Services for Supporting
Family Carers of Elderly People in Europe:
Characteristics, Coverage and Usage

EUROFAMCARE

National Background Report for Portugal

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Content

Summary of Main Findings

- In Portugal there are no representative organizations of family carers. There are some associations indirectly related to family carers of elderly people: Association of Families of Alzheimer's Disease Patients, Association of Parkinson's Disease Patients … Marginally, the influence of the Senior Card Foundation can be considered.
- Specifically concerning the National Health System there is currently no official organization that advocates on behalf of patients in Portugal. There are a number of quite active disease-based advocacy groups such as those based around diabetics, haemophilia, AIDS, cancer. These are narrow interest groups that usually promote the allocation of more resources for the care and treatment of patients in that particular disease group. In addition, some mechanisms have been developed by regional agencies as part of their remit for giving citizens a voice about their health care. A citizens' representative who will act as intermediary between the regional agencies and the community, will be involved in the development of local health systems. In general, there are mechanisms for consumers to make complaints in every public institution.
- The recognition of informal carers, particularly family carers, as agents of care and partners in the still non-existent global system of care depends on a vast change in social policies, mentalities and professional culture. Pursuing that recognition demands the acceptance of two principles: the right of the older person to choose who will provide the care he / she needs; the right of families to choose whether they wish to be carers and to formulate the conditions to perform that role. In Portugal, family care of elderly people is assumed as a natural process, culturally justified and socially accepted.
- In Portugal there are any services specifically targeted at family carers of elderly people, however some social services, such as home care support services and day centres, play an effective indirect role in supporting family carers.
- In Portugal, as in other southern European countries (Greece, Italy and Spain), the extended family plays the most important role as informal provider of care. There are clear obligations within the nuclear family (from spouses to each other and from parents to children), which are embedded within a much wider set of familial obligations, and include grandparents, siblings, uncles and aunts. Families are expected to support one another across a broad range of relationships and someone in need is expected to look first to their family for support. Services that exist are mainly for those without family. Cash benefits usually recognise spouses but may also cover a wider range of dependents (survivors' benefits, for example, recognise other relationships apart from widowhood). 'Non-family'

relationships, such as cohabitation, are unlikely to be perceived as giving rise to obligations in the same way as kin relationships.

- Furthermore, in our country there is a strong sense of family privacy with an assumption that families should be left alone and policy should be generally non-interventionist. However, this is not necessarily privacy between spouses, or between parents and children. Rather it is a privacy that exists within the extended family as a whole. Thus, for example, other family members are expected to provide care for dependent adults and to substitute for parental care. Nor is individual autonomy a central goal of policy; instead assumptions of dependency relationships are pervasive in policy in respect of both cash transfers and care provisions.
- So Portugal may be described as a country with a strong and explicit ideological commitment to the family, but a low profile as far as family policy is concerned. In the past, social policy measures were introduced and improved later than in other member states, in the seventies and eighties, and usually in the context of severe economic constraints and a weak development of the welfare state. In this setting, the family has always been seen and taken largely for granted as the basic provider, carer and problem-solver for individuals, its capacities acting as a compensation for the uncertainties and weaknesses of social policies. This does not mean that there have been no changes affecting families. Over the last two decades, there have been major legislative changes relating to marriage and divorce, parental responsibilities, women and children's rights, as well as a slow, irregular, build-up of financial support measures and services. Seen in a comparative perspective, however, social provision for families, especially where service provision and support for vulnerable families are concerned, has been sketchy and poor in Portugal.
- The large majority of support services for elderly and dependent people exist within the Social Security system, which makes available support in money and services. Service providers are mostly Private Welfare Institutions (co-financed by the State) (Instituições Particulares de Solidariedade Social). The coordination between PWI and the state takes place by means of agreements signed by the Regional Social Security Offices in connection with social action. The state financially supports the PWI and is also responsible for regulating their activities.
- In the domain of Health care support for the elderly and their families is enquadra-se… in the general norms of the National Health Service, in other words, it is governed by the norms which exist for the population as a whole, having some discounts for the elderly and their dependents.
- In Portugal, the family is the main entity responsible for meeting the needs of elderly and disabled people. Financial and service-based forms of support are still poorly developed, with the public and non-profit making sector aimed primarily at supporting the less well-off social groups.

Families with elderly physically dependent or disabled persons often complain of a lack of support in fundamental situations such as moving a disabled person without having to call an ambulance or removing architectural barriers in public buildings. A National Survey on Disabilities, Handicaps and Disadvantages in Portugal also showed that extremely low percentages of disabled people, between 17 and 27 percent of those aged over 55, ever had access to rehabilitation.

- Concern about the situation, especially the care of the elderly, has nevertheless been a constant trend in public debate over the last few years and has led to some policy response. For example, an effort to increase home-based care services (up from 20,568 users in 1992 to 24,934 in 1994) and day care centres (up from 27,967 in 1992 to 30,224 in 1994), to assess systematically the quality of care in homes, to close down those designated as unfit and to promote the creation of new homes. The supply of residential care places is low. According to social security statistics, in 1994 there were 26 homes belonging to the public social security network (25 in 1993) and 690 private establishments (657 in 1993); 28,802 people were on waiting lists for homes. The Programme for the Integrated Support of the Elderly (PAII), created in 1994, has also continued to be developed and, in 1995 / 96, began setting up two types of services: the Telealarm Service, which allows elderly people living alone to be in immediate contact with an outside network of carers and health professionals when in need; and the SAD (Serviço de Apoio Domiciliário), a home-based 24-hour care service which includes medical and nursing care (46 projects and 1,574 users in 1995 / 96).
- Political structures in Portugal are national, there is no local autonomy, thus regional and local differences are limited to the availability of finances and citizens' involvement in community life.
- At the moment in Portugal, policy makers are centred on poverty and unemployment, although increasing attention has focused on family care of elderly people, mainly on the problem of reconciling occupation and family life, given that the country has one of the highest indices of female participation in the workforce in the whole EU, as well as with long-term care and pensions.
- Furthermore, policy makers are aware that family care tends to become fragile due to demographic alterations, so the future will bring growing needs for family carers, arising from an erosion of family networks and growing individualization of lifestyles. Family relationships still remain but they are transformed through a greater demand of autonomy.
- Policy makers are conscious that a new wave of social policies should, in brief, emerge in Portugal, since families nowadays have organizational models that require new social and health services, in order to facilitate

women's participation in the labour market as well as men's participation in family life.

- Recently, the Minister of Social Security and Labour, in a public speech maintained that financial support to family carers of elderly people should be made available to families, instead of institutions, and that families should decide about caring for the elderly at home or in an institution.

Introduction – An Overview on Family Care

In Portugal family carers are not registered, and additional services are aimed at helping the elderly not supporting family carers, so it is not possible to obtain accurate data concerning the situation of family carers (their number, age, gender, sources of income and education).

According to the data from the 2001 national census, Portugal (including the Azores and Madeira) has a total of 10,356,117 inhabitants, 8,641,537 of whom live in mainland Portugal. In the continent, 1,524,127 of the inhabitants are over 65 years of age (17.6 %). The elderly population has doubled during the last 40 years, and this trend will persist at least during the next 20 years. This is due to the decreasing of the younger population, and to the increasing of the elderly. The ageing of the population is particularly visible amongst women, in fact life expectancy at 65-69 years is 80.7 % for men and 84.2 % for women. The percentage of men aged 65 or more in comparison to the overall number of men is 7.9 %, while elderly women make up 18.1 % of all women. Among the elderly, the ratio of men to women is: 1 man to 3.4 women. The oldest people (aged 80 or more) make up 3.9 % of the population.

As previously pointed out, family carers are not registered in Portugal, thus their number can only be calculated based upon the number of elderly disabled people living within the family. These calculations indicate that 2.3 % of the total resident population is caring for an elderly person, and it is predicted that this number will increase in the coming years, since the older population, mainly those over 85 are increasing.

The family is the basis of support in Portugal, and family networks and reciprocity is strong, as Santos (1993: 46) put it: “in Portugal a weak welfare state co-exists with a strong welfare society”. The term “welfare society” is deemed to include the whole set of “networks of relations of mutual acquaintanceship, mutual recognition and self-help based on kinship and neighbourhood ties, by means of which small social groups exchange goods and services on a non-commercial basis and on a principle of reciprocity” (Santos 1995).

In rural communities (located mostly in the interior regions of the country) informal networks, particularly kinship networks, are the main source of support for elderly people. In fact, they are the only possible resource due to the major lack or often the non-existence of social services and facilities in the community.

In the urban context, the older person’s place of residence takes on particular significance. If the older person is living with the main carer, then it is the latter that provides care, with the help of other people in the household or with the support from some formal service. When the older person does not live with the main carer, there is often a need to combine informal support with formal support. In most cases, this means that the informal network provides emo-

tional support, while the formal network provides practical or instrumental support such as daily hygiene, domestic cleaning, and the cooking of meals (Quaresma 1996; Sousa and Figueiredo 2002b; Kröger 2001).

There is another point on which the conclusions of most studies converge: informal support networks are made up almost solely of women who are predominantly relatives of the woman who takes on the role of main carer. Recently, Santos (2002) dared to propose the substitution of the term welfare society for the term "welfare woman", confirming women's supremacy at this level. Indeed, women undertake, in the overwhelming majority of cases, central roles in both contexts: in the interaction with social agencies and in informal social networks (Matos and Sousa 2004).

In Portugal there is no public (or private) state or local care service provision specifically directed to family carers of elderly relatives. Social policies have supported the creation of facilities and services for the elderly, which indirectly help family carers. Nevertheless, it is important to highlight that Portuguese social protection services are specially directed at the economically deprived sections of the population, as it is clear in Article 81 of the Portuguese Constitution that defines the objectives guiding social policy in Portugal: "a) to promote the improvement in the social and economic welfare and the quality of life of the people, particularly the most disadvantaged, within the framework of a strategy of sustainable development; b) to promote social justice, ensure equality of opportunities and correct inequalities in the distribution of wealth and income by means of fiscal policy". Therefore, Social Action is applied at two levels:

- The provision of services with direct management of social facilities (particularly, kindergartens, homes for the elderly, etc) or with the establishment of agreements with private welfare institutions that ensure such management.
- The award of benefits to a population that visits its information and advisory services. It will be noted that the award of such benefits is totally discretionary, the amounts depending on sums available in each region at the time, and very often on the subjective assessment made by the social services staff.

Old age as an area of social intervention has received a lack of support for families, whether this be in terms of monetary benefits from the state social security system or in terms of social services and facilities (Hespanha and others 2000; Quaresma 1996), although the extent of coverage has tended to increase in recent years. Most social services and facilities for older people are a part of the Private Welfare Institutions (Instituições Particulares de Solidariedade Social).

Given this structural framework, it is clear that the range of possible solutions open to Portuguese families for taking care of their older relatives is limited

from the outset, given that formal networks are still inadequate to respond satisfactorily to families' needs. Therefore, it can be stated that, in general, the care of older people, is part of a structural context in which there is a weak welfare state, a debilitated private non-profit sector, a private for-profit sector which is not yet extensive, and a very limited welfare society (Hespanha and others 2000).

In Portugal high-medium and high-class families tend to purchase private personal care services through the employment of housekeepers that may be hired as care workers or not, but who, in any case, effectively have that role. Traditionally this role was played by Portuguese women from lower socio-economic classes, but during the last decade the increase of migrants, both from the ex-Portuguese colonies (Brazil, Angola, Mozambique) and (during the last 5 years) from the Eastern European ex-Communist countries, have increased the employment of migrants that constitute cheap labour. In 2001, 350,503 migrants were given residence permits, and between1981 and 2001, the number of migrants has increased 68.8 % (SEF 2002).

