



Learning from Long-Term Care practices
for the European Care Strategy

The meanings of long-term care work in Portugal

National report



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List of Acronyms

ADLs	Activities of Daily Living
CACI	Occupational Centre for Persons with Disabilities
CNIS	Confederation of IPSS
ECCID	Home-based Teams of Continuous Care
EGA	Hospital Discharge Teams
ERPI	Residential Care Facilities for Older Persons
IADLs	Instrumental Activities of Daily Living
IPSS	Private Institution of Social Solidarity
INE	National Statistics Office
LTC	Long-Term Care
RAI	Autonomous Residences for Persons with Disabilities
RNCCI	National Network of Continuous Integrated Care
RRP	Recovery and Resilience Plan
SAD	Homecare for Older Persons
SCM	Holy House of Mercy
SNS	National Health Service
UC	Convalescence Unit
ULDM	Long Duration and Maintenance Unit
UMDR	Medium Duration and Rehabilitation Unit

Executive summary

There is no formal concept of care work in Portugal. The word 'carer' (*Cuidador*), which has a gender inflexion for the female form (*Cuidadora*) – which is the form that is used more often - has been historically used to designate informal carers or, in some cases, carers directly employed by the person receiving care or by his/her family to provide in-house care. Professionals employed in the care sector are not usually designated as carers but rather identified by the specific professional group they belong to. More recently, and as the private commercial homecare services market grew, the workers of these services that visit users at their homes are sometimes called carers.

There are two main groups of workers in the LTC sector mirroring a fundamental split between healthcare and social care. Care work is generally regarded as unfairly treated in the labour market, namely because it has poor salaries, hard working conditions and little social recognition.. There is also a general perception that there are shortages of care workers. This shortage is explained by the low attractiveness of care work but also because of how the LTC system is set up.

Quality of care work is analysed along two main ideas. On the one hand low quality of care provision is explained by lack of qualifications of workers. This applies mostly to those employed in the social care sector. On the other hand, low quality of care services is explained by the shortage of workers, leading to overburden and low motivation.

Migrant care workers are a relatively recent phenomenon, but there is a shared understanding of their relevance for the sustainability of LTC in the country.

Informal care provision, even if currently formally recognised, is still not described as care work but rather as caring (*Cuidar*) or even looking after (*Tomar Conta*). The word in Portuguese merges the idea of looking after someone and carries a meaning that is generally associated to relationships of affection between carer and cared after.

Debates about care work are very much confined to discussions about shortage of workers and strategies to increase attractiveness and capacity of retention of workers.

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Introduction

This report is part of the European research project **LeTs-Care: Learning from Long-Term Care practices for the European care strategy**, a collaborative research project that engages and supports policy makers and other stakeholders in addressing the challenges posed by long-term care (LTC) across the European Union countries.

LeTs-Care brings together a consortium of seven European academic institutions, a unique European Network of Cities and Regions, and several social economy organisations operating in Austria, Denmark, Italy, Lithuania, the Netherlands, Portugal, and Spain. The project is coordinated by Ca' Foscari University of Venice, and in Portugal the research is conducted by University of Porto. The project started in April 2024 and will run until December 2027. It is funded by the European Union under Horizon Europe as stipulated in Contract 10113270.

Long-term care (LTC) systems across EU countries are facing important challenges and are trying to strike a balance between ensuring affordable, accessible and good quality care; high quality of work in the care sector and financial sustainability. According to the European Union's "care strategy", we should invest in practices that promote integrated and person-centred care to address these challenges.

However, to date, there is little systematic knowledge of the specific LTC challenges and of the meanings of, for instance, quality of care and quality of work in care across national and local contexts. In addition, we know that "good practices" are difficult to transfer or to extend because their outcomes are highly dependent on the context.

