Long-term care in Portugal: copping with one of the oldest populations in Europe?

Curso de verano Universidad Internacional Menéndez Pelayo

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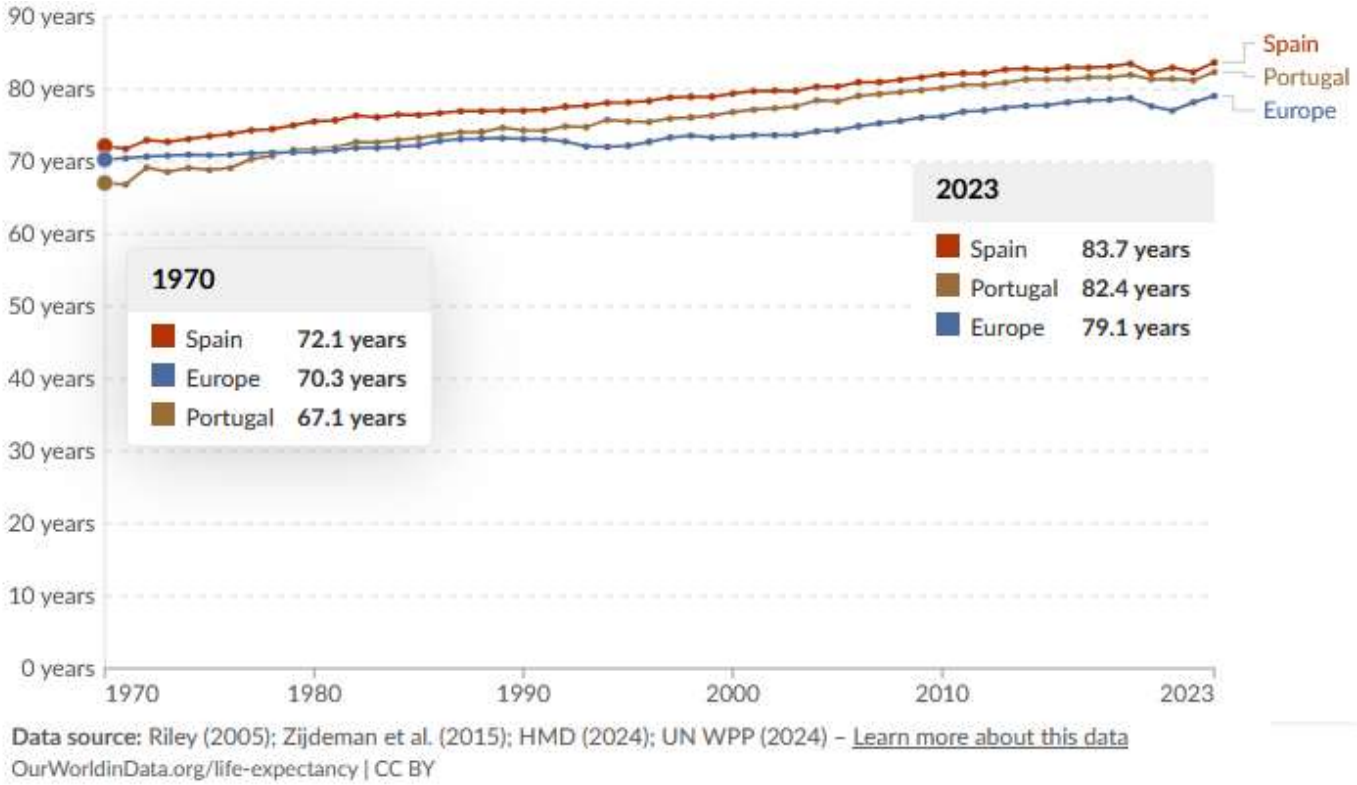
Structure

1. Needs among an ageing population
2. Familialism by default
3. Delivery of services
4. Performance
5. Weaknesses, strenghts and possible developments