This market is mostly irregular or illegal. As far as Portuguese workers are concerned, they are usually hired in an informal way, which does not mean illegal, because these activities are legislated. Such carers often substitute family carers in terms of the practical tasks of care, though family carers usually remain in charge of their payment, supervision and management. Family carers maintain the role of emotional support, transportation and financial management.

According to Almeida and Ferrão (2002) there were around 50,000 persons working as volunteers in 2001, the majority in Fire Offices and associations for infants and adolescents. Old age is not yet attractive for volunteers, mainly due to the scarcity of services for this population.

Neighbours and friends are the second most relevant informal unpaid care, often supporting family carers by sitting with the dependent older person while the carer undertakes essential tasks. They are important, also, as emotional supporters, both for the elderly person and the family carer. The Catholic Church, dominant in Portugal, provides support to older people in local parishes; but the degree to which they help family carers is unknown.

There are no epidemiological Survey data on disability levels amongst elderly Portuguese people. However, results of the 2001 census reveal that the incidence of deficiency increases with age, thus in the age group 0 to 16 years the percentage of deficiency is 1/3 lower than the percentage of deficiency amongst elderly people. This tendency exists in all areas of deficiency, except for mental deficiency where the ratio is similar in all ages. Furthermore, the incidence of chronic disease (National Health Enquiry 1998 / 99) has showed that hypertension as well as pain is most frequent among elderly people; additionally, diabetes shows a higher incidence among older women.

An investigation carried out by The National Health Observatory (ONSA 2001), with a representative sample of elderly Portuguese people, showed that 8.3 % of that population comprises highly impaired persons, while 12 % need every day support for activities of daily living. According to this data, 20.3 % of people with 65 years or more need daily care.

Another study, carried out with a representative sample of 1,747 elderly people aged 75 years and more, aimed at defining "dependency groups" taking into consideration the competence of older people to perform ADLs (activities of daily living) and IADLs (instrumental activities of daily living). This study found that: 54 % were completely independent; 15.8 % showed IADL limitations only; 14.7 % were very dependent; and 12.5 % were completely dependent (Sousa and Figueiredo 2002a). According to this data, 46 % of people aged 75 years or more need some type of care.

Portugal is now confronted with the consequences of the ageing phenomenon, in terms of pension systems, but not yet fully engaged with the implications of care for the elderly and frail. For the moment, the main social and political preoccupations are centred on poverty and unemployment.

In Portugal, Voluntary Health Insurance (VHI) exists as a substitutive measure, covering those persons excluded from statutory protection. In 1998 (OECD 2000), VHI represented 1.7 % of total expenditure on health. In Portugal over 70 % of VHI is bought by employers as a way of obtaining lower unit costs and younger and healthier employees. VHI expansion is being promoted through tax incentives.

Access to the national health system is universal, based on social contributions and taxation, while access to social security is universal and free.

The Revolution of 25th April 1974, which brought to an end the dictatorship regime in Portugal, led also to a profound reform of social protection policies (Hespanha and others 2000), essentially based on a significant political state responsibility: a national health system was launched and an integrated system of social security was developed.

In the health domain, the State assumed the role of main finance provider and direct producer of goods and services, both in the field of hospitalisation and ambulatory care. Social security assumed responsibility for the rectification of social inequalities, providing support for in-risk groups (handicapped and dependent, elderly, unemployed), and a "social pension" for all those with invalidity, aged 65 years or over, without any other income. Within civil society, several organizations emerged as a result of citizens' involvement in community life.

Furthermore, while Portugal was a country of emigration before the revolution, its emigrants returned to their mother country after 1974. In general, however, their sons and daughters preferred to stay in the foreign countries, so that only the elderly returned, usually to the rural areas where they were born (Fernan-

des 1997). As a consequence of those social transformations, the natural solidarity between generations, a kind of life insurance that constitutes an important component of the cultural patrimony has been declining (Fernandes 1997).

1 Profile of family carers of older people

In Portugal family carers are not registered, and additional services aimed at helping the elderly not supporting family carers, thus it is not possible to obtain accurate data concerning the situation of family carers (their number, age, gender, sources of income and education). Nevertheless, there are available a set of relatively recent studies (mainly since 1995) on the care of older people in Portugal. The studies fall into two main types: i) research projects carried out within the context of the social sciences; ii) studies carried out mostly by the Ministry of Social Security and Labour (Ministério da Segurança Social e do Trabalho). The following profile of family carers of older people is based on data from these studies.

1.1 Number of carers

As previously pointed out family carers are not registered in Portugal, thus their number can only be calculated on the basis of the number of elderly disabled people living within the families.

According to the data from the last Census on the Portuguese population (2001), 77.5 % of the elderly population live within classic families, 5.1 % live in institutional families and 17.4 % live alone. Data indicate that these percentages vary according to gender and age groups: as the age rises, the proportion of elderly living in institutions increases, and the proportion of the female population in institutions is quite high.

National data related to long-term illness and disability are not available, but ONSA (2001) produced a study where 8.3 % of elderly people were found to be highly dependent and 12 % dependent on a daily basis for daily living activities, so it is possible to consider a rate of dependence of 20.3 % amongst elderly people. Therefore, if 1,181,669 elderly people live in classic families (including households composed by an elderly couple), then 239,878 need a carer, which represents 2.3 % of the total population in carers of elderly people. It is important to emphasize again that this number is just a estimate, based on the available data.

1.2 Age of carers

According to research evidence it is possible to identify two main age groups of family carers: i) those with 65 years or more, usually the spouse; ii) those between 45 and 55 years old, usually daughter or daughter-in-law. The first group represents approximately 20 % of all family carers, while the second groups represents about 64.3 % (Bris 1994; Quaresma 1996; Sousa and Figueiredo 2002b; Brito 2001; Rebelo 1996).

1.3 Gender of carers

A large majority of family carers are women (approximately 75 %), while men assume the care role almost only regarding their wives, but as women's life expectancy is higher, men represent just 25 % of family care (Bris 1994; Quaresma 1996; Sousa and Figueiredo 2002b; Brito 2001). Thus, family carers are usually older or middle aged women, either in rural and urban areas.

1.4 Income of carers

There are no accurate data available on this topic. Nevertheless, it is important to say that the elderly population are, in general, poor and that women (main family carers) are poorer than men. There are massive wage gaps between men and women: in 1998, women earned no more than 70 % of a male wage for the same work. In 1995, 65 % of self-reported home-workers were women. Finally in 1998, the proportion of women receiving survivors' pensions was fairly significant at 84 %. The share of women living on the lowest pension (non-contributory scheme) was 76 % compared to 24 % of older men (Kröger 2001).

Moreover, in Portugal family carers do not receive any pension or other kind of financial support regarding the role of family carer. There are only two types of financial support for informal carers: "dependency complement", awarded to people on an invalidity, old age or survival pension whose degree of dependency is such that he / she needs the assistance of a third party to attend his / her basic needs. Sometimes the elderly person can pay the family carer, or other family members contribute financially to the one who cares, or in some situations, different members of the family (usually the children) care for the elderly on a regular exchange basis (e.g. the elderly stay at each child's home for 1 month, or 1 week).

1.5 Hours of caring and caring tasks, caring for more than one person

Hours of caring depend on the level of (in)dependency of the elderly person. According to Rebelo (1996), 68.3 % of family carers spend more than 4 hours per day caring for their elderly relative. The time spent in caring is closely associated to the level of affiliation between carer and older person: the hours of caring increase as the relationship is more intimate.

Family care tends to be performed on a daily basis. According to Quaresma (1996), 56.8 % of caring is "day after day", and only 6.9 % is occasional. In 17.2 % of cases, the family carer relies on formal support, while 6.9 % are rotational.

Caring for an older relative is usually a long-term activity. Brito (2001) maintains that only 19.5 % of family carers assume the role for less than a year,

while 41.5 % perform this role from 1 to 5 years and 26.8 % for more than 10 years.

Caring for an older person is usually a solitary task, which means that the principal carer only receives help occasionally. In general, family carers care for just one person and in 39 % of the cases without sharing responsibility or activities with any one else. The remaining 61 % have support from social agencies, from other relatives and / or from a housekeeper (Brito 2001; Quaresma 1996).

Family carers perform all the tasks resulting from the elderly person's needs: housework, hygiene, personal care, emotional and social support, financial support, transportation, alimentation, company, … (Quaresma 1996; Sousa and Figueiredo 2002b; Brito 2001).

1.6 Level of education and / or Profession / Employment of family carer

In spite of the inexistence of data on this specific topic, levels of education amongst the Portuguese population are quite low, and especially low amongst the elderly population (table 1).

Table 1: Levels of education of Portuguese population by age group

	25-34 years	35-44 years	45-54 years	55-64 years	≥ 65 years
Total	100	100	100	100	100
6 years or less	43.8	59.2	71.3	81.2	89.1
9 years	18.8	15.3	10	7.3	4.2
Secondary	21.2	13.9	8.9	5	2.8
Higher education	16.1	11.5	9.8	6.5	3.8

Source: INE 2001

So, when the carer is also an elderly person, a low educational level, most often primary level (4 years of schooling), is to be expected. When the carer is middle-aged, the educational level will increase to 6 years of schooling. A lower educational level is also to be expected amongst women than men.

As far as profession or employment of family carers is concerned, there are also no specific data available. But using data related to the total Portuguese population (table 2), it is possible to understand that: if the carer is an elderly man, he can be expected to be a pensioner or retired, while if the carer is an elderly women she will probably be a pensioner or a housewife (e.g. without a proper income); when the carer is middle aged, whether it is a man or a woman, he / she is more likely to be employed on a full time basis.

Table 2: Professional situation of the Portuguese population by age group

	25-34 years	35-44 years	45-54 years	55-64 years	≥ 65 years
Employment	83	81	70.6	39	4.2
Income (from property or business)	0.2	0.5	0.9	1.4	1
Eventual subsidies	3	3.3	4.4	5.5	0.2
Guaranteed Minimum Income	0.7	0.7	0.6	0.7	0.2
Pension / retirement	1.1	2.3	8.1	35.6	89.1
Social support	0.3	0.2	0.2	0.3	0.3
Dependent on family	10.5	10.6	12.9	14.7	4.2
Other situation	1.3	1.4	2.2	2.6	0.8
Total	100	100	100	100	100

Source: INE 2001

1.7 Generation of carer, Relationship of carer to OP

In hierarchical order, family carers are: wife, husband, daughter, daughter-in-law, niece and sister (Bris 1994; Quaresma 1996). Nevertheless, the main initial carer is the spouse when he or she is still alive (Kröger 2001).

1.8 Residence patterns (household structure, proximity to older person needing care, kinds of housing etc.)

It is possible to identify two main patterns of households with older persons (Quaresma 1996; INE 2001): i) nuclear family comprising two elderly members (usually a couple), one caring for the other; ii) family composed of the elderly people, his / her daughter / son and daughter / son-in-law and the grandchildren. In approximately 70 % of the cases, elderly people and family carer live in cohabitation (Quarema 1996; Brito 2001), while, in the remaining cases, they either live very close by or the elderly person is cared for in rotation.