Furthermore, while "good practices" in care provision are frequently promoted across Europe, experience shows that their transferability is limited. What works effectively in one context may not yield the same results elsewhere, because outcomes are strongly shaped by local governance models, policy environments, available resources, and community networks. This complexity calls for a comparative, context-sensitive approach to the study of LTC systems — an approach that LeTs-Care aims to provide.

LeTs Care has three aims:

1. To provide a new, in-depth, reflexive understanding of LTC challenges across national and local contexts, for and with stakeholders and policy makers.
2. To understand how "integrative" and "innovative" practices work in context and to highlight the possibilities and limitations to their transfer.
3. To develop a new model for policy learning with and for stakeholders.

To achieve the first aim, the LeTs-Care team set out to understand the meanings of five structuring concepts within long-term care systems: *needs*; *care and quality of care*; *work and quality of work*; *sustainability*; and *inequalities*. Methodologically, LeTs-Care adopted a mixed-methods approach, combining the analysis of secondary data (including a review of national literature, both academic and grey literature, as well as policy documents) with the collection and analysis of primary data obtained through interviews with *stakeholders* and *policy makers* at national and subnational levels.

For each of the five key concepts, every national research team produced a dedicated report focusing on a contextualised understanding of its meaning within the respective long-term care system. The present document is one of these reports, forming part of the series of five national reports developed by the Portuguese research team within the framework of LeTs-Care. Specifically, this report focuses on the concept of long-term care needs in Portugal, examining how it is understood, articulated, and addressed within the national policy and care landscape. Equivalent

reports were produced by all research teams in the other participating countries. Building on the insights generated through these national analyses, the research consortium developed a comparative report that examines the five key concepts across the different national contexts, identifying convergences, contrasts, and shared challenges within European long-term care systems.

1. Definitions and History

There is no formal concept of care work. The word ‘carer’ (*Cuidador*), which has a gender inflexion for the female form (*Cuidadora*) – which is the form that is used more often - has been historically used to designate informal carers or, in some cases, carers directly employed by the person receiving care or by his/her family to provide in-house care. Professionals employed in the care sector are not usually designated as carers but rather identified by the specific professional group they belong to. More recently, and as the private commercial homecare services market grew, the workers of these services that visit users at their homes are sometimes called carers.

To fully understand how care work is organised in Portugal one must consider how LTC is organised in the country. Portugal has a dual system that mirrors classic splits between healthcare and social care. Traditionally LTC in Portugal has developed from social assistance and therefore the concept in use more commonly is “social care”. This system covers all areas of social care, organised along a menu of services that target different groups of the population (children, persons with disabilities, older persons, among others) and that include homecare, residential care, day-care, teleassistance, occupational centres, autonomous residences, among others. For a detailed list of what social care provision involves in Portugal see report on meanings of care. More recently, in 2006, it was created a new parallel system, the National Network of Integrated Continuous Care (*RNCCI – Rede Nacional de Cuidados Continuados Integrados*), bringing together the Ministry of Health and the Ministry of Labour, Solidarity and Social Security, to create a new type of service that would focus on securing continuous, long-duration and focused on rehabilitation and reablement care, as well as palliative care. This new system merges healthcare and social care, but the healthcare component is dominant in both the design and in the operational aspects of care services (see more on this in the report of meanings of care and quality of care).

There are two main groups of workers in the LTC sector mirroring this fundamental split between healthcare and social care:

1. **Healthcare professionals:** in LTC, and as part of the RNCCI, these professionals are mostly nurses (*Enfermeiros/as*). Other professionals associated to the sector include medical doctors, psychologists, physiotherapists, occupational therapists, speech therapists and nutritionists. These are the professionals that are legally defined as part of the RNCCI and that are considered for the purpose of licensing of services and of calculations of costs and public funding.
2. **Social care professionals:** here there are three main professional groups, also defined in the legislation for the purpose of licencing of services and calculation of costs of operations. The first group is the technical staff with planning and coordination responsibilities, which usually involves social workers, sociologists, psychologists, gerontologists and similar professionals (*Técnicos Superiores*) and the Socio-cultural animator (*Animador Sócio-Cultural*). The second group concerns the care assistants that deal with the daily tasks of caregiving (*Ajudante de Ação Direta*). And finally, there is the group of the auxiliary staff performing complementary tasks such as cooking, cleaning, laundering and others of the same nature (*Empregado Auxiliar*).