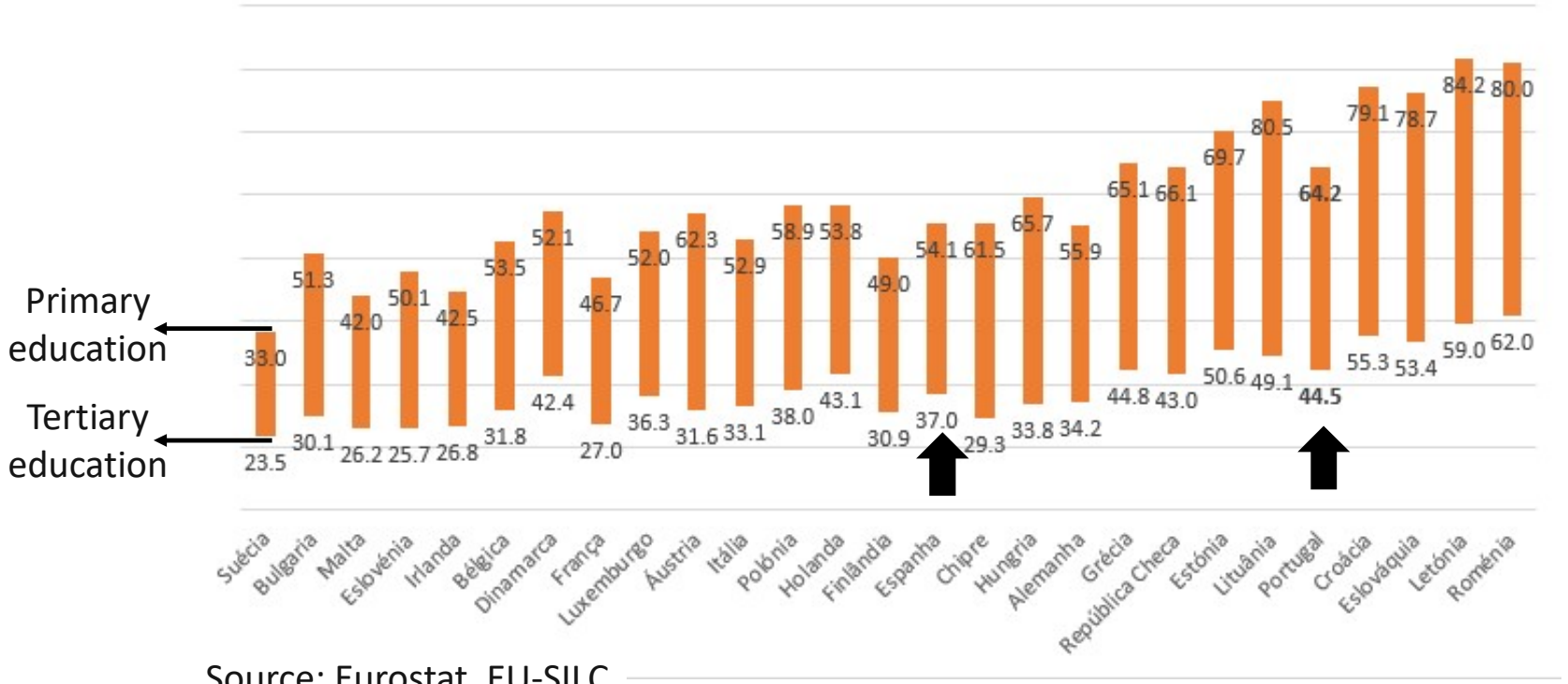
A success story: a dramatic increase in life expectancy

Life expectancy at birth between 1970 and 2023



A *long and (not so) prosperous life*

Percentage of the population aged 65+ reporting health limitation (some or severe), by education level (2021)