A study carried out by the General Directory of Social Action (DGAS 1998) into the socio-economic and housing conditions of elderly people showed large numbers living in precarious conditions. More specifically, elderly people live in houses which have the basic infra-structures (water, electricity, kitchen, and bathroom), but which are considered substandard: 8 % lack a simple fridge, 23 % have no washing machine; 23 % do not have a telephone; 19 % are in a bad state of conservation.

1.9 Working and caring

As previously stated, when the carer is an elderly person, he / she will be retired, but if the carer is middle aged he / she will, in general, be in full time employment. Moreover, within the European Union, Portugal has one of the highest rates of female work: 61.2 % (Eurostat 2003).

In Portugal, there is only one legal measure that supports family carers of elderly people, that is: public employees have the right to 15 days per year, under the cover of "family medical certification", to care for their elderly relatives; other workers only have the right to those 15 days to care for descendents under the age of 10 years.

A study carried out by the Committee for the Equality in Work and Employment (CITE 1995) found that domestic service companies are those where the impact of workers caring for elderly people is more relevant, since women are predominant in this area of employment and they assume the caring role.

1.10 General employment rates by age

The percentage of the population in employment is quite high in all age groups, around 90 %, and slightly higher in the male sex (table 3). The majority of workers, men and women, work full time (35 hours or more).

Table 3: Employment rates, by age-group and sex (2001)

	Total (employed + unemployed)	15-24 years			25-34 years			35-44 years			≥ 45 years		
		total	Emp. (N)	%	total	Emp. (N)	%	total	Emp. (N)	%	total	Emp. (N)	%
Total	4,990,208	730,228	639277	87.5	1,396,429	1,310,914	93.4	1,281,285	1,213,481	94.7	1,582,266	1,487,275	94
Male	2742035	401,020	360578	89.9	733,290	701,521	95.7	688,354	664,206	96.5	919,371	872,783	94.9
Female	2,248,173	329,208	278699	84.7	663,139	609,393	91.9	59,2931	549,275	92.6	662,895	614,492	92.7

Source: INE 2001

Table 4: Average working hours per week, by age-group

Age group	Total	1-14h		15h-34h		35h-44h		45h or more	
		N	%	N	%	N	%	N	%
15-24 years	606,624	23,217	3.8	43,144	7.1	426,284	70.3	113,979	18.8
25-34 years	1,251,992	37,090	2.9	85,537	6.8	841,038	67.1	288,327	23.2
35-44 years	1,159,013	34,929	3	86,174	7.4	744,494	64.3	293,416	25.3
45-54 years	910,818	30,233	3.3	77,731	8.5	573,039	62.9	229,815	25.3
55-64 years	436,488	22,592	5.2	42,887	9.8	255,200	58.5	115,809	26.5
65-74 years	73,951	6,015	8.1	10,758	14.5	37,585	50.8	19,593	26.6
75-84 years	11,042	1,147	10.4	2,096	19	5,147	46.6	2,652	24
≥ 85 years	783	79	10.1	140	17.9	374	47.8	190	24.2

Source: INE 2001

1.11 Positive and negative aspects of care-giving

Family carers identify both positive and negative aspects of caregiving; negative aspects, however, have been more studied than positive ones (Bris 1994; Quaresma 1996; Rebelo 1996; Brito 2001).

Positive aspects are: self-satisfaction following the sense of fulfilling a duty (maintaining the elderly person at home); a form of repayment to the elderly person; being appreciated by others for this role, especially by the one who is cared for and by more intimate relatives.

Negative aspects are:

- On a personal level: physical and psychological stress and burden; depression (Brito, 2001, found that 56.1 % of carers show symptoms of depression, 26.5 % of them have severe or moderate depression); fear of being unable to respond appropriately to a given situation; missing some aspects of self-realization, especially at a professional level.
- On a family level: conflicts with the spouse and / or children related to the lack of time for them; conflicts with the extended family, which does not help but criticizes the carer (the carer feels exploited by the other members of the family).
- On a social level: restriction on leisure times and cultural activities, which results in isolation and loneliness.

- On a financial level: increasing expenditure.
- On the level of the relationship with the elderly person: fear of losing him / her; fear of dying before the elderly person; sometimes conflict with the elderly person.

Family carers' needs are also identified: information about community supporting services; training for the acquisition and development of knowledge and skills in order to understand the elderly person and feel more self-confident and capable of managing the situation; training in being able to care for themselves; economical support for medication, technical aids, the acquisition of services; legal measures that support the accumulation of work and caring; more formal support, especially available 24 hours per day, and formal respite care (for substitution for holidays or leisure time); company and social relationships; help with domestic tasks; self-help groups.

Needs vary according to household income (not according to urban or rural residence), so families without financial problems are mostly concerned about leisure time, while those with lower income are preoccupied with financial support.

Regarding abuse of the elderly, there is no accurate data in Portugal. Research reveals very few cases of abuse of the elderly, and the few that are identified refer mainly to emotional or psychological abuse, perpetrated either by the elderly people or the carer. The cases reported in research (Quaresma 1996; Brito 2001) refer to affective blackmail by both parts involved, for example: the carer says to the elderly person "without my support you would already be dead"; the elderly people says to the carer "you don't love me anymore".

1.12 Profile of migrant care and domestic workers (legal and illegal). Trends in supply and demand

There are no official statistics available on the subject of care provided by migrants and illegally employed persons in Portugal. In the course of the last few years, there has been an influx of immigrants from Eastern Europe into Portugal. These workers are much cheaper than their Portuguese counterparts and have higher levels of qualification. Women are often employed as housekeepers.

In Portugal, families with medium and medium-high levels of income frequently hire housekeepers to help with domestic work and / or to help with the care of an elderly person. Some times these housekeepers are at the disposal of their employers 24 hours a day, taking care of some less intimate tasks with the elderly person: preparing meals, shopping, mobility and company (Sousa and Figueiredo 2002b). The hiring of domestic employees is legislated, so legal immigrants are also under that legal protection.

2 Care policies for family carers and the older person needing care

2.1 Introduction: Family ethics and expectations – the national framework of policies and practices for family care of dependent older people

There are no specific policies or support services for family carers of elderly people or dependent people in Portugal. Family support is indirect, namely carried out in day centres and health centres. The lack of public debate about this question and the absence of political measures in this area arise, above all, from the fact that the family is considered "the centre of the tradition of collective responsibility to provide care" (Anderson 1992). Indeed, the image of family solidarity, including the oldest members who are cared for within the family circle, is deeply rooted in the cultural values of Portuguese society, and so, whilst the family continues to provide care for its old, it has not yet been the object of any specific political measure. Definitions of family and its social obligations, as found in the legislation and in the practices of social policy in Portugal, have changed over time in response to different social, economic and political contexts. In a brief characterization of this process, four main periods can be identified (Wall 1995):

- Until the 19th Century, in a context preceding social policy legislation, social assistance was based on private charitable institutions (normally linked to the Church), directly or indirectly financed by the royal house. The non-intervention of the state in their activity was underlined.
- In the 19th Century and the beginning of the 20th, state intervention began to be considered a necessary response to the limitations of the private institutions of social protection, although the social response continued to be centred on the charitable institutions. Several pension and retirement funds were set up, through public and private initiatives and legislation about obligatory social security appeared.
- The regime instituted in the 30s and which lasted until 1974 was characterized by the gradual implementation of a system of social protection. The role of the State was redefined and beggar to take charge of the institutions of welfare and social assistance.
- Social policy in the period following the revolution of 25th April 1974 was characterized by a widening of objectives, both in terms of the State and in terms of the beneficiary population, as well as range of coverage and types of benefits and services. It is on this period that we will concentrate.

The current social security scheme as a right secured for all citizens was established in Portugal following the April 1974 Revolution, the state being re-

sponsible for “organizing, coordinating and subsidizing a unified and decentralized social security scheme” that “will protect citizens in sickness, old age, disability, widowhood and orphanhood, and in unemployment and all other situations of a lack of or reduction in means of subsistence or the capacity of work” (Constitution of Portuguese Republic, 3rd Revision, 1997, Article 63, 2 and 4).

2.1.1 What are the expectations and ideology about family care? Is this changing? How far are intergenerational support and reciprocity important? Do minority groups have different ideologies?

Portuguese tradition attributes to family members, particularly women (wife, daughter, daughter-in-law) the responsibility for the care of elderly relatives. Additionally, until the 1974 Revolution, the public system of social security was so limited (both in terms of facilities and subsidy provision) that family care and solidarity was the only option for those in need. Therefore, in Portugal, care of elderly relatives is seen as an extension of normal family roles, making of families the most important provider of care (Madeira 1996; Quaresma 1996; Hespanha and others 2000).

This social ideology places on the family a strong pressure to remain responsible for the care, without thinking about what the family needs in order to bear the responsibility of that role (Bonfim 1996). Family caring for elderly people (or other dependent relative) is socially assumed as a family obligation that should not be supported by social services. Furthermore this social pressure is accompanied by hostility towards institutions. This ideology does not facilitate family carers constituting pressure groups or claiming social protection.

Nevertheless, expectations and ideology are gradually changing, mostly because families face competing demands (child care and employment) and are less available to care for older relatives, and older people accept and understand that. Furthermore, the increasing sustainability of social provision in Portugal is a facilitator of those transformations (PNAI 2001). The new directions in social policy point to a situation of partnership between formal and informal carers, so families and communities will be equally responsible for social progress and well being (PNAI 2001).

Minority groups are rare. It is important to note that Portugal is still a very homogeneous country.

2.1.2 Are there any legal or public institutional definitions of dependency – physical and mental? Are these age-related? Are there legal entitlements to benefits for caring?

Definitions of dependency are associated to the criteria underlying the granting of pensions or other social benefits, but are not age-related.

In the scope of legislation that regulates the attribution of the “Dependency Supplement” it is stated that a pensioner (not age-related, since pensions can be granted to persons over 18 years) is in a situation of dependency when he /

she is unable to carry out autonomously the indispensable activities related to the satisfaction of his / her basic daily needs, and requires assistance from a third party, namely to perform domestic daily tasks, mobility, hygiene. To attribute the "dependency supplement" and determine the amount, two levels of dependency are conceded: the first level includes people incapable of executing, with autonomy, the indispensable acts leading to the satisfaction of their daily basic needs (such as: alimentation, locomotion, hygiene); the second includes those persons that accumulate the first level of dependency and, additionally, are bed-ridden or present severe dementia.

The Social Invalidity Pension is granted to persons aged 18 years or more, having permanent incapacity to work in any professional activity, certified by the National System of Incapacities Verification, and whose monthly income is not superior to 30 % of the National Minimum Wage or 50 % of that amount in the case of couples.

2.1.3 Who is legally responsible for providing, financing and managing care for older people in need of help in daily living (physical care, financial support, psycho-social support or similar)?

In Portugal, under the Civil Law Code (article 2009º, nº1, d), descendents are obliged by law to provide for their ascendants whatever is indispensable to their sustenance, housing and clothing. Where the family cannot provide such care, then Social Security policy operates.

2.1.4 Is there any relevant case law on the rights and obligations of family carers?

Portuguese Civil Rights include rules which aim to protect the elderly, namely the dispositions on Family Rights, concerning the right to sustenance, a compulsory right under strong protection by the Portuguese jurisdictional order. Descendents to the 2nd degree, under Civil Law Code (Article 2003 and subsequently) are responsible for providing all that is indispensable to the sustenance, housing and clothing. Article 2009, nº 1b, of the Civil Law Code, obliges descendents to the 2nd degree to provide sustenance support. Where the family cannot provide such care, then Social Security policy operates.