Qualifications, careers and salaries vary significantly across the two LTC subsystems. Healthcare professionals are typically highly qualified professionals, with regulated careers and salaries set according to standards for the healthcare sector. Social care professionals receive salaries that are generally considered very low. In the case of the workers in charge of daily tasks of

caregiving, the salaries are at the level of the national minimum wage. Contrary to what happens in the healthcare sector, there are no formally defined career pathways in the social care sector.

Further to this healthcare vs. social care divide, there are further differences that relate to the nature of the employer. In both the RNCCI and in the social care sector, the majority of care provision is secured by non-profits (in 2023 they accounted for 77,8% of care provision in the RNCCI and 83,8% in the social care sector), which pay salaries that are lower than the ones paid by public providers (in the RNCCI 6,7%% of services are provided by public hospitals) and by private commercial providers (with a weight of 15,5% in the RNCCI and in the social care sector of 16,2%).

I believe that there is no proper valorisation of this type of profession, in other words, they are poorly paid professions, they are professions that basically require a lot of responsibility, we are basically looking after others and they are not well regarded. Then there also has to be work to dignify the worker who works in these area.

Interviewee Code: DTN_1111

Care work is generally regarded as unfairly treated in the labour market. All interviewees recognise it is not properly valued from a social point of view and not adequately rewarded within the LTC system, namely in terms of salaries and career pathways. The gender bias in care work is thoroughly discussed in the literature and by stakeholders alike and seen as an additional manifestation of the lack of social recognition of care professionals. Baker et al. (2014) quoted by Chagas (2015), report research findings with a sample of care workers engaged in homecare services: all females, with schooling level below lower secondary education (ISCED2 or less), working on average 38,8 hours per week and one third in shifts. 87.2% of workers in the same study said they feel psychologically tired and 95.3% said they felt physically tired. The results of self-reported symptoms of pain were prevalent in the lower back (86.0%), upper back (82.6%), neck (66.3%), shoulders (64.0%) and wrists/hands (61.0%). The study discusses the psychosocial risks faced by workers which include the overload caused by contact with the suffering of patients, pain and death, working in shifts, the pace of work, multiple, dispersed and repetitive tasks, which can cause headaches, respiratory problems, sleep disorders, depression, anxiety, alcohol consumption and isolation.

There is a general perception that there are shortages of care workers. This shortage is explained by the low attractiveness of care work but also because of how the LTC system is set up. Interviewees mentioned that there is an element of unfair competition brought by salary and career pathway differences between careers in the public sector and careers in the LTC sector, mostly run by non-profits, as well as compared to the private commercial sector. This is particularly felt regarding healthcare workers that are increasingly hard to hire and retain in non-profit providers. In the social care sector, the salaries are so low that competition comes from other sectors of the economy that are also absorbing non-qualified workers with more attractive salaries and better working conditions.

And we're the poor relative, who doesn't go on strike, who doesn't... So that's it. By the way, you've certainly heard some of my speeches, I've argued, for example, that we, in the third sector, and also in long-term care, the people who work here provide a public service, bearing in mind, I often use the expression boss, that the boss is the same, in other words, the government decides the pay rises for civil servants, but it also decides ours, even if indirectly.

And if you want to do it directly, I challenge the government to give us the conditions to pay salaries equal to the civil servants, and then to create an collective labour regulation so that the extra money you give us is actually for care providers to comply and pay salaries equal to the civil servants.