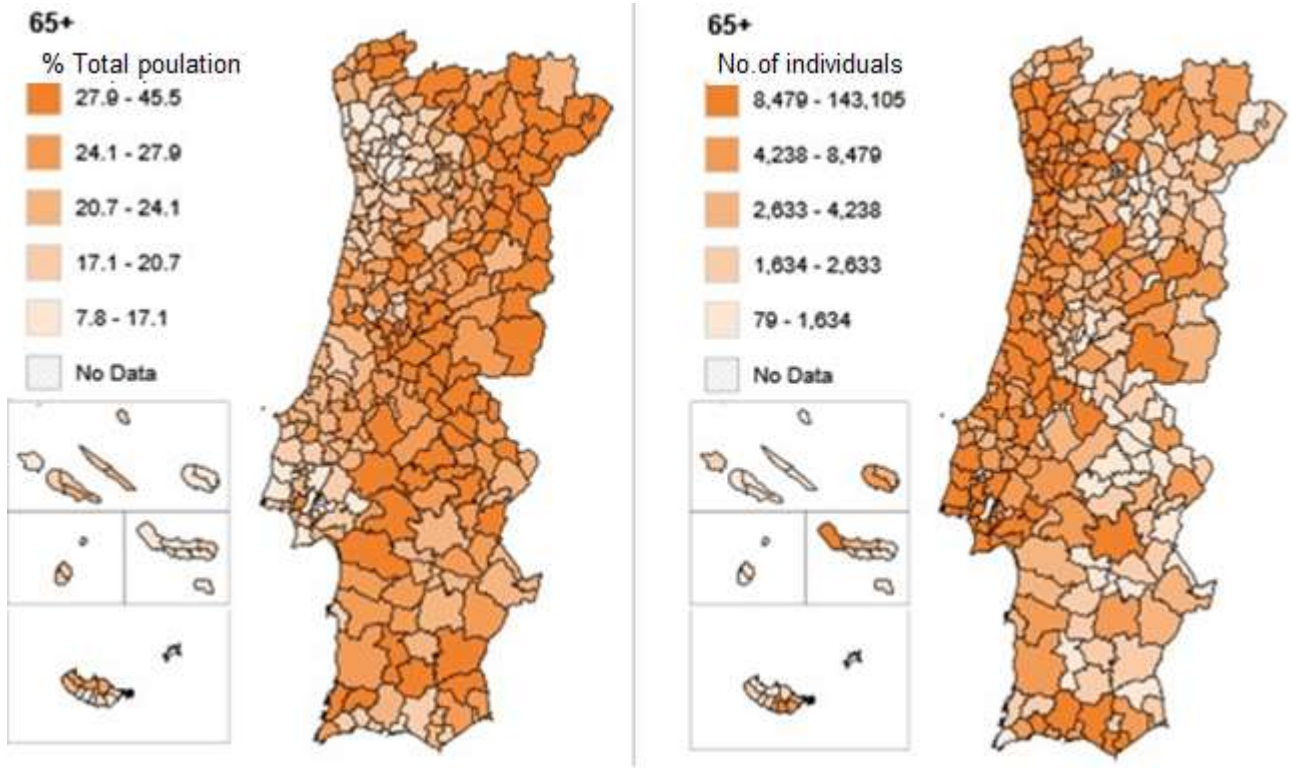


Source: Eurostat, EU-SILC

Profound territorial inequalities as well... not always as expected

- While 65+ with tertiary education have better health than EU average, those with lower education do not
- Important inequalities in social determinants of health: income, housing, access to health care

Distribution of the old-age (65+) population in Portugal, by municipality (2018)

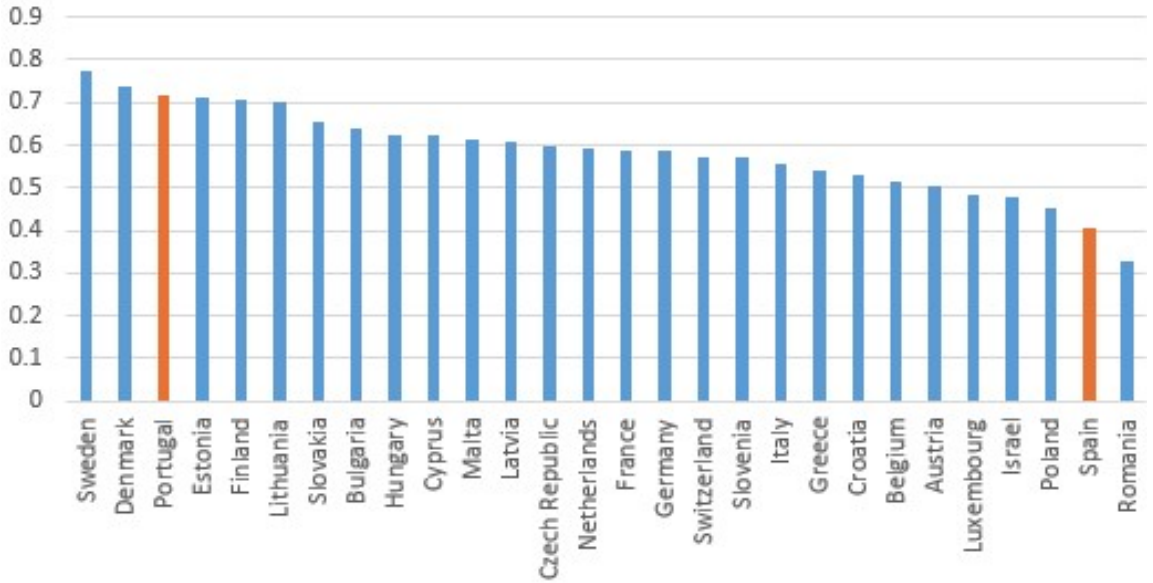


Source: INE, Pordata

Familialism by default – the relevance of informal care in Portugal

- More than 25% of those aged 50+ provide care (even higher among 50-64 women and 65-74 men) (Rodrigues et al, forthcoming)
- Around 6% of 65+ receive informal care

Proportion of informal carers aged 50-64 who work full-time (2022)