2.1.5 What is the national legal definition of old age, which confers rights (e.g. pensions, benefits, etc.)?

There exists the term "retirement age" (age when a person can retire), which is misinterpreted by employers as the age when a person must retire. Public administration workers can retire from the age of 60, and must retire from the age of 70. For other workers the retirement age is 65 for men and 62 for women. The discussion on introducing an equal retirement age for men and women has been going on for many years but public opinion is unclear on this point.

The Social Old Age Pension is granted to those over 65, whose monthly income is not superior to 30 % to the National Minimum Wage or 50 % of that

amount in the case of couples. The age that confers rights to social benefits, more precisely, to an Old Age Pension is 65 years. However, this pension can be granted before that age, with a reduced amount.

2.2 Currently existing national policies

In general, the Basic Law on Social Security (1984) provides two integrated areas comprising social protection: Social Action and Social Security, by means of its general and non-contributory schemes.

The general scheme covers the working population and their families and is applied through the award of cash benefits in the event of sickness, maternity, industrial accidents, unemployment, disability, old age or death. This scheme is mandatory for all employees and the self-employed and is financed by earnings-related contributions from workers and employers.

The non-contributory scheme is designed to ensure protection in situations of economic or social hardship not actually covered by the general scheme and is applied through the award of benefits in kind (encompassing in particular the use of social services and facilities) and cash benefits in cases similar to those referred to for the general scheme. Contrary to what occurs in the general scheme, the award of the benefit in this case is means-tested rather than being dependent on the payment of social security contributions. Access to benefits is generally based on the beneficiary earning monthly incomes below 40 % of the national minimum wage, or on a family income less than 1.5 times the minimum wage. Transfers from the state exclusively finance the scheme.

The non-contributory scheme is completed with Social Action, which, according to the 1984 Basic Law, is designed to prevent economic hardship and social inadaptability and marginalisation and at the same time to promote the integration of the people involved. Social Action is therefore designed to protect the most vulnerable groups – particularly children, young people, the elderly and the disabled – in as much as the hardship they suffer can be overcome by means of social security schemes.

2.2.1 Family carers?

There are no specific policies for family carers. However, the Dependency Supplement is granted to people dependent on a third party, and aims at helping the dependent person to pay for that care, which, most of the time, is family care.

2.2.2 Disabled and / or dependent older people in need of care / support?

Disabled or dependent older people in need of care have benefits in kind (encompassing, in particular, the use of social services and facilities) and cash benefits.

Cash benefits include the Invalidity Pension, a monthly payment given during their lifetime to those who having completed a guaranteed period of 60 months of registered remuneration and who, before reaching the age of retirement, find they are definitively unable to work due to illness or accident.

The elderly and the dependent can also benefit from some assistance with health care expenditure, such as in emergencies, with medication and disposable material and with transportation to medical appointments. They also receive discount on telephones (60 % reduction on the subscription fee and 25 free units per month), on the price of tickets on public urban transportation, buses and trains. Besides this, Inatel and Senior Tourism also give reductions or benefits to the elderly on holiday.

2.2.3 Working carers: Are there any measures to support employed family carers (rights to leave, rights to job sharing, part time work, etc)?

In Portugal, there is only one legal measure that supports family carers of elderly people, that is: public employees have the right to 15 days per year, under the cover of “family medical certification”, to care for their elderly relatives; other workers only have the right to those 15 days to care for descendents under the age of 10 years.

2.3 Are there local or regional policies, or different legal frameworks for carers and dependent older people?

In Portugal it is not possible to talk about local policies since local and regional policies are based on nationwide regulations. However, depending on local initiatives and the financial abilities of local communities, initiatives can be undertaken leading to the improvement of the quality of care and working conditions of family carers. Observations show that the highest number of such initiatives appears where there are well-organised self-help groups and non-governmental organisations for the elderly. They force local institutions to assign appropriate funds**.** Some programs are being run at local levels with a positive impact on family carers of elderly people, for example:

- Support in kind, such as, providing: domestic equipment (for example: fridges, washing machines and televisions); repairs on houses; technical aids.
- Support in services and facilities, such as: respite residence (to facilitate family carers’ holidays or weekends off); volunteer groups to provide company or surveillance).
- Socio-emotional support, namely, self-support groups.
- Information and training, some workshops are carried out for elderly people and / or informal carers.

Moreover, programmes of local development and community action should be mentioned, for example the QCA II – Sub-programme: Integration – Measure I, which includes projects which aim to improve the quality of life of the elderly, promoting social integration through the development of family support services and training of social agents providing care for the elderly.

2.4 Are there differences between local authority areas in policy and / or provision for family carers and / or older people?

There are no differences between local authorities since social policies are defined at a national level. So, regional differences depend on financial possibilities and on the awareness of citizens, the activity of local authorities and the efficiency of non-governmental organisations.

The elderly, especially the disabled, are a socially weak group with not enough influence to present their needs to local authorities. A recent study carried out in the District of Aveiro (one of the most developed districts in Portugal) showed that the area of caring for the elderly and their families is the most deprived social area in the region (Rodrigues and Sousa 2003).

3 Services for family carers

In Portugal there is no formal system for supporting family carers[1], nevertheless some facilities, like day centres and home support systems constitute indirect measures that help family carers. When a family carer needs complementary help, it is usually another family member who fills in permanently or temporarily for the family carer in caring for the elderly. In larger communities, one can temporarily use the help of voluntary or private carers (for example in the form of "granny-sitting"). In rural areas neighbours tend to support family carers. Because of the low financial resources of the elderly, using paid services of private carers is infrequent, and only found in critical situations. Families with medium-high incomes, tend to hire housekeepers (full or part time) to help the family.

Services for family carers	Availability			Statutory	Public, Non statutory	Voluntary		Private
	Not	Partially	Totally			Public funding	No public funding	
Needs assessment (formal – standardised assessment of the caring situation)	X							
Counselling and Advice (e.g. in filling in forms for help	X							
Self-help support groups		X					X	X
"Granny-sitting"		X						X
Practical training in caring, protecting their own physical and mental health, relaxation etc.		X				X	X	X
Weekend breaks		X			X			X
Respite care services		X			X		X	X
Monetary transfers	X							
Management of crises	X							
Integrated planning of care for elderly and families (in hospital or at home)	X							
Special services for family carers of different ethnic groups	X							
Other								

[1] The table suggested in the scheme is not adequate to the situation of family carers in Portugal.

3.1 Examples

3.1.1 Good practices

- National Action Plan towards Inclusion (PNAI): defines as priorities the improvement of support for dependent persons and the development of actions centred on preserving family solidarity.
- Elderly People's Homes Programme: seeks to develop and intensify the offer of homes for the elderly and other social responses.
- Elderly Citizen line: a free telephone line to inform elderly people about benefits.
- Elderly Card Foundation: provides financial support for elderly people.
- Grandparents Plan: aims at defining a process to certify the quality of institutions.

3.1.2 Innovative practices

- Programme of Integrated Support for the Elderly (Dispatch Collection nº 259 / 97 of 21st August). This programme is innovative in two areas: integrating health and social care and taking notice of family carers' needs.
- Integrated Response – Social Action and Health (Dispatch Collection nº 407 / 98 of 15th May).
- Concerning new technologies, Portugal Telecom has developed a set of specific solutions for citizens with special needs (including elderly people).
- Incentives for micro-enterprises (DL nº 34 / 95, 11th February).

4 Supporting family carers through health and social services for older people

4.1 Health and Social Care Services

Health and social care services comprise the health sector and the social services sector. Within the health sector, the focus is on hospitals, doctors and primary care centres. Social services is an extremely heterogeneous and diverse sub-sector which splits into a variety of institutions and types of service. So hospital care includes: in-patient care, out-patients department, day hospitalization, emergency, imaging and laboratory. Primary health care includes: family doctors, day care, public health facilities, other paramedical and socio-medical services, community nursing, specialists, pharmacy. Social care involves: day centres, home care support services, recreational centres,...

Traditionally, there has been a tendency to define fairly clear boundaries between medical and social services, as well as between hospital and ambulatory care. Often this results in poor communication across sectors with a lack of co-ordination and continuity of care for patients.

In Portugal there are now moves to integrate medical and social aspects better. In spite of the existence of the Integrated Support Programme for the Elderly (Dispatch Collection nº 407 / 98 of 15st May), which promotes the integration between health care and social services, in practice these two areas are completely fragmented.

4.1.1 Health services

Regarding health care services, the elderly Portuguese population does not have specific services or resources available; the same is true for family carers. The general health care system is designed for the general population, both in the sphere of primary health care and in specialized and differentiated care. The strategy that has been adopted is that of integrating specific responses to the needs of the elderly into the global health policy.

Since 1979 a nationwide network of hospitals and health centres has been established under the National Health Service (NHS). In 1993 five regional health administrations were established by law under the NHS Statute. It was also established that primary as well as secondary and tertiary care fell under the same hierarchical authority (previously they were separate in terms of authority). There are also health subsystems, which pre-date the establishment of the NHS, and are normally financed through employer / employee contributions. Contributions by employees are obligatory for most funds (about 1 % of the salary).

The NHS is financed from tax revenues and provides free access to primary care and hospital care. The NHS is centralized: responsibility for its function-

ing, organization and management is shared between the Ministry of Health and the five regional authorities. The NHS manages all public hospitals and the primary health care centres. Diagnostic tests at a primary health care level are usually done privately but the NHS makes co-payments.

The number of practising physicians is slightly above the EU average, but there are wide geographical variations in the availability of health personnel and some districts are clearly understaffed. About 60 % of health professionals work in Lisbon, Oporto and Coimbra, leaving the rest of the country with comparatively few staff (OECD 1999).

Drugs and medications on an approved list are free or subjected to co-payments. However, in some situations there is also rationing of supply and a private sector is developing to meet remaining demands.

Poor accessibility to health services is the most serious barrier consumers have to face in order to get a medical appointment, and this is most relevant for the oldest sector of the population. The geographical location of health care facilities produces unequal ease of access for different groups of consumers and influences patterns of use. Examining the distribution of health service resources is an important way to understand the inequities of access to health and to health care.

4.1.1.1 Primary health care

A mix of private and public health service providers deliver primary health care in Portugal. Primary health care is taken to cover all health care provided out-of-hospital by both generalists and specialists, and other non-specialist care and services such as dental care services, physiotherapy, radiology, and diagnostic services.

Family doctors in the health centre setting deliver most primary care. However, some health centres also provide a limited range of specialized care. The range of services provided by family doctors in health centres is as follows: general medical care, for the adult population and the elderly; prenatal care; child care; family planning and perinatal care; first aid; certification of incapacity for work; home visits (there are very few home visits made by family doctors – less than 48 per year per health centre); preventive services, which include immunization and screening for breast, cervical and breast cancer (EOHCS 1999).

Patients must be registered with a family doctor. Theoretically, there is a freedom of choice, people can choose among the available practitioners within a geographical area. Some people seek health care services in the area where they work but must choose a family doctor in their residential area.

Other medical disciplines represented in health centres include public health, gynecology and pediatrics. Only a few health centres are equipped for carrying out X-rays and laboratory diagnostic tests, and patients are frequently referred

to private practices for these procedures. Primary care is also provided by extensions and health posts. In sparsely populated areas, physicians sometimes serve more than one post.