Interviewee Code: DTN_1009

It's very difficult, it's very difficult to look after and keep workers. On the other side, of the different professions, we have another problem. Another problem, essentially, is that if we don't have a career, I'm talking about nurses and other specialised technicians, they also run away. This all has to be balanced. What is the biggest difficulty in the long-term care network? It's the flight to the hospital network. Because at the moment there's a shortage and so if they come with some training in long-term care, it's good for their CV and therefore for absorption at hospital level.

Interviewee Code: DPN_0212

As a summary, table 1 below lists the professionals that are formally recognised and explicitly associated to LTC in Portugal, with a short description of the legal definition of their roles and responsibilities.

Table 1. List of professions that are legally defined and associated to LTC

PROFESSIONS	SECTOR	ROLES AND RESPONSIBILITIES
Medical doctors	RNCCI	General practitioner: carries out medical examinations; requests auxiliary diagnostic tests and makes diagnoses; defines drug and other therapies; refers patients to specialist doctors; carries out minor surgical interventions. Specialist doctor - Specialises in a specific branch of medicine.
Nurses	RNCCI Social Care ^{a)}	Works in prevention, diagnosis, treatment and rehabilitation, collaborating with multidisciplinary teams. Performs technical procedures, administers medication, monitors vital signs and ensures the hygiene and comfort of patients. Advises patients and their families on the administration of medication and treatments.
Physiotherapists	RNCCI	It applies therapies to promote health, prevent illness, disability, incapacity and maladaptation, as well as to treat, train or rehabilitate, with a view to maximum functionality.
Speech Therapist	RNCCI	Preventing, assessing and treating human communication disorders, including the functions associated with understanding and expressing oral and written language and non-verbal communication.
Occupational Therapist	RNCCI	Assessing, treating and enabling individuals with physical, mental, developmental, social or other dysfunctions; working to prevent disability through appropriate strategies, including technical aids, aimed at maximum performance and autonomy in personal functions.

Table 1. List of professions that are legally defined and associated to LTC (cont.)

PROFESSIONS	SECTOR	ROLES AND RESPONSIBILITIES
Social worker	Social care RNCCI	Identifying and mobilising the resources available (social facilities, support) to help solve the problems of adaptation, rehabilitation or social inclusion of individuals, liaising with other bodies. Analysing social service problems related to institutional services.
Nutritionist	Social care RNCCI	Promoting health and collaborating in recovery/treatment by providing guidance on appropriate diet plans.
Psychologist	Social care RNCCI	Analysing human behaviour and mental processes - thoughts, feelings and behaviour. Their intervention can be individual, family, group or community, aimed at societal and individual well-being.
Socio-cultural Animator	Social care RNCCI	Organising, coordinating and/or promoting social and cultural activities aimed at users, in line with the institution's objectives. Their work aims to strengthen people's sense of belonging, cooperation and solidarity, as well as developing their capacity for expression and fulfilment.
Direct action assistants	Social care	The following tasks are carried out: accompanying users in and out of establishments and services, guiding, assisting and stimulating them; ensuring regular meals; providing hygiene and comfort care for users and collaborating in the provision of health care that does not require specific knowledge, namely applying medicinal creams, carrying out small dressings and administering medication, at the prescribed times and according to instructions received; replacing bed linen and bathroom linen, as well as users' clothing, liaising with laundry services. In home care, she also takes on the task of cleaning the home.
Healthcare assistants	RNCCI	Performs the following tasks: messenger service and specific cleaning of the medical services; preparing and washing technical service material; accompanying/transporting users with or without technical aids; external and internal transport of medicines and everyday products; organising dirty/washed clothes; preparing light meals in the services and distributing diets; collaborating in providing hygiene and comfort care to patients, under the guidance of the nursing staff; transporting and distributing oxygen bullets and sterilised materials to the medical services.
Personal assistant	Social care	Contributes to the independent living of people with disabilities by supporting them in carrying out activities of daily living

Source: Boletim do Trabalho e Emprego n.º 8, February 2023. https://cnis.pt/wp-content/uploads/2023/02/bte8_-de-28fev2023.pdf

(a) The inclusion of a nurse in residential care facilities for older persons is mandatory when the facility has a capacity for 20 or more residents.