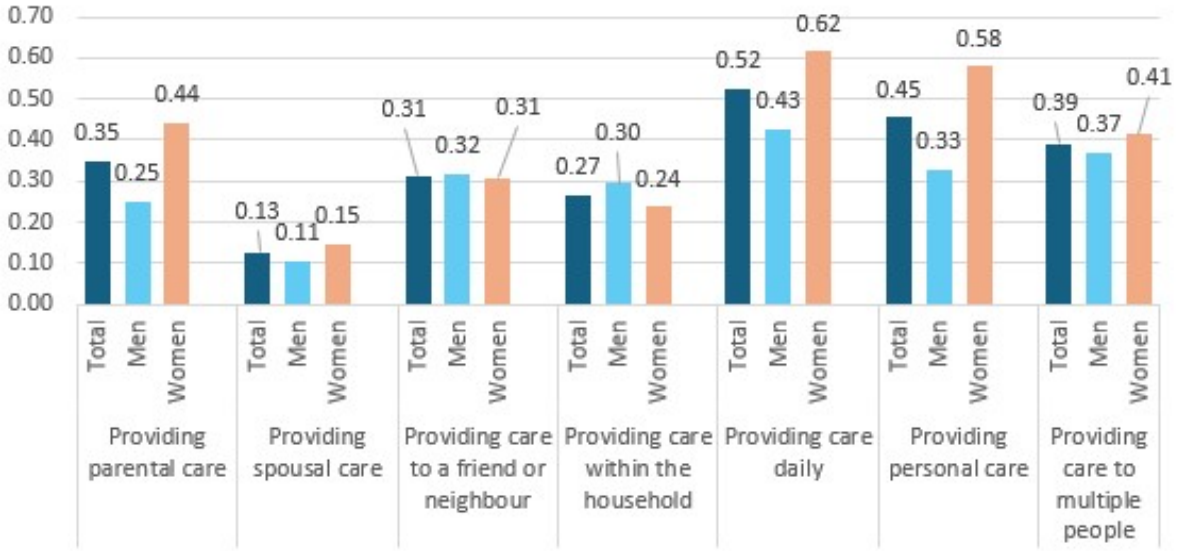


Source: Rodrigues et al (forthcoming), Barometer on unpaid care, based on SHARE data (wave 9), weighted data.

Familialism by default – the profile of caregiving in Portugal

- Mostly upward intergenerational care
- For women especially, potentially high care burden (daily, personal care, to more than one person)
- Marked gender differences

Proportion of informal carers aged 50+ providing different types of care in Portugal, by sex, 2022



Source: Rodrigues et al (forthcoming), Barometer on unpaid care, based on SHARE data (wave 9), weighted data.

Familialism by default – a focus on the duty to care, not on the right to (provide) care

- General dependency supplement (akin to top-up pension):

130.62 EUR to 261.25 EUR monthly, no means-test, conditional on needs, wide take-up

- Care leave schemes to care for dependent relatives (short-term)
- **Informal carer Statute** (2019):

Stringent means test: 624.56 EUR (2022) monthly equivalised income

Co-residing family carers, now extended to co-residing carers

Incompatible with several sources of income

Symbolic only? 5652 beneficiaries receiving on average 309 EUR monthly (2022)

Other benefits: respite care, pension entitlements (under certain conditions)

The current formal long-term care system(s) in Portugal

3 systems/benefits coexist, each with its own eligibility, financing and benefits:

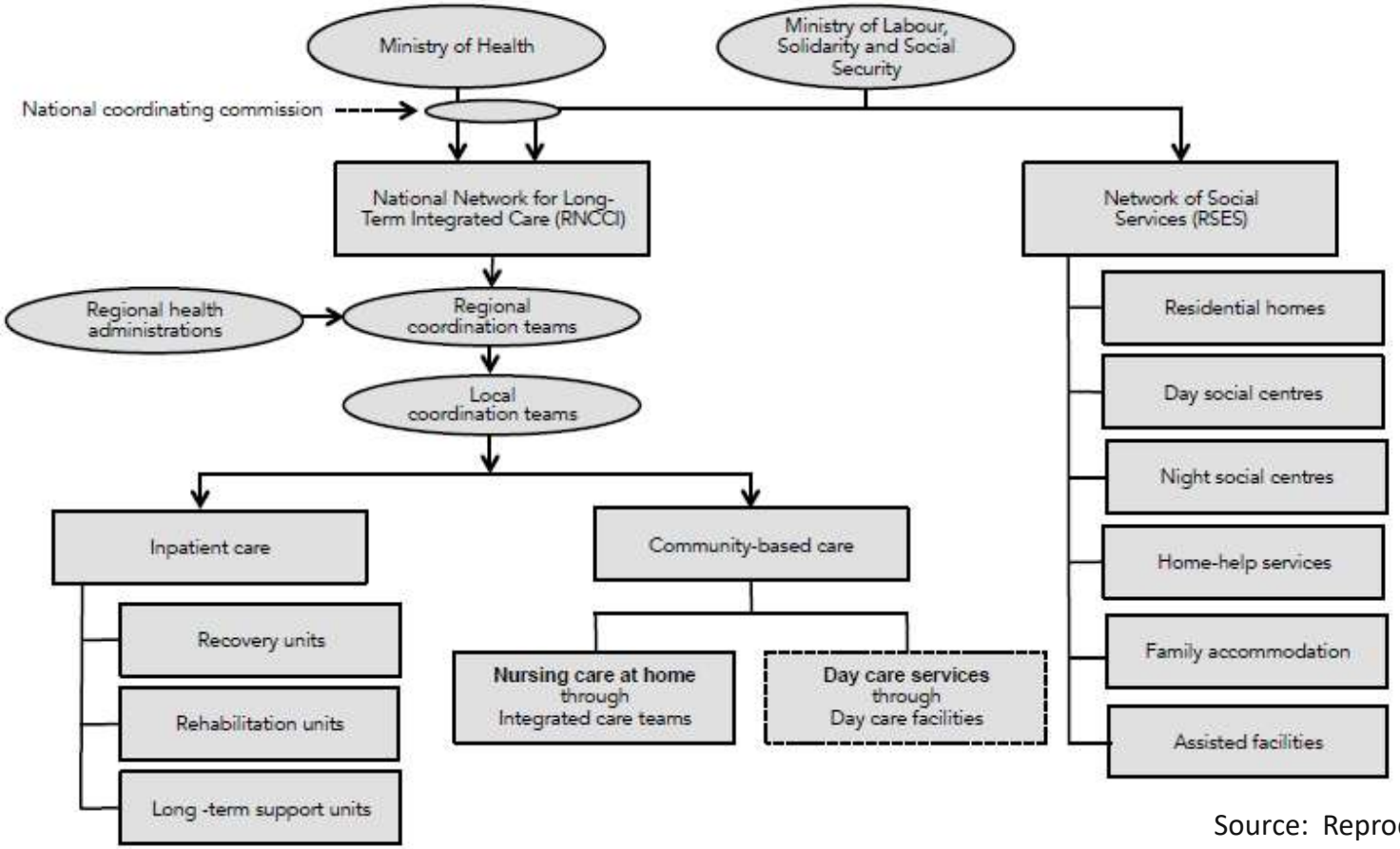
- *Rede Serviços e Equipamentos Sociais - RSES* (**Network of Social Services**): mostly social care (residential and home care), in practice means-tested, mostly non-for profit, workforce with limited qualifications, funded through general taxation
- *Rede Nacional de Cuidados Continuados Integrados* – RNCCI (the **National Network for Long-term Integrated Care**): mostly medically-based care (e.g. nursing home care), focus on rehabilitation, universal, public and non-profit, regulated qualifications requirements for staff, funded through general taxation
- Cash benefits (insurance and social assistance): mentioned before, general taxation and social contributions

Multiple entry points: discharge management, GPs, social security offices, families/providers

No right to care and diverse instruments to assess needs

Different regulations concerning quality standards (mostly structural for RSES, processes and outcomes for RNCCI) and inspections

The current formal long-term care system in Portugal



Source: Reproduced frm WHO (2020)

Another important player: private (non-profit) providers

- Non-profit providers (many faith based - *Misericórdias*) have between 60% and 80% of residential and home care capacity (RSES).
- Publicly-provided care is limited, except for Lisbon.
- Umbrella organization negotiates:

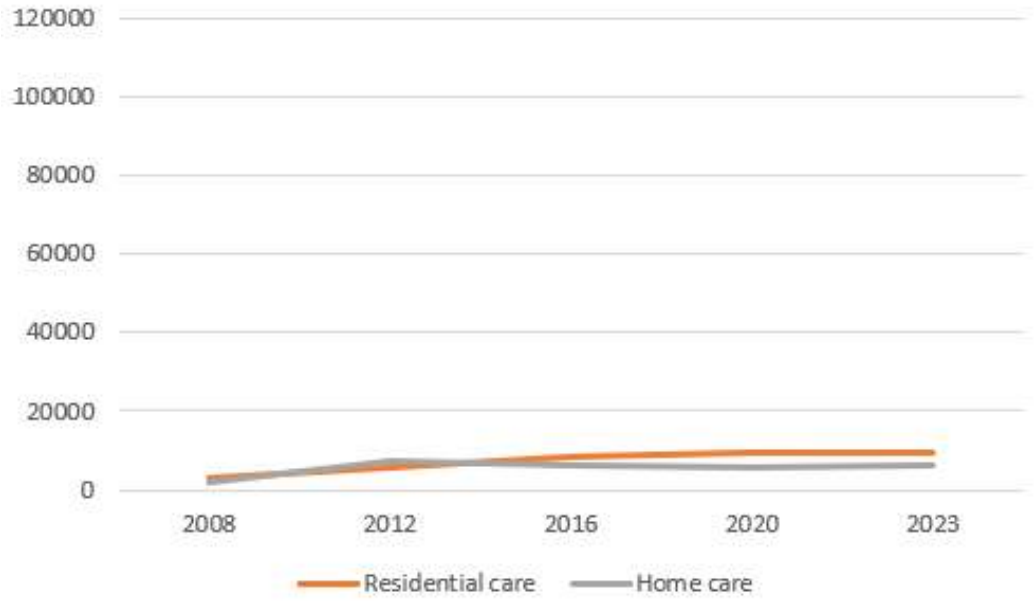
operating subsidies with the Ministry of Social Affairs

Wages, through collective bargaining agreements with unions (about 80% of employees covered, but many on ‘0’ hours contracts)

- Cross-subsidising of users in non-profit residential care

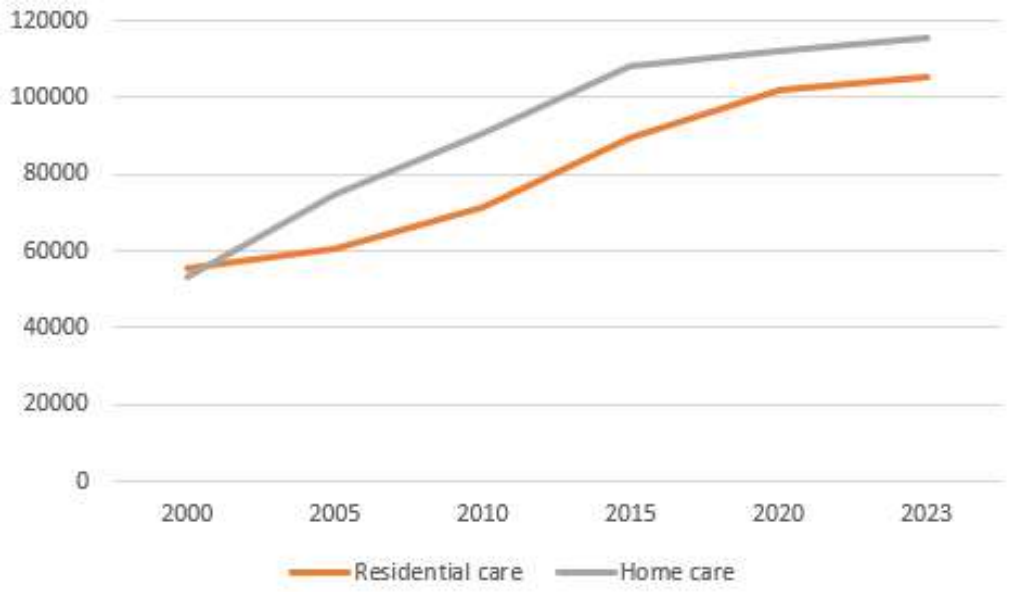
Different trends in long-term care services between

Capacity in the National Network for Long-term Integrated Care (2008-2023)



Source: WHO (2020), ERS (2022, 2025)

Capacity in the Network of Social Services (2008-2023)

