or something like that because his family don't want him left alone". During this time, María meets up with her friends or attends extramural studies for older people. For Mercedes, in her own words, "leaving my house to come here [Paco's house] is a lifesaver for me". Mercedes has fewer economic resources than María and must care for her husband, who has pulmonary insufficiency, and her 42-year-old daughter, who has cerebral palsy. During the week, her daughter is in residential care but comes home on Friday evenings for the weekend: "when she arrives on Friday, that's it. I'm stuck there with the

furniture, I mean [laughter] my daughter and my husband. That's why I say leaving the house is a real joy for me" (Mercedes, 69 years old, domestic worker).

Mercedes' case is an example of the social and gender inequalities on which long-term care is based and of how they are highlighted and propagated by the expanding market in care service provision. Moreover, Mercedes is representative of a generation of Spanish women, many from a rural background and poorly educated, who in past decades were employed as domestic workers but are now retired and have been replaced mainly by immigrant women workers (Martínez-Buján 2015).

We have been able to confirm that native-born workers who continue to do domestic work are usually employed by the hour and carry out cleaning chores, which is the case of Mercedes' daughter-in-law. However, live-in work, in which care provision is much more intense and workers take care of "everything", seems to be reserved for migrant women, many of whom are irregularly resident and must face tough working conditions, including informality, low wages or no respect for their rest days and holidays (Offenhenden and Bofill-Poch 2022). Moreover, it is not unusual for them to lose their job from one day to the next, either because the care recipient has died or because their health has worsened and they have been placed in residential care. In these cases, domestic workers must find a new job, as well as somewhere to live.

The sweeping deregulation of domestic work places women workers in a situation of extreme vulnerability, exposing them to accept working conditions they themselves describe as slavery and aggravated, until the recent changes in legislation,[3] by the situation of total defencelessness and lack of protection in which they found themselves on losing their jobs. In any case, we understand that if no effective control mechanisms are put in place, the high degree of informality and widespread non-compliance of labour regulations that characterise domestic work are unlikely to be reversed. Furthermore, to obtain a residence and work permit, immigrant workers must show they have lived in Spain for two years, which forces them to work in the underground economy. If the badly resolved question of foreign status is not addressed, there can be no progress in dignifying this work activity, since many of the workers will be excluded from the advances made in the realm of employment rights and social protection.

Moreover, the marketisation of care is not a solution because it depends on the economic capacity of families and does not modify gender patterns, underpinning the basis of stratified reproduction. Indeed, in a context of weak public policies, women, especially those in the most vulnerable sectors of society, are at the forefront of (paid and unpaid) care work, which in turn exacerbates gender and social inequalities as we shall see in the next case.

[3] Royal Decree-Law 16/2022, of 6 September, for the improvement of working conditions and Social Security of domestic workers and Royal Decree-Law 893/2024, of 10 September, regulating occupational health and safety protections for workers in domestic household employment.

Social and healthcare services: few resources and much demand

Diana returned to the village where her parents lived in the middle of the pandemic (November 2020). She was concerned about her brother's mental health problems and wanted to find a solution to the care needs of both her parents, especially her father, who was 100 years old when we did this interview and had various health issues. Her 91-year-old mother looks after her husband and cooks every day but can do little more because she too has health issues. Diana, who was a nurse and lived in Andalucía, visited her parents and brother often until the pandemic broke out and the worsening family situation forced what would be an important change in her life: she moved back to be near her parents and take charge of their care needs and her brother's. She had recently retired and did not doubt for an instant that at that point in her life she should take control of her complex family situation. This is a modest family that had lived off the father's income as a labourer.

Although Diana can occasionally count on her brother's help, she is the one who organises the logistics of their parents' everyday health and care needs. Her nursing knowledge enables her to solve many health issues arising from her father's delicate health. In the end, the care needs are managed thanks to her own efforts and those of her mother and brother, with recourse to private medicine and direct care employment.

As regards the healthcare sector, Diana rates primary care in the village where she lives as precarious, and in critical situations she has had to turn to private professionals. She believes her father is not properly attended because of his advanced age. "Because he's 100 years old, he no longer has any right to anything. They haven't even come to see him. They simply call from their office". Her mother is also denied certain diagnostic tests that Diana would usually request in similar situations when she was a nurse.