Migrant care workers are a recent phenomenon when compared to other European countries. Historically their presence was not significant, but in the last two decades they have been steadily taking a significant share of care work, especially in the social care sector. There are no clear

statistics on the topic, but the perception is that they are essential today for the operations of the social care sector. The Portuguese government has signed already some agreements with African countries, former colonies, to regulate labour mobility, which should in fact be read as import of workers. According to reports by the interviewed stakeholders, care workers from Angola, Cape Vert and Guinee-Bissau, but also from Brasil, are already a backbone of the labour force of many social care providers in the country. These are mostly females willing to work for low salaries and endure hard working conditions. Their competitive advantage is the fact that they speak Portuguese, which facilitates their quick integration in the workplace.

We're talking above all about human resources, direct action assistants, the direct carers of the elderly. And not just in quantity, but also in terms of quality. As in many other sectors, for some years now there has been enormous difficulty in recruiting new staff. And these new employees come en masse from Cape Verde, Angola, Brazil and so on. And they come with very few qualifications for the jobs they then get in Portugal.

Interviewee Code: DRN_1209

But, for example, if it's other nationalities, language ends up being a barrier, because many of these people have difficulties in understanding, I'm even talking about the users, they have cognitive difficulties and so if we have someone who can't express themselves fully in Portuguese, it's going to be very difficult for them, in other words, sometimes we're not excluding, but really in the profile we have to have adequate communication in Portuguese, because otherwise people have a lot of cognitive difficulties, they have dementias, they have others, and it's not possible to overcome this. So there's certainly an adaptation, but when it comes to caring for people directly it's necessary, language is a barrier if we don't have this criterion.

Interviewee Code: PIN_2709

Informal carers have historically been the main source of care provision in Portugal, as discussed in the literature about welfare state models. Although there are some known difficulties with measuring the true size of informal care provision, estimates point to around 12% of the total population over 15 years of age being involved in informal care provision which accounts for a total of a little over 1 million informal carers (Source: INE, 2019, available at <https://www.ine.pt>, last access on the 30th of January 2025). What is more distinctive about informal care in Portugal is the fact that it will usually involve a high dedication measured in number of hours of care (around 45% do it 10 or more hours per week, according to data from the National Health Survey 2019). Despite their importance, informal carers were not officially recognised as such up to recently. The literature includes many references that discuss not only the relative importance of informal care in the global care system (Pereira, 2014; Capucha, 2014; Lima, 2016) but also the impacts of caregiving in informal care settings, for both the caregiver (Barbosa et al, 2023; Tavares & Freitas, 2020) and for the care receiver (Figueiredo et al, 2014). On this topic the national literature mirrors the debates found in international academic fora.

Informal care provision, even if currently formally recognised, is still not described as care work but rather as caring (*Cuidar*) or even looking after (*Tomar Conta*). The word in Portuguese merges the idea of looking after someone and carries a meaning that is generally associated to relationships of affection between carer and cared after.

More recently, and largely because of some grass-roots pressures coupled with pressures from some political forces that tend to take-up as political flags topics related to social groups perceived as marginalised, the theme of informal care was put in the political agenda. In late 2019, and after

more than two years of debates and consultations, the National Parliament voted the Informal Care Act (*Estatuto do Cuidador Informal*) (Law 100/2019, 6th of September 2019). The legislation was recently revised to broaden the scope of what is considered informal care but not changed in its fundamental aspects (Decree 86/2024), following a previous revision that addressed general labour legislation and that also included dispositions on informal carers (Law 13/2023). Altogether, the legislation stipulates the conditions that need to be met for someone to be recognised as main informal caregiver, which entitles the person to a series of rights regarding participation in the labour market, pension entitlements, access to support and training as well as the possibility to be awarded a specific cash benefit to compensate for loss of income (carer's allowance). The legislation also defines the criteria for someone to be acknowledged as a secondary informal carer, which also covers aspects of labour market participation. Table 2 below summarises the criteria that need to be met to be awarded the status of primary informal carer and secondary informal carer.