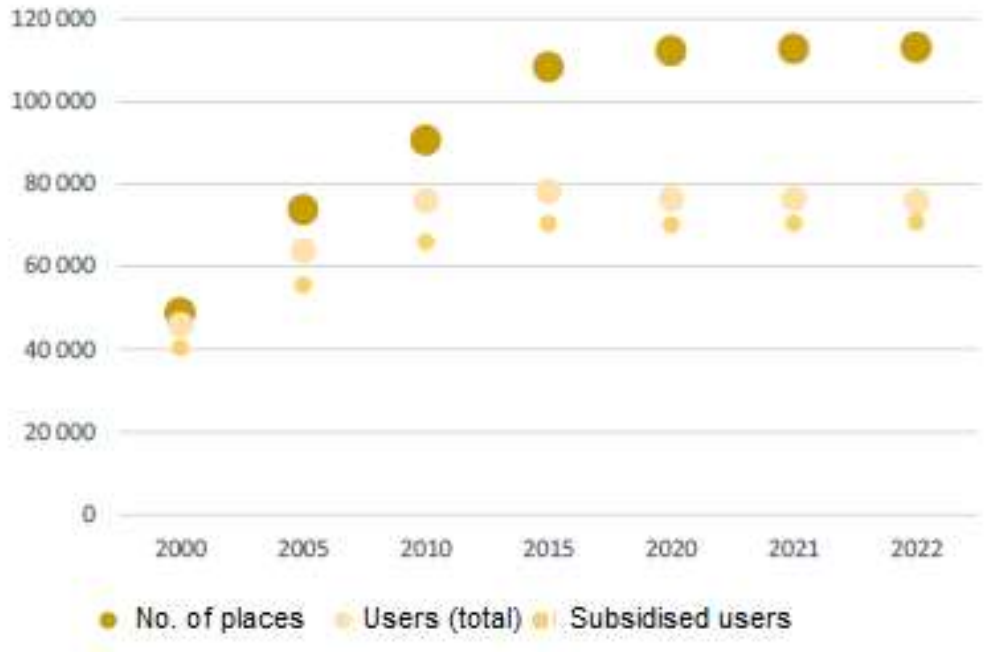


Source: GEP (2015, 2023)

Puzzle: non-take of home care in RSES

- Most users are subsidised, few pay full costs of care
- Most have difficulties with moving around or bathing
- Costs perceived as high and internalized by families?
- Mismatch with needs of people with dementia?
- Cultural reasons?

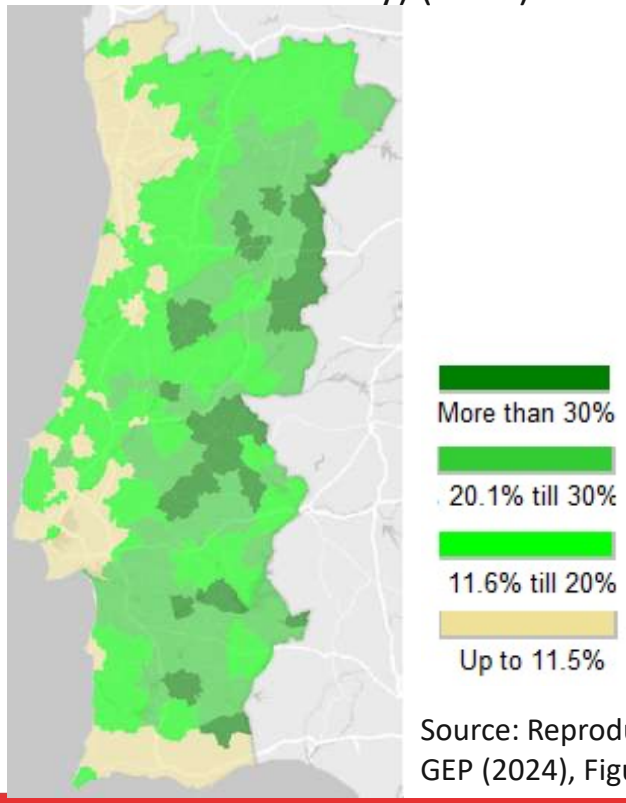
Capacity, users and subsidised users in home care (RSES)



Source: GEP (2023)