As regards the social sector, her mother receives some financial aid for home care (PECEF), which is covered by the LAPAD.[4] Diana arranged for her father to be assessed for grade three dependency in early September 2022. The assessment was done in January and the family began to receive aid from the PECEF in April 2023. Eight months without receiving the additional aid, even though caring had become more complicated because her father could no longer walk, and another person was hired to get him up and put him to bed. The benefit was still insufficient, and the family considered applying for domiciliary care. However, they decided against that as they would have to forfeit the PECEF and contribute to the cost of domiciliary care through co-payment.

Diana changed her whole life to take care of her family and at present all her energy is devoted to that purpose. What motivates her is a profound religious sentiment and her duty to her family. Although she is pleased with what she is doing, the effort involved is exhausting and requires total dedication. It is also a strain because her mother did not initially accept Diana's involvement in their care ("she wouldn't

[4] The amount of the PECEF for grade two dependency was € 268.79€ per month. For the third grade, it rose to €387.64 per month.

let me do it", Diana tells us). Moreover, she has had to spend some of her savings on private medical care. Added to this is the ongoing support she lends her brother. As someone who knows the health system and who is aware of the right to public assistance, she complains bitterly about its inefficiency in the situation faced by her parents, as well as the difficulty of accessing hospital services. However, she is not critical of social services, though the help received is derisory and ineffective, because she accepts that the family should be responsible for these situations of care.

Social services are stretched because of their incapacity to swiftly meet families' emerging care needs. Unlike healthcare services, the population is largely unaware of their activity, which is often associated with a form of charity welfare. The existence of the LAPAD creates expectations that cannot be met, which is disappointing for those facing a situation of dependency. The aid provided cannot meet existing needs, as the economic benefits are limited. They merely complement the costs that families must assume and, in practice, foster the commodification of care (Martínez-Buján 2011). Furthermore, waiting lists for the benefits set down in the law are long, in excess of one year, owing to a heavily bureaucratised process and lack of flexibility in emergency situations.

The healthcare sector is stretched for various reasons, which include the budgetary cutbacks of recent years that have had a negative impact on primary care in particular. The sector has also been affected by the problems that social services face in finding solutions to the emergency situations confronting the healthcare system and which should be handled by the social care system. That dependency becomes medicalised is not unusual when social services cannot find the appropriate care package for a person who has been admitted to the healthcare system via the emergency service and has lost their autonomy.

The lack of coordination between social and healthcare services shows that both systems devalue care or confine it to the private sphere (Comas-d'Argemir and Bofill-Poch 2022). We want to highlight the negative impact that this lack of coordination has on care recipients and the families providing that care. Diana's case has revealed how the weaknesses of both systems and their lack of connection thwart the provision of care within the family.

Conclusions

In this paper, we have undertaken a comprehensive analysis of all the agents involved in long-term home-based care. As a theoretical and methodological concept, the mosaic of care resources has enabled us to observe the interaction of the agents and resources involved in the provision of home-based care and the resulting tensions that must be interpreted as an expression of the crisis of care and the stratified logics of social reproduction that have global reach. This ethnographic perspective focusing on the home is vital at a time when, on a political level, the home itself is being endorsed as a place for ageing.

Family-centred care, as we have seen, continues to be an indispensable agent in long-term care in the home. Responsibilities are constructed and distributed

hierarchically between family members through a sense of moral obligation, based on reciprocity, social debt and affection. The non-commodified logics of reproductive work are what sustain life and have a great impact on the stratified organisation of society that the capitalist economy uses to its benefit. In each of the three care ethnographies reviewed, we have observed the interconnection between the sense of moral obligation with which families face the responsibilities of long-term care and the need to obtain external resources, whether public or private, by means of commodified logics (domiciliary care workers or domestic workers) that meet their resourcing requirements. Both logics (moral and commercial) coexist in homes, interacting in order to guarantee long-term care in the context of a care crisis.

Moreover, the contradiction between the accumulation of capital and social reproduction results in a buildup of tensions that culminate in the organisation of home-based long-term care. Weak public policies consign responsibility for care to families reinforcing the reproduction of inequalities of class, gender and foreign status on which this care is based, while putting pressure on the different agents that participate in care provision in the home, as we have already outlined. Socio-economic conditions, proximity of services, recognised degree of dependency and availability of care provision within the family are factors that determine the composition of the mosaic of care resources in the home. The result of this combination determines the strategies families deploy to provide care at home and the difficulties that they must face.