Table 2. Informal carer status: criteria and rights

Informal carer	Eligibility criteria	Rights
Primary	• Aged 18 or over • Legally resident in Portugal • Provide permanent care for the cared-for person • Have adequate health conditions to provide care (not be an invalidity pensioner or receive dependency benefit) • Do not receive income from work or unemployment benefit • If family member a): must have a proven relationship of mutual support and sharing of resources with the person being cared for, and may or may not have the same fiscal residence. • If not a family member: live in a shared household and have the same fiscal residence as the cared-for person	• Access the carer's allowance for the main informal carer • To be covered by Social Security through the payment of benefits under the Voluntary Social Security Scheme. • Benefit from the Carer's Rest scheme • Receive training to develop competences related to caring • Access information on the progress of the cared-for person's illness and the support to which they are entitled • Receive psychological support from health services (including bereavement support)
Secondary	• Be aged 18 or over • Legally resident in Portugal • Provide regular care for the cared-for person • Be a relative (up to a certain kinship level) • A third party who lives in the same house as the person being cared for and has the same fiscal address • May or may not receive remuneration for their professional activity or for the care they provide to the cared-for person, • May be in receipt of unemployment benefit	• Benefit from the Carer's Rest social service; • Receive training to develop competences related to caring • Access information on the progress of the cared-for person's illness and the support to which they are entitled • Receive psychological support from health services (including bereavement support) • Reconcile the provision of care with professional life, under the terms of labour legislation.

Source: Decree-Law no. 86/2024, of 6 November, Series I of 2024-11-06.

Regarding the **quality of care work**, there is a general perception that care work is hard, both physically and emotionally. The working conditions of professionals who provide care at home are considered worse compared to their peers who work in institutions since they are exposed to greater occupational risks related to musculoskeletal injuries and falls (Chagas, 2015). However, there are no specific protocols to assess the quality of care work besides the ones in place to evaluate service provision altogether (see report on meaning of care and care quality). Professionals are evaluated on a regular basis, as part of common protocols of assessment of performance in place for many years in public institutions and that were incorporated by non-profits. This assessment tends to focus on indicators of productivity but there is no common standard for the sector.

Quality of care work is analysed in the literature and discussed by interviewees along two main ideas. On the one hand low quality of care provision is explained by lack of qualifications of workers. This applies mostly to those employed in the social care sector. On the other hand, low quality of care services is explained by the shortage of workers, leading to overburden and low motivation. This applies to both workers in the RNCCI and those employed in the social care sector.

And [quality] has dropped a lot at various levels, from the point of view of the lack of human resources, which means that the teams aren't complete and therefore the care of the patients isn't as good as it should be, the quality of the food, the very materials they use, nappies, etc., and so on.

Interviewee Code: DRN_1009

And the State continues to think that we're giving the same response when we can't. So, I can't have the turnover I have, entries and exits. So, I can't have the turnover of nurses that I have, coming and going. I have to stabilise teams for this quality, which is necessary. I have to stabilise the medical presence. I have to stabilise, and this is easier, technical areas. There's no shortage on the market, so these areas are more stabilised. But, for example, it doesn't make any sense for me, in long-term care and maintenance, not to have speech therapist hours. Of course I have our speech therapist here, of course she provides support. How could I ethically and deontologically accept not having one?

Interviewee Code: MPL_0310

2. Boundaries, Differentiation and Interrelations

LTC work is divided into big professional groups that relate to divisions between healthcare and social care as described in the previous section. This division is the basis for differences in career pathways and salaries, but also for the definition of tasks that each professional can or cannot perform, as described above under table 1.