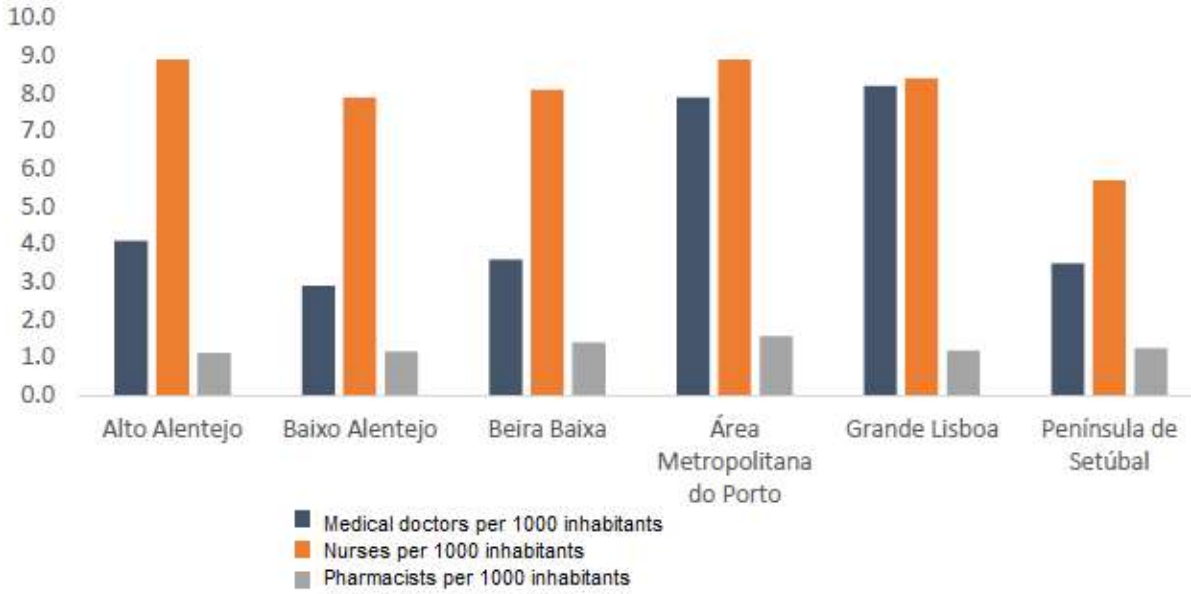
‘Welfare municipality’ despite a centralized system

Share of 65+ with access to long-term care (Network of Social Services - RSES only) (2022)



Source: Reproduced from GEP (2024), Figure 78

Regional distribution of medical staff per 1000 inhabitants, per region (2022)



Source: INE (2023)

Workforce shortages and a dual system of qualifications, wages…

- Portugal compares unfavourably with other EU countries in terms of care staff (1.5 per 1000 inhabitants, compared to 8 for Spain, 10 for Germany and 24 for Sweden) (OECD, 2017)
- In RNCCI: 1 nurse per 1 care assistant (home care) or 1 nurse for 3 care assistants (residential care)
- Wage premium in long-term care (except for men), but low qualifications and task profile mean low-wages (Szenkurök and Rodrigues, forthcoming)
- High qualifications for RNCCI vs low qualifications and job profile for RSES→ labour shortages, especially in the RSES

Performance of the system

- Better than EU-average of amenable mortality
- Better than EU-average avoidable hospitalizations caused by chronic conditions, low hospitalizations due to ambulatory-sensitive conditions (12%, against 20% in Germany) and low unplanned hospital admissions related to re-admissions (4.1%) (WHO, 2022)

An efficient and effective systems, particularly healthcare, but…

- High level of unmet needs, especially due to financial reasons
- Waiting times for the RNCCI have increased (for rehabilitation centres 17-51 days, for long-term inpatient care 22-73 days) (ERS, 2025)
- Low patient satisfaction with services

Weaknesses – no country for old persons?

Weaknesses:

- Lack of resources (formal care and workforce)
- No recognised ‘right to care’→ reliance on family, own resources and local availability → inequality in access
- Reliance on informal care, limited support to carers
- Different system(s) (financing, eligibility, coverage, information systems…)
- Focus on residential care, limited take-up of home care
- Low on the political agenda

Welfare state focuses on cash benefits=pensions

Limited advocacy or pressure from civil society


Expresso

NCÊNDIOS ECONOMIA REVISTA TRIBUNA BLITZ OPINIÃO PODCASTS JOGOS

SOCIEDADE

Seis idosos morreram em incêndio no lar da Misericórdia de Mirandela

ESTELA SILVA/Lusa

Source: Expresso online (16.9.2025)

Strenghts – nonetheless, it seems to work

Strengths:

- ‘Granularity’ of the system (RSES) in rural areas
- Relevance of primary care (identification and delaying of needs)
- Despite ‘duality’ and centralized system, evidence of coordination at local level (case management, discharge teams, role of local actors)
- Cohort effects: new generations of older people with better social determinants of health (Eurostat: 2.2 years of HLE at 65 gained between 2014 and 2023 – only Italy and Slovenia have a better performance)
- Overall efficiency and efficacy of the system

Possible developments (?) – some good, some we don't know

- Expert group on Sustainability of Contributory Pensions (2025): including long-term care as a risk covered by the contributory system (potentially replacing risk of survival)
- Personal assistants: MAVI (Independent Living Support Model) piloted for people with disabilities (up to 65 years-old), but…
- Personal budgets? Concerns about financial abuse and (strong) opposition of providers
- 'Grey market of care' based on migrant carers? Akin to 24h carers, high income users
- Spill-overs from other policy areas: housing (a strong determinant in transitions to residential care), social determinants of care (education, income)

Thank you very much for your attention!

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