The basic health care for the elderly is provided by family doctors, who are placed within each community. The family doctor also makes home visits in case of severe disease or for people with reduced mobility, but these are exceptions. It is also important to note that in the interior and rural areas of Portugal there is a substantial lack of doctors. So, access to the doctor can be difficult for people who live in smaller villages and do not have sufficient communication (bus, train) with the larger village. The family doctor's help is free of charge, or subject to a small fee (however dependent people are exempt from fees). This applies also to the services of a community nurse co-operating with the family doctor. Patients, regardless of their age, pay for medication, some of which is partially paid for by the Ministry of Health.

Both in cities and in the country there are significant problems with getting home visits by a dentist, taking diagnostic material at the patients' home, and rehabilitation.

4.1.1.2 Acute hospital and Tertiary care

Secondary and tertiary care is mainly provided in hospitals although some health centres employ specialists who provide specialist ambulatory services. These positions are gradually diminishing in number and do not form a significant secondary and tertiary provision. Some 80 % of all hospital beds are in the public sector (OECD 1999). The hospital network includes some specialized psychiatric, oncology, maternity and rehabilitation hospitals.

In Portugal there are no geriatric units, so acute hospital and tertiary care is for all ages. In fact, the specialization in geriatrics for doctors is not available. During recent years the first specialized nurses and therapists began to appear, but there are neither structures nor institutions offering specifically geriatric care. Consequently, the elderly person is treated in generalist hospitals in a fragmented way. Regarding psychiatric pathology there is some organization and care, namely in the geronto-psychiatric consultations available in some hospitals.

The recent development of a private sector (almost half of the private hospitals belong to for-profit organizations) in order to satisfy unmet needs has created a growing problem of equity. In particular, those few old people's homes for dependent people that exist are in the private sector and are very expensive. Private health insurance is a new phenomenon that is still developing. Despite important developments in this area in the 1980s, and despite the fact that private insurance contributions are partially tax-deductible, only around 10 % of Portuguese people have private insurance. The relationship with the private sector is settled by contracts and agreements.

The majority of specialist consultations take place in the private sector whereas the public sector provides the overwhelming majority of general consultations. One of the main areas of private activity is in provision of diagnostic tests and examinations: pathology, blood tests and X-rays. In addition treatment by physiotherapists and dental care is largely provided by the private sector.

4.1.1.3 Are there long-term health care facilities (includes public and private clinics)?

In Portugal there are several different kinds of health care facilities, mostly private, whether profit or non-profit: nursing homes for the permanent residence of elderly persons who are or risk becoming severely dependent; homes for people over the age of 16 with permanent or temporary disabilities; homes providing support environments for persons with permanent mental disabilities; homes providing protective environments for adults with serious, and likely to become probably permanent psychological problems; homes providing autonomous living environments for adults with serious, and likely to become permanent psychological problems, but who maintain a certain degree of autonomy; Temporary Reception Centres for Emergencies for old people in difficult social situations; Night Centres for old and isolated people in need of aid during the night.

4.1.1.4 Are there hospice / palliative / terminal care facilities?

There is palliative care for cancer patients, regardless of their age. There are some palliative units, both for ambulatory and hospitalized care, but these are mainly projects. There are also some psychiatric in-patient facilities.

4.1.1.5 Are family carers expected to play an active role in any form of in-patient health care?

When patients are hospitalized, it is expected that members of the family visit the patient, and that when the patient goes home, they follow doctors' instructions regarding medicines or other prescriptions (such as, alimentation).

4.1.2 Social services

There is a very little provision of community care services in Portugal, including long-term care, day centres and social services for the chronically ill, the elderly and other groups with special needs, such as the mentally ill and the mentally and physically disabled.

Some social services are provided in each region through Social Security; the Misericórdias, however, which are independent charitable organizations, are the key providers of social care services, along with Private Welfare Institutions which are financed by the State. Table 5 shows the number of facilities available for elderly persons in 1998.

Table 5: Social facilities for elderly people in Portugal (1998)

Old People's Homes	Residential homes	Home Support Services	Day centre	Community centres	Accommodation in Families
848	56	1,329	1,314	287	52

Source: DGAS 1998

4.1.2.1 Residential care (long-term, respite)

The Portuguese Social Services provide two types of residential care: old people's homes and residential care. Both are mainly long-term care, since respite care is extremely rare.

The Old People's Homes are the most widely available. They are units of collective accommodation to be used on a permanent or temporary basis, by old people most at risk of losing their independence and / or autonomy. Their objectives are: the development of necessary support for the families of the elderly; contribution to the stabilization and delaying of the ageing process; supply of suitable and permanent services for the problems of the elderly; reinforcing inter-family relationships. The services supplied by these units are: accommodation, food, health care, hygiene and comfort; companionship, recreation, animation and occupation. Traditional old age homes are going through a transformation into care intensive nursing homes or sheltered housing.

Residential care is still rare in Portugal. Nevertheless, it is possible to find a few long-term residences, some for independent elderly people, others for the highly dependent (nursing homes); and also respite residential care (very rare, usually integrated in Old People's Homes or Residences, thus making use of the same facilities). Residences are usually private; some are non-profit private institutions, financed by the State.

4.1.2.1.1 Basic data on % of > 65s in residential care by age group and type of residential care (sheltered housing, residential homes)

In 2001, there were 1,550 residential homes and old people's homes in Portugal, with a utilization rate of 95.8 % (INE 2001). In this same year, a total of 50,607 people over the age of 65 were living in collective accommodation, and amongst these, a greater number were women and the most elderly (table 6).

Table 6: Elderly people in residential care by age group and gender

Age group	Total		Male		Female	
	N	%	N	%	N	%
65-69 years	3,314	6.5	1,477	44.6	1,837	55.4
70-74 years	6,007	11.9	2,259	37.6	3,748	62.4
75-79 years	10,197	20.1	3,337	32.7	6,860	67.3
80-84 years	12,528	24.8	3,627	28.9	8,901	71.1
85-89 years	11,893	23.5	3,160	26.6	8,733	73.4
≥ 90 years	6,668	13.2	1,471	22.1	5,197	73.9
Total	**50,607**	**100**	**15,331**	**30.3**	**35,276**	**69.7**

Source: INE 2001

4.1.2.1.2 Criteria for admission (degree of dependency, income etc.)

Since the majority of these services are provided within the private sector (profit or non-profit), it is the institutions which define the criteria for admission despite the general regulation of the State. Institutions normally prefer single elderly people, with low income and without family support. However, it should be noted that Old People's Homes do not usually accept elderly persons who are highly dependent or bed-ridden.

4.1.2.1.3 Public / private / NGO status

Most residential care, approximately 85 %, is provided by Private Welfare Institutions (MTS 2001).

4.1.2.1.4 Does residential care involve the participation of carers or work with carers?

When elderly people are placed in a home or residential care, these institutions usually make it their goal to maintain the ties with the family. However, this takes place mainly through the presence of the family at festivities (Christmas, Carnival, …), visits, accompanying relatives to doctor's appointments and spending the weekend with the family. There is no specific work with the carers. The participation required is not active, nor is it based on a partnership; it is expected that families accede to the requests or invitations of the institutions.

4.1.2.2 Community care services (statutory coverage and whether aimed primarily at older people living alone or including support to family carers)

Community care services in Portugal aim primarily to support elderly people living alone, with a low income or with a disability; indirectly they play an important role in helping family carers. These services were created by the Ministry of Employment and Social Security, within the programme of social action. They aim: to prevent situations leading to the degradation of the ageing process amongst individuals; to promote conditions favourable to the socio-family and cultural integration of the elderly; to encourage autonomy amongst the elderly, through their participation in the community; to recognize the value of the elderly in the family; to rediscover the value of the elderly in the family; to support informal care-providers; to promote solidarity between generations.

4.1.2.2.1 Home-help

In Portugal there are Home-Support Services, which consist of providing individualized and personalized care in the home to people and families when, due to illness, impairment, etc. they cannot take care of their everyday needs and / or activities, on a temporary or permanent basis. These services aim: to contribute to improving the quality of life of the elderly; to contribute to delaying or even avoiding institutionalization; to provide physical, psychological and social care for the elderly; to ensure that the basic needs of the elderly will be taken care of. Home care is expanding as a result of a joint venture between the Ministry of Health and the Ministry of Employment and Social Security, called the Integrated Support Plan for the Elderly. According to the needs, this service can offer: meals, cleaning and tidying the home, personal care, company and recreation, small repairs in the home, shopping, transport, laundry, …

4.1.2.2.2 Personal care

Personal care is provided within the scope of the Home-Support Services.

4.1.2.2.3 Meals service

Meal services can be provided at home by the Home-Support Services or in Day Centres, in which case, elderly people must go to the facility and have the meal there.

4.1.2.2.4 Other home care services (transport, laundry, shopping etc.)

Transport, laundry, shopping, hairdressing, and other services are available within the scope of the Home-Support Services.

4.1.2.2.5 Community care centres

Recreation Centres are designed for the elderly within specific communities, developing a set of cultural and recreational activities. In 1998, there were 287 (DGAS 2001) such recreation centres. Their objectives are: to create a centre for meeting and social relations; to delay dependency amongst the elderly; to promote leisure and occupation.

4.1.2.2.6 Day care ("protective" care)

Day Centres offer a range of services provided in the unit, contributing to the care of the elderly in the community. They provide a range of services, including activities, meals, food to take home, laundry services, bathing and even assistance with obtaining medication and attendance at health centres. A small means-tested contribution is usually charged. Day centres for the elderly provided 41,195 places in 1998 (MSS).

4.1.2.3 Other social care services

Other services are:

- Social attendance / company: designed to inform, orient, guide, and support individuals and families.
- Family accommodation (DL nº 391 / 91, 10th October): consists in temporary or permanent integration of the elderly in families considered suitable, in cases where the absence of family and / or insufficient social support, prevent them being cared for at home. In 1998, 52 families received elderly persons within this scheme (DGAS 2001).
- Technical aids: Social Security finances the technical aids necessary for the elderly and the disabled, in accordance with medical prescription, up to 100 %.
- Holiday Centres: provide a program of activities that aim to provide leisure and break the routine of elderly people. In these centres, priority is given to the elderly living in dysfunctional families, in social and / or geographical isolation, who have no opportunity to spend holidays with their own families.
- Temporary emergency reception centres for the elderly: social response, well-developed in equipment, and preferably based on an existing structure, which provide for the temporary reception of elderly persons in situations of social emergency, with a view to redirection either to the family or to another more permanent social service.
- Night centres: social response, well-developed in equipment, and preferably based on an existing structure, aimed at autonomous elderly persons, who are at home during the day, but who require support at night on account of their isolation.

- Within the scope of the Programme of Integrated Support for the Elderly, the following measures were adopted, among others: i) Integrated Home Support (Dispatch Collection nº 407 / 98, 15th May), which aims to ensure nursing and medical care for the elderly and the social support necessary for meeting their basic needs (in 1999, 189 such units attended 2,044 patients, DGAS, 1999); ii) Integrated Support Units (Dispatch Collection nº 407 / 98, 15th May), centres of multidisciplinary care for convalescence and rehabilitation which can not be undertaken at home on account of technical differentiation (in 1999, 51 of these units attended 778 patients, DGAS, 1999); iii) Forhum, aimed at the training of formal and informal carers.

4.2 Quality of formal care services and its impact on family caregivers: systems of evaluation and supervision, implementation and modelling of both home and other support care services

The recently implemented Grandparent Plan aims to develop measures for the certification of institutional quality. At present, this plan is under development; nevertheless, the activities of the various services of formal support are regulated and their functioning supervised. However, the impact of their quality on family carers has not been studied.

