Portugal

Long-term Care

18 May 2011

Key Facts

- In 2009, 17.7 % of the population was aged 65 years and over, and 4.4% was aged 80 years and over, which is above the OECD average (14.9 % and 3.9 %, OECD Health Data, 2010).
- The percentage of the 65 and over population is expected to reach 32% by 2050 with the population 80 and over expected to be 11% by 2050 (OECD Social and Labour Demographics, 2010)
- In 2006 Portugal spent 0.1% GDP for long-term nursing care.
- Number of beds in day centres, nursing homes and residences for elderly has risen from 79 000 in 1998 to 120 000 in 2005 (Pita Barros and de Almeida Simões, 2007).

Background

Until recently, the provision of long-term care (LTC) services was mainly under the responsibility of families and charity organisations, while the public provision played a minor role (Pita Barros and de Almeida Simões, 2007). The situation is rapidly changing as a result of organizational, legislative and financing reforms (Santana, 2010).

In 2006, the Ministry of Health and the Ministry of Labour and Social Solidarity jointly established a National Network for Long-term Care (*Rede Nacional de Cuidados Continuados Integrados - RNCCI*) as a response to the lack of resources and infrastructure in long-term and palliative care. This may lead to some movement from informal to formal care and a cost shift from families to the NHS (Pita Barros and de Almeida Simões, 2007). The National Health Plan 2011 – 2016 (*Plano Nacional de Saúde 2011 – 2016*) describes the present status of health and long-term care and makes future projections.

The Portuguese Government has recently announced an investment of EUR 140 million in the RNCCI. The Government plans to achieve national coverage under the RNCCI by 2016 (Press release by the Ministry of Health, 4/6/2010).

Benefits and Eligibility Criteria

All citizens who are dependent and need support with care are eligible to publicly funded LTC. To be eligible to admission to a RNCCI facility, a person has to be in one or more of the following situations: transitory functional dependency due to convalescence or similar situation, prolonged functional dependency, being a frail elderly, experiencing severe incapacity with strong psychosocial impact or, severe illness and being in advanced or terminal phase (Santana, 2010). Admission into the care network is decided either by the care teams themselves, hospital discharge management team (MD, RN, social workers), or by a primary care team (Law N.101/2006 of the 6th June).

Delivery

LTC service providers include private, non-profit and NHS organizations. These non-profit organizations, (namely *Misericórdias)*, have also been the main providers of other social services, including meals, laundry services and assistance in obtaining medication. Long term care is also provided at home to patients who do not need to be institutionalised. The importance of home care is growing, and in some regions the infrastructure has been developed through partnership between non-profit organisations, local government and regional health administrations.

The RNCCI comprises teams and units providing continuing care and/or social support, which are organised at a regional and local level (Law n.101/2006 of 6th of June). The RNCCI provides

convalescence and rehabilitation services, long-term care maintenance, palliative care, day care and services to promote users' autonomy (Pita Barros and de Almeida Simões, 2007; Santana, 2010).

By mid 2008, 61% of the RNCCI providers were *Misericórdias*, 16 % other non-profit organisations (*Instituicoes Particulares de Solidariedade Social* – IPSS's), 11 % entities belonging to the NHS, and 12 % for-profit private organisations. Currently the *Misericórdias* take up 48% of the total providers; 23% are private, 20% are non-profit organizations and 9% are public national health services organizations.

Funding and Coverage

The LTC services provided by the NHS tend to be free of charge or with nominal payments by users. Long waiting times have increased demand for private services by those who can afford them (Santana, 2010). Social care services are usually subject to means tested co-payments calculated according to taxable income (Pita Barros and de Almeida Simões, 2007; Santana, 2010).

Health care costs, such as the costs of convalescense and palliative care units, are covered out of the budget of the Ministry of Health and are free to users. The medium-term and rehabilitation units are financed by the Ministry of Health and Labour, and to a lesser extent by the Ministry of Social Solidarity (*i.e.* when patients do not have the resources to pay their part). Long term care is mainly covered by the Ministry of Labour and Social Solidarity (*i.e.* when patients do not have the resources to pay their part) and to a lesser extent by the Ministry of Health.

Family carers

Long-term care is still heavily reliant on informal carers, but exclusive reliance on family carers is changing due to the growing availability of good-quality solutions through RNCCI (Santana, 2010). According to Alzheimer Europe (2009), family carers are mainly women (75%), and male carers are usually husbands caring for their wives.

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