The first stress factor in caring at home occurs within the family, which is central to the social organisation of long-term care. Family-centred care gradually increases as the situation of dependency worsens and the initial monitoring ("keeping an eye on") begins to involve more time and tasks to meet the growing needs of the care recipient (Soronellas and Jabbaz 2022). According to the availability of time, money and public or community services, families outsource part of that care by adding new pieces to their particular mosaic or resources: women care workers, public resources, technological devices and support from extended family or the local community.

Caregiving at home leads to tension and isolation, and placing it in the private sphere disconnects it from public demands for a better distribution of long-term care responsibilities through public policy. For those who can afford it, hiring long-term care services is a solution. Yet it is unfair and unequal because women, now mostly immigrants, continue to take on care work, while the idea that caring should be solved in the private sphere according to the resources available continues to gather strength (individualisation of risk). All act against the politicisation of care work and a better redistribution of care between families and the state. At the same time, the domestic sphere renders care work invisible by obstructing professionalisation and condemning it to the realm of the precarious.

The second stress factor derives precisely from that: paid care work. In Spain, as in other Mediterranean countries, the strategy of paying for care, essentially through domestic work (Bettio et al. 2006; Williams 2012), has been an escape route for those who can afford it and has contributed to strengthening an employment sector that is largely undervalued, highly precarious and heavily feminised. Many of these care workers are immigrant women, especially those who are employed as live-in workers and who are particularly vulnerable to labour abuses. Those employed in domiciliary

care, however, have more regulated jobs but must also contend with temporary contracts, difficulty finding full-time work and low salaries. The care crisis is resolved through the precarious work of women, which is devalued precisely because it is considered women's work. The *global lens* enables us to ratify the internationalisation of this crisis and the moral regimes that uphold it (Anderson 2000; Parreñas 2015).

The lack of recognition of care work influences the lack of professionalisation in the sector. Social class and foreign status mean that women accept these jobs because other employment options (e.g., hospitality or retail) do not necessarily offer better working conditions and are perceived as less gratifying (Hebson et al. 2015; Recoil et al. 2015). Caring entails ensuring the wellbeing of others, and the perception of doing a socially significant job can be an important source of personal satisfaction, despite the low wages, informality, temporary contracts, part-time working and intense timetables. At this juncture, it is important to mention that paid care workers can also participate in the moral logics of care, which Hochschild (2000) named the *emotional added value* received by families that purchase affection and care. Moreover, because this sector demands few training requirements, it enables many women to capitalise on the know-how acquired from their own experience of family-centred care, which is also inherent in moral logics. It all generates a perverse circle that reproduces the social and gender inequalities on which long-term care is sustained and condemns these women workers to precarious livelihoods (Buch 2018; Coe 2019).

The third stress factor stems from public social and healthcare services, which cannot satisfactorily meet the rising demand for care by dependent persons, which has direct repercussions on family-centred care. Public policies are weak not only because of the scant services and benefits they offer but also because they create expectations and demands that are not fulfilled, and it is families that suffer the consequences of these delays. Social services are thus stretched by demands that exceed their problem-solving capacity. This also entails problems for the healthcare system, which must often take charge of situations that do not so much affect the health of the persons requiring care but rather their situation of functional or cognitive dependency. In any case, the issue at stake is a conspicuous lack of coordination between the social and healthcare sectors, which also has adverse repercussions on the problems affecting the home-based care of older dependents.

The three ethnographies of situations of long-term care manifest the combination and complementarity of the diverse care agents (family, state, market and community) that are required, while families are expected to solve the difficulties of caring at home. Facing the challenge of deinstitutionalisation, without overburdening families at a time of longer and increasingly more complex care needs, entails considerable social and political effort. Substantial change is needed to avert the current fragmentation of the mosaic of care resources and to aim for better synergies between home-based care and existing resources in the local community. Personalised care on a local and community basis requires more public resources, more support for family carers, significant improvement in job quality and social and healthcare coordination, as has been recognised by expert knowledge and international political agencies. Without these conditions, deinstitutionalisation will only escalate existing tensions in home-based care and increase the injustices of gender, class and origin on which they are based.

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