4.2.1 Who manages and supervises home care services?

Private Welfare Institutions, which are financed from the state budget, employ their own staff full and part time in the given institution. Care and administrative activities are controlled and evaluated by the Regional Centres of Social Security.

4.2.2 Is there a regular quality control of these services and a legal basis for this quality control? Who is authorized to run these quality controls?

Appropriate acts of law regulate the rules of control, its frequency and criteria. The primary organ of control is the Ministry of Labour and Solidarity. Social work specialists perform control and consultations. Control over the economy of social care institutions is based on annual (or quarterly) activity reports. Control over non-governmental organizations is limited to the range decided by contracts for the realisation of certain services by the NGO and the financial support, which can be granted by the ministry. Most of this control is restricted to the financial aspects and legal basis of the NGO's activity.

4.2.3 Is there any professional certification for professional (home and residential) care workers? Average length of training?

There are no specific professional qualifications for working in facilities of the elderly, although within the scope of the Programme of Integrated Support for

the Elderly, the training of all those who work with elderly people has been encouraged. As a norm, facilities for the elderly have a technical director with a degree in the area of the social services, and, in this case, they have a university level education of four or five years.

In the academic year 2003 / 04, the University of Aveiro opened a licenciatura degree course in the area of Gerontology and Specialization Courses in Geriatrics and Gerontology for health and social action professionals who are working with the elderly.

4.2.4 Is training compulsory?

Training is not compulsory.

4.2.5 Are there problems in the recruitment and retention of care workers?

In Portugal, hiring enough social workers and carers is not a problem, neither is keeping them. However, there are obstacles in the form of low earnings, which can have a negative effect on choosing the best and most professional employees, and limited financial capabilities of institutions, as a result of which the number of employees is not always equal to the actual needs.

4.3 Case management and integrated care (integration of health and social care at both the sectoral and professional levels)

A recently created legal diploma (Dispatch nº 407 / 98, 18th of June) supports the creation of a working group comprising representatives from the Ministry of Health and the Ministry of Labour and Solidarity (Social Action), which aims to diagnose and analyze situations whose solutions should involve combined intervention. This is directed at dependent people, some of whom are elderly. In the scope of this legal dispatch, integrated responses have been implemented, namely:

- Integrated Home Support, which provides home assistance, combining health and social support.
- Integrated Support Units, a unit with a maximum capacity for 30 users, whose aims are to provide temporary, global and integrated care for dependent people that are unable to be supported at home, but who do not need the clinical care of hospitalization.

4.3.1 Are family carers' opinions actively sought by health and social care professionals usually?

Professionals usually do not seek family carers' opinions; the relationship is developed based on an expert-client basis. Professionals are experts that give some information and indications, and family carers, as well as the older person, are expected to follow the indications.

5 The Cost – Benefits of Caring

5.1 What percentage of public spending is given to pensions, social welfare and health?

In 2000, Social Welfare represented a total of 22.7 % of the GDP (table), while in the same year, spending on pensions represented 9.2 % (tables 7 and 8).

Table 7: Social welfare spending as percentage of GDP (Portugal, 1980-2001)

Social welfare spending	1980	1986	1990	1992	1999	2000
Portugal	14.7	16.3	15.2	17.6	22.9	22.7

Source: Eurostat 2003

Table 8: Spending on pensions in Portugal (1990-2001)

	% GDP 1990	% GDP 1999	% GDP 2000	% GDP 2001	% of social benefits: 1999	Share of each pension category on the total number of pensions - 1999			
						Old-age	Invalidity	Survivors	Other pensions
Portugal	6.2	10.1	9.0	9.2	51.3	65.4	20.4	12.7	1.5
EU average	7.3	12.7	8.1	8.4	47.9	75.3	9.9	9.7	5.1

Source: Bulletin EU (2002); OECD Health Data 2003

Total health care expenditure in Portugal as a share of GDP was 9.2 % in 2001. The percentage has risen steadily from a low 3 % in 1970 to its present level (table 9).

Table 9: Table 9. Health care spending as percentage of GDP (Portugal, 1990-2001)

Health care spending as percentage of GDP	1990	2000	2001
Portugal	6.2	9.0	9.2
OECD average	7.3	8.1	8.4

Source: OECD Health Data 2003

5.2 How much - private and public - is spent on long term care (LTC)?

Long-term care is financed throughout contributions and taxation. Long term care is mostly provided by informal carers. However, 0.2 % of GDP is for long-term care (table 10).

Table 10: Health and long term care expenditures, 1997 (% of GDP)

Total health expenditure	7.5
Public health expenditure	5.0
Public long-term care	0.2

Source*:* OECD Health Data 2001 and OECD SOCX Database for long term care (services for the elderly and disabled people).

5.3 Are there additional costs to users associated with using any public health and social services?

Flat rate payments exist for consultation (primary care, hospital out-patients, district hospitals), emergency visits (health centres, hospitals), home visits and diagnostic tests and therapeutic procedures (variable). The patient pays transportation costs, except in special circumstances, such as long distance travel, when costs are subsidized. Patients are exempt from co-payments and user charges if they are classified as “low income” (i.e. in receipt of supplementary benefit or unemployed), have special medical needs (i.e. the physically handicapped or those with chronic illnesses) and special patient groups, such as pregnant women, children up to 12 years of age, drug addicts in rehabilitation and chronic mental patients.

Concerning social services, they are usually subject to a co-payment from the user according to his / her income.

5.4 What is the estimated public / private mix in health and social care?

The Portuguese health care system is a mix of public and private financing (table 11). The NHS, which provides universal coverage, is predominantly funded through general taxation. The health sub-systems, which provide comprehensive coverage to about a quarter of the population, are funded mainly through employee / employer contributions (including state contributions as an employer). A large proportion of funding is private, mainly in the form of direct payments by the patient and to a lesser extent in the form of premiums to private insurance schemes and mutual institutions. Table 11 shows the percentage of total health expenditure financed through different agents. Taxation accounts for the largest amount.

Table 11: Main sources of finance by funding agents, 1985-1997 (as % of total expenditure on health care)

Source of finance	1990	1992	1994	1996	1997
Public					
Taxes	54.8	55.9	68.2	63.0	61.6
Health subsystems	3.7	4.5	5.2	4.8	-
Private					
Out-of-pocket	46.3	44.0	46.6	-	-
Voluntary insurance	0.8	1.2	1.4	1.5	1.7

Source: OECD health data 1998

Out-of-pocket payments have consistently accounted for about 45 % of total health expenditure, the majority of this expenditure is on drugs (around 50 %); medical, nursing and paramedical services and therapeutic products make up the bulk of the rest (INE 1996).

Theoretically, there are no services explicitly excluded from NHS coverage. However, throughout Portugal, there are some types of care which should be provided by the NHS but which are not available in practice (for example, adult dental care). In these cases, activity is mostly in the private sector and reimbursed by the NHS. Apart from these instances, the NHS, at least in theory, is totally comprehensive.

5.5 What are the minimum, maximum and average costs of using residential care, in relation to average wages?

Means-tested assistance is available, and social services will pay a proportion of residential costs depending upon income. The alternative is the homes run by the Misericórdias and other non-profit institutions, which are of better quality and only request a nominal contribution from patients and their families.

5.6 To what extent is the funding of care for older people undertaken by the public sector (state, local authorities)? Is it funded through taxation or / and social contributions?

The care of elderly people is undertaken mostly in the family context. The public sector is fully funded through taxation and social contributions.

5.7 Funding of family carers

Family carers of dependent individuals receive a pension, the Dependency Supplement, which constitutes a benefit granted to pensioners aiming at helping them pay the carer. In 2001, 8,085 people received this pension (IIES 2003).

5.7.1 Are family carers given any benefits (cash, pension credits / rights, allowances etc.) for their care? Are these means tested?

Family carers do not receive any benefits.

5.7.2 Is there any information on the take up of benefits or services?

There is no information available on this topic, although some studies indicate that individuals take up benefits fundamentally through information obtained from their network of informal relations (Matos and Sousa 2004).

5.7.3 Are there tax benefits and allowances for family carers?

At present there are no tax benefits for family carers, but it is expected that measures will be taken to encourage keeping the elderly person in the family. This would involve more favourable treatment as regards Individual Income Tax for families with adolescents in their charge who live in financial communion.

5.7.4 Does inheritance or transfers of property play a role in caregiving situation? If yes, how?

No.

5.7.5 Carers' or Users' contribution to elderly care costs

a. Medical, nursing and rehabilitation services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
General practitioner	X					
Specialist doctor	X					
Psychologist		X				
Acute Hospital	X					
Long-term medical residential care (for terminal patients, rehabilitation, RSA, etc.)	X					
Day hospital						
Home care for terminal patients	X					
Rehabilitation at home		X		X		
Nursing care at home (Day / Night)		X		X		
Laboratory tests or other diagnostic tests at home		X		X		
Telemedicine for monitoring						
Other, specify: home help						

b. Social-care services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Permanent admission into residential care / old people's home		X		X		
Temporary admission into residential care / old people's home in order to relieve the family carer		X		X		
Protected accommodation / sheltered housing (house-hotel, apartments with common facilities, etc.)		X		X		
Laundry service		X		X		
Special transport services		X		X		
Hairdresser at home			X			
Meals at home		X		X		
Chiropodist / Podologist			X			
Telerescue / Tele-alarm (connection with the central first-aid station)	X					
Care aids	X					
Home modifications			X			
Company for the elderly			X			
Social worker	X					
Day care (public or private) in community centre or old people's home		X		X		
Night care (public or private) at home or old people's home		X		X		
Private cohabitant assistant ("paid carer")			X			
Daily private home care for hygiene and personal care			X			
Social home care for help and cleaning services / "Home help"		X		X		
Social home care for hygiene and personal care	X			X		
Telephone service offered by associations for the elderly (friend-phone, etc.)	X					
Counselling and advice services for the elderly			X			
Social recreational centre	X			X		
Other, specify						

c. Special services for family carers	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Training courses on caring	X					
Telephone service offered by associations for family members*						
Internet Services			X			
Support or self-help groups for family members	X					
Counselling services for family carers*						
Regular relief home service (supervision of the elderly for a few hours a day during the week)		X				
Temporary relief home service (substitution of the family carer for brief periods of time, for example, a week)		X				
Assessment of the needs			X			
Monetary transfers						
Management of crises			X			
Integrated planning of care for the elderly and families at home or in hospital*						
Services for family carers of different ethnic groups*						
Other, specify						

* Not available

6 Current trends and future perspectives

Briefly, it is possible to identify the following current trends:

- The ways of helping the elderly and disabled in Portugal show that the social support system is still inefficient, despite recent measures undertaken to improve it.
- The family is the main provider of care for the elderly.
- In Portugal, there are no registers or statistics concerning family carers.
- Family carers do not have any particular benefits or support mechanisms in their work.
- Intervention with elderly and dependent persons shows extreme fragmentation, mainly between social and health services towards families. Social agencies assume the task of supporting these populations, but the situations gain complexity when health problems are present.

Future tasks:

- Creating a system for supporting family carers is one of the most important tasks of social policy towards the elderly and disabled.
- Developing articulation between social support systems and health care systems.
- Developing and implementing measures to support family carers.
- Integration of the family in the system of caring.
- Training courses for informal and formal care providers.

6.1 What are the major policy and practice issues debated on family care of the elderly in your country from the carers' point of view? Are older people and / or carer abuse among these issues?

The topic of family care of elderly relatives starts being visible in policy, practice and public debate. Nevertheless, debate on this issue is biased by the tradition that considers family as “the centre of collective responsibility to provide care” (Anderson 1992). Indeed, the image of family solidarity, including caring for its oldest members within the family circle, is deeply rooted in Portuguese society’s cultural values, and so whilst the family continues to provide care for its old, it has not yet been the object of any specific political measures.

Moreover, there is a large distance separating the affirmation of family rights in the field of social protection and the possibility of its effectiveness, mostly due to the lack or insufficiency of resources made available throughout social policies (Madeira 1996). Indeed, in Portugal, the social protection of elderly people

is a scarcity, and points towards the need to consolidate institutional and professional practices centred on the elderly person and his / her social and familiar environment (Bonfim and others1996).

6.2 Do you expect there to be any changing trends in services to support family carers, e.g. more state or more family support, more services or more cash?

We expect to have more services to support elderly people in the community, and indirectly their family carers, as well as more services designed specifically for family carers. Private profit and non-profit institutions will mostly develop these services. We do not believe that more public cash will be spent on these services.

6.3 What is the role played by carer groups / organisations, "pressure groups"?

There are no carer pressure groups in Portugal.

6.4 Are there any tensions between carers' interests and those of older people?

No.

6.5 State of research and future research needs (neglected issues and innovations)

In Portugal, despite the absence of specific policies and services for family carers, much has been done in terms of research, but using small samples. So, we think it would be important to make a countrywide characterization of family carers.

6.6 New technologies – are there developments which can help in the care of older people and support family carers?

The ‘Green Paper on the Information Society’, approved by the Council of Ministers of April 17th 1997, is intended to provide a catalytic contribution to future actions in the Information Society and is considered a first step in the elaboration of an action plan to guide Portugal in using ICTs to its advantage. It also postulates the integration of disadvantaged groups of the population in the Information Society, according to the general principle of equality, independently of the social and economical conditions of the end users.

The Access Initiative is an initiative of the Department of Science and Technology, the Ministry with responsibility for the co-ordination and follow-up of

Government policies related to the Information Society and their impact on citizens' with special needs, including older people. A Resolution (no. 97 / 99) passed by the Council of Ministers sets out to ensure that the information on all Public Administration websites should be understood and accessible to all citizens, including older people and people with special needs.

The 'Internet Initiative' of the Council of Ministers promotes the general utilisation of the Internet in Portugal.

Through the Network of disabled and elderly people, the Ministry of Science and Technology is offering such organisations the necessary equipment for Internet connection free, the free installation of the same, 24 hours free access, 64 kbps bandwith, and 40 Mbytes of disk storage.

Concerning new technologies, Portugal Telecom has developed a set of specific solutions for citizens with special needs (which includes elderly people):

- PTMinha Voz (Grid).
- PTVoz Activa (texts on the internet may be listened to, instead of read).
- PTConversas (text phone).
- Terminal PTEmergência (Emergency terminal with free hand telephone).
- Serviço TeleAlarme (Alarm Service connected 24h to the Portuguese Red Cross).
- PTAmplificador Portátil (portable amplifier).
- Pt Avisador Luminoso de Chamadas (luminous call sign).
- Discounts for pensioners and retired persons.
- Facilities in the acquisition of equipment.

6.7 Comments and recommendations from the authors

The care of the elderly and the family members who care for them demand the articulation of actions between services, particularly in the areas of health and social action. In spite of the fact that this articulation is legally created, its effective implementation is still underway.

Similarly, it will be important to encourage the training of multidisciplinary teams which include formal (the professionals) and informal (family, neighbours, volunteers) providers of care to the elderly. It is fundamental to ensure the training of both types of providers.

Following this line of thinking, the need for specialized training in the areas of geriatrics and gerontology is highlighted. The Lisbon European Council (2000) reiterated the need to reform the systems of social protection in order to continue to offer health care systems of quality, underlining the need for long-term

health care, both ambulatory, and in regimes of long-term internment and in psychiatric care units (CCE 2001).

The importance of and urgent need for continued home care services can be added, along with palliative care internment services.

In general terms, greater emphasis should be given to the autonomy and independence of the elderly and to the specific support of family carers.

7 Appendix to the National Background Report for Portugal

7.1 Socio-demographic data

7.1.1 Profile of the elderly population-past trends and future projections

Table 12: Resident population (1990-2000)

Year	Population (1000)			Structure by age group (%)			Growth of population (%)
	Total	Male	Female	< 15	15-64	≥ 65	
1990	9872,9	4759,6	5133,3	20.9	66	13.1	1989 / 90=-0.2
2000	10262,9	4953,3	5309,5	16	67.6	16.4	1999 / 00 = 0.6

Area: 91950 km².
Source: INE 2001

Table 13: Rates of birth, death, marriage, divorce and ageing (1996-2001)

Year	Birth rate[1]	Death rate[2]		Marriage rate[3]	Divorce rate[4]	Ageing rate
		Total	Infant			
1996	10.8	10.6	6.6	6.3	1.3	88.2
2001	10.8	10.2	4.8	5.6	1.8	104.9

[1] Birth rate: Number of live births per 1000 inhabitants; [2] Death rate: Number of deaths per 1000 inhabitants; [3] Marriage rate: Number of marriages per 1000 inhabitants; [4] Divorce rate: Number of divorces per 1000 inhabitants.
Source: INE 2001

7.1.1.1 Life expectancy at birth (male / female) and at age 65 years

Table 14: Life expectancy at birth

Year	Male	Female
1980	69.1	76.7
1985	69.7	76.7
1990	70.2	77.3
1995	71.5	78.6
2000	72.4	79.4
2002	73.7	80.6

Source: INE 2003

Table 15: Life expectancy at age 65-69 years

Year	Male	Female
2002	80.7	84.2

Source: INE 2003

7.1.1.2 % of > 65 year-olds in total population by 5 or 10 year age groups

Table 16: % of > 65 year-olds in total population by 5 or 10 year age groups, and gender (2001)

Age group	Total		Male		Female	
	N	%	N	%	N	%
Total Portugal (mainland)	8,641,537		4,137,196		12,778,733	
65-69	516,994	6 %	235,296	5.7 %	752,290	5.8 %
70-74	436,564	5.1 %	189,532	4.6 %	626,096	4.9 %
75-79	334,961	3.9 %	138,305	3.3 %	473,266	3.7 %
80-84	194,072	2.2 %	73,256	1.8 %	267,328	2.1 %
85-89	104,469	1.2 %	34,925	0.8 %	139,394	1.1 %
90-94	34,703	0.4 %	9,901	0.2 %	44,604	0.3 %
95-99	6,266	0.07 %	1,372	0.03 %	7,638	0.06 %
≥ 100	567	0.007 %	94	0.002 %	661	0.005 %
All together	**1,524,127**	**17.6 %**	**682,681**	**7.9 %**	**2311277**	**18.1 %**

Source: INE 2001

7.1.1.3 Marital status of > 65 year-olds (by gender and age group)

Table 17: Marital status of > 65 year-olds (by gender and age group)

Age group / Marital status	Altogether	Men		Women	
		N	%	N	%
65-74 years old					
Altogether	953,558	424,828	100	528,730	100
Single	58,516	17,857	4.2	40,659	7.7
Married	678,713	36,6119	86.2	312,594	59.1
Widowed	191,575	32,598	7.7	158,977	30.1
Divorced	18,190	5,580	1.3	12,610	2.4
Separated	6,564	2,674	0.6	3,890	0.7
75-84 years old					
Altogether	529,033	211,561	100	317,472	100
Single	39,454	9,194	4.3	30,260	9.5
Married	266,581	157,701	74.5	108,880	34.3
Widowed	213,144	41,761	19.7	171,383	54
Divorced	7,162	1,807	0.9	5,355	1.7
Separated	2,692	1,098	0.5	1,594	0.5
> 85 years old					
Altogether	146,005	46,292	100	99,713	100
Single	13,090	2,078	4.5	11,012	11
Married	36,698	23,504	50.8	13,194	13.2
Widowed	93,841	20,165	43.6	73,676	73.9
Divorced	1,896	356	0.8	1,540	1.5
Separated	480	189	0.4	291	0.3

Source: INE 2001

7.1.1.4 Living alone and co-residence of > 65 year-olds by gender and 5-year age groups

Table 18: People over 65 living in one-person households or in two-person household (2001)

Total of clas-sic families	One person over 65						Two persons over 65)	
	Altogether		Men		Women			
	N	%	N	%	N	%	N	%
3650757	321,054	8.8	73,015	2	248,039	6.8	306,416	8.4

Source: INE 2001

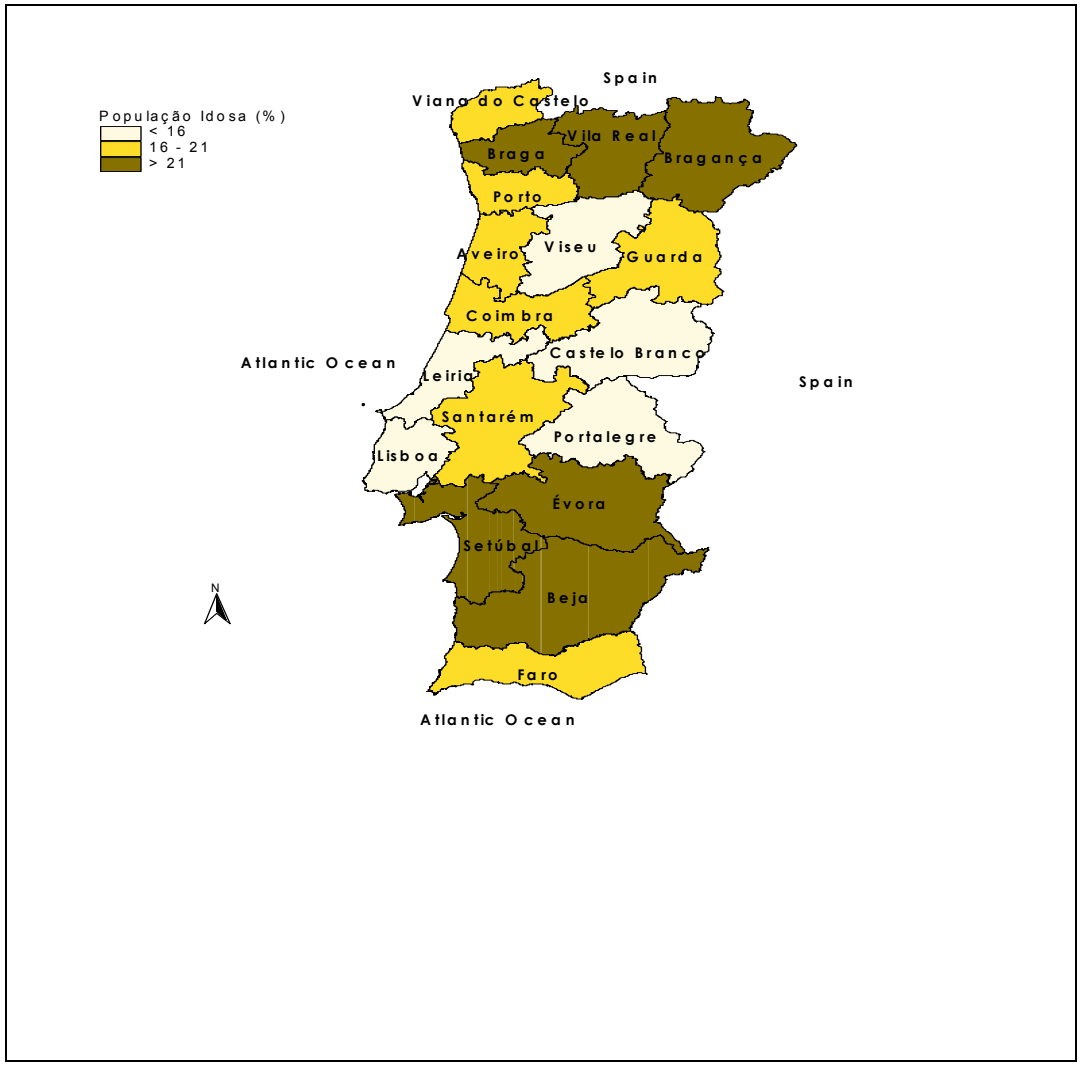
Table 19: Classic families according to the number of persons over 65, by size of family (2001)

Class.	Total		0 person		1 person		2 persons		3 or more	
fam.*	N	%	N	%	N	%	N	%	N	%
1 person	631,762	17.3	310,708	8.5	321,054	8.8	-		-	
2 persons	1,036,312	28.4	543,951	14.9	185,945	5.1	306,416	8.4	-	
3 persons	918,735	25.2	756,553	20.7	89,887	2.5	63,740	1.7	8,555	0.2
4 persons	718,492	19.7	627,853	17.2	66,114	1.8	21,724	0.6	2,801	0.08
5 or more	345,456	9.5	231,962	6.4	79,228	2.2	31,738	0.9	2,528	0.07

* Total of classic families: 3,650,757.
Source: INE 2001

7.1.1.5 Urban / rural distribution by age

Figure 1: % of elderly people by district



Urban / rural distribution is not relevant. Yet the map shows that the districts with a higher percentage of elderly population are locate at the north and south of Portugal, while the districts with lower percentage of elderly are at the centre of the country.

7.1.1.6 Disability rates amongst > 65 year-olds. Estimates of dependency and needs for care

Table 20: % of disabled amongst > 65 year-olds per total of population and total of disabled population

Age groups	Total disabled (N)	Total disabled (% by the total of age group) (n=1,524,127)	% of total population (8,641,537)	% of total disabled (613,762)
65-74 (n=953,558)	102,591	10.8 %	1.2 %	16.7 %
75-84 (n=529,033)	74,973	14.2 %	0.9 %	12.2 %
> 85 (n=146,005)	28,309	19.4 %	0.3 %	4.6 %
All together	205,873	13.5 %	2.4 %	33.5 %

Source: INE 2001

Table 21: Dependency ratio (1991-2002)

Year	Total (a)	Elderly (b)
1991	49.9	20.9
1995	48.2	22.2
2000	47.8	24.2
2001	48	24.5
2002	48.1	24.7

(a) Total dependency ratio = [Pop. 0-14 + Pop. 65 or more] / Pop. 15-64
(b) Elderly dependency ratio= Pop. 65 or more / Pop. 15-64
Source: INE 2001

7.1.1.7 Income distribution for top and bottom deciles i.e. % aged > 65 years in top 20 % of income, or % > 65s in top 20 %, and the same for poorest 20 % income groups

Table 22: Annual income by adult according to the age of the individual (in thousands of escudos*) (1995)

	Age	%	Mean
Global	< 25	5.7	901
	25-34	23.4	1,226
	35-44	26	1,170
	45-54	19.1	1,318
	55-64	12.6	1,163
	≥ 65	13.2	939
Poor	< 25	6	400
	25-34	14.3	442
	35-44	24.6	367
	45-54	17.8	386
	55-64	13.1	348
	≥ 65	24.2	411

1 Euro = 200,482 escudos.
Source: INE, Inquérito aos Orçamentos Familiares 1994 / 95

Table 23: Distribution of poor population (1990 / 95)

Poor population	1990		1995	
	Individuals	%	Individuals	%
Total Population	1,779,753	100	1,842,644	100
Elderly Population	588,892	33.1	648,761	35.2
Non-elderly Population	1,190,861	66.9	1,193,883	64.8

Source: INE, Inquérito aos Orçamentos Familiares 1994 / 95

7.1.1.8 % > 65 year-olds in different ethnic groups

There is no information available about ethnic groups, nor is this information very relevant in Portugal. Data is presented about the resident population in Portugal by nationality.

Table 24: Resident foreign population according to age-groups, by nationality and gender (2001)

Nationality	Gender	Total	65-69	70-74	75-79	80-84	≥ 85
Other European countries	Female	70,523	1,993	1,465	968	537	456
	Male	39,882	1,064	743	478	210	149
Africa	Female	102,379	1,318	939	535	350	260
	Male	53,890	523	306	159	93	50
America	Female	41,295	378	402	370	280	162
	Male	21,898	141	154	135	79	41
Asia	Female	6,228	78	50	51	39	25
	Male	3,926	36	17	17	11	9
Oceania	Female	415	12	7	4	1	1
	Male	198	2	4	3	0	0
More than 1 nationality	Female	230,776	5,913	4,167	2,480	1,338	894
	Male	108,623	2,907	1,905	1,038	456	257
Other situations	Female	5,825	82	61	41	26	19
	Male	2,953	38	27	20	12	7

Source: INE 2001

7.1.1.9 % Home ownership (urban / rural areas) by age group

No information provided.

7.1.1.10 Housing standards / conditions if available by age group e.g. % without indoor plumbing, electricity, TV, telephone, lift (if above ground floor), etc.

Table 25: Some characteristics of housing according to type of household (1995)

Characteristics	Total households	Households with elderly people	Type of household			
			Single Elderly Person	Elderly couple	Couple with 1 elderly person	Other households with elderly people
I Type of Building						
Detached house	71.2	78.7	73.3	81.4	77.8	80.3
Flat	27.2	20.3	24.3	18.1	21.8	19.3
Degraded housing, other	1.6	0.9	2.4	0.4	0.3	0.7
II Age of Construction						
Before 1946	33.3	48.8	57.2	49.2	39.5	44.2
After 1970	39.9	20.7	14.6	15.9	25.5	33.6
III Habitable area						
< 20m^2	1.5	2	4.4	1.4	0.3	1
20 m^2-39 m^2	9.2	11.6	19.2	11.8	10.4	6.6
40m^2-59m^2	21.3	25.2	30	29.7	26.1	18.7
60m^2 – 79m^2	23.5	23.3	20.7	21.3	28.6	24.5
≥ 80 ^{2}	44.5	37.9	25.8	35.9	24.6	53.6

Source: INE, Inquérito aos orçamentos familiares 1994 / 95

Table 26: Existence of basic infra-structures in housing in accordance with type of household (1995)

Characteristics	Total households	Households with elderly people	Type of household			
			Single Elderly Person	Elderly couple	Couple with 1 elderly person	Other households with elderly people
With kitchen	99.2	99.2	97.2	99	99.8	99.3
With running water	93.2	90.4	84.9	90	95.9	93.2
With electricity	98.2	97.2	95.4	97.5	99.3	97.8
With sanitation	92.9	88.7	81.7	87.2	93.3	93.7
With sewage system	92.4	88.2	81.4	86.6	93.2	92.3
Without basic conditions (water, electricity and sanitation)	1.0	1.5	3.1	1.5	0.5	0.8

Source: INE, Inquérito aos orçamentos familiares 1994 / 95

7.2 Examples of good or innovative practices in support services

Program of Integrated Support for the Elderly. The program has the following objectives: to ensure the provision of care of an urgent or permanent nature aimed at maintaining the autonomy of the elderly person in his / her own home and in his / her family environment; to establish the means to ensure the mobility of the elderly and access to benefits and services; to implement support for families who have provided care and attendance to dependent family members, namely the elderly; to promote and support initiatives for the initial and in-service training of professionals, volunteers, family members and other people in the community; to promote attitudes and measures to prevent isolation, exclusion and dependency and to contribute to intergenerational solidarity as well as creating jobs. Within the scope of this program the following initiatives were carried out:

- **Home Support Service (SAD):** aims to keep elderly and dependent persons in their habitual living environment, close to their family, neighbours and friends. In this initiative, projects are developed which take into account the breadth of existing coverage, the extension of 24-hour support, the improvement of the quality of the services provided and the adequacy of the home environment to the needs of the elderly persons.
- **Support Centre for the Dependent / Pluridisciplinary Resource Centre (CAD):** these support centres are resource centres, open to the community, for temporary support, which focus on prevention and the

rehabilitation of dependent persons**.** They are developed on the basis of already existing structures, providing a range of support and care with a view to promoting as much autonomy as possible and the continuation of an active life project. The institutionalization component which this response may encompass is developed in small units, of a family and humane nature, with strong links to the home support service, creating conditions for the participation of the family and the return to the habitual living environment as rapidly as possible.

- **Human Resource Training Centre (FORHUM):** designed for family members, neighbours, volunteers as well as for professionals, particularly in the areas of health and social services, and other members of the community, enabling them to provide formal and informal care.
- **Telealarm Service (STA):** a free 24 hour telephone line for emergency situations.
- **Health and Heat**: designed to allow the elderly with more limited financial resources to access thermal treatments by means of an allowance.
- **Travel Pass:** elimination of timetable restrictions for people aged 65 or over on transport in the uban and sub-urban areas of Lisbon and Porto.

Elderly citizen line: Consists in a free telephone line that provides information to the elderly, on a wide range of rights and benefits.

Elderly Card Foundation: aims to develop and promote initiatives designed to encourage well-being, self-realization and the full social participation of the over 65s. Under this scheme, a Card 65 was created, with which the bearer can take advantage of discounts on services or on the purchase of goods in various sectors of activity.

Grandparent Plan. This plan was conceived to develop a process of revision of the legislation on the topic of residential care for elderly people, renovations or replacement of elderly people's facilities, repairs to their homes and the widening of the home support services. Additionally, it aims to improve the training of staff involved. As a main goal, this plan aims to define the process of certifying institutional quality.

National Action Plan for Inclusion (PNAI): defines as priorities the improvement of support for dependent persons and the development of actions centred on preserving family solidarity. It relies on the information society and the knowledge economy to overcome backwardness. Special attention is given to the disabled. One of the objectives of PNAI is to develop initiatives designed to preserve family solidarity in all its forms.

Incentives for microenterprises: (DL nº 34 / 95, 11th February) – supports the creation and development of local investment initiatives. Among several objectives, those related to social action can be highlighted: creation and development of locally and proximity based services which aim to improve the condi-

tions of social, environmneta., cultural and recreational life; the direct creation of jobs.

Elderly People's Homes Programme: seeks to develop and intensify the offer of homes for the elderly and other social responses, having as objectives: the re-accommodation of elderly persons coming from lucrative homes without conditions for functioning; the satisfaction of needs for homes in areas not yet covered, or weakly covered.

Integrated Response – social action and health (Dispatch Collection nº 407 / 98, 15th May). The target group are people who are physically, mentally or socially dependent, temporarily or permanently. The objectives are the promotion of autonomy and reinforcement of the capacities and skills of families in relation to the treatment and accompaniment of these situations.

QCA II – Sub-programme Integrate – Measure I: projects with the objective of improving the quality of life of the elderly, promoting their social integration through the development of family support services and the training of care providers to the elderly.

National Programme against Poverty: includes specific activities for the elderly: home support services, day centres, social clubs, holiday centres, homes and residences.

Training of agents who work with the elderly: aimed at the long-term unemployed, who after special training, are integrated within the bodies promoting social support services.

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