Although there are clearly defined roles and responsibilities for different professionals in the legislation, the practical aspects of care work sometimes generate overlapping that can in turn generate some tensions. We would highlight three aspects.

One topic that is addressed in both the literature and in the interviews with stakeholders is the topic of the difficulty of collaboration between healthcare and social care professionals. This is an old

divide that also manifests at higher levels, even at the policy making level. One of our interviewees, on this topic, quoted a respected former Health Minister that described the relationship between Social Security and Health ministers as the one typically found among rival brothers. Social care professionals are less valued and in settings where there are healthcare professionals these tend to take the lead. Some stakeholders were describing this phenomenon in a rather detailed manner and considered this difficulty of cross-professions collaboration as one of the main reasons why the care system is unable to reach higher levels of care integration. In the specific case of the RNCCI, that is designed to incorporate the integration of health and social care, this is even more flagrant. The dominance of healthcare professionals is described as a building block of what some stakeholders consider a biomedical approach to LTC, which they criticise as failing to reach the intended goals of the RNCCI and of what LTC should be.

It's also a very important challenge to get the social area and the health area working together. It's all very well, we say we work together, but it's very difficult, it's very difficult. And you have to be, shall we say, very flexible because the social area and the health area often have different criteria, different demands

It's just that people don't talk to each other. (...) And everyone wants to take centre stage. Do you realise that? My staff and I have reached some homes where, when the health team gets there and sees that we're there, they wait at the door. That's impossible. So this kind of education of the different sectors involved in this network would also have to happen. I think that's difficult. It's difficult because... It's difficult because all the sectors want to play a very significant role.

Interviewee Code: ORN2_2410

What training do doctors have at universities, for example, in social science? I ask. What knowledge do they have? None. Now, by saying where we send them, in this case the elderly, where there's a vacancy is because there's going to be one, there's a lack of knowledge of what's going to happen next. It's not just ignorance, it's devaluation, because social care and social areas have been greatly devalued, unfairly attacked and with a huge ignorance on the part of the population about what they actually represent. And when I say the population, I include health professionals. In other words, there needs to be a pedagogy in the sense of greater information about what is social and what is health, in order to know that the boundaries are blurred, that these boundaries need to be crossed and that without this knowledge people simply discharge patients, which they call social discharges, but we need to know what social discharges are. Do we all agree on what inappropriate discharges are, sorry, inappropriate hospitalisations and social hospitalisations? Do we all agree, including the elderly themselves, that after a fractured neck of the femur they are discharged and do their physiotherapy afterwards, where, who helps them? There are many responses at local level, almost all of them provided by institutions, including health institutions, but we're a long way from realising the model that is theoretically well-designed, or may even be well-designed.

Interviewee Code: ORN_2410

Another topic that sometimes generates some tensions involves tasks that are officially under healthcare but that sometimes need to be performed by other professionals. This happens more commonly in social care services where users increasingly present themselves with healthcare needs, some of them quite complex. However, most social care services do not include in their teams healthcare professionals. The regulations for residential care facilities, for example, require that one nurse is employed as part of the staff per each 40 residents. But there are no such dispositions for homecare services. In residential care facilities, even when there is a nurse in the staff, it is unlikely the healthcare component can be secured 24/7. This means that tasks related to medication, nasogastric feeding, changing of dressings, and direct administration of some medication, all tasks that must be performed exclusively by nurses, may on occasions be performed by other

professionals that have no credited training in healthcare. This raises issues of safety and quality of care but also creates tensions among workers and discomfort with aspects related to liabilities and pay rates.

And here we also have a part of the social responses that also needs health care and this articulation is not done in the way it should have been done. So we also have steps to take here. Once again, it's more this integration of care, we started the conversation there, didn't we?

Interviewee Code: DPN_0212

Because Portugal doesn't have something that is common abroad, which is called nursing homes, and which we don't have, and which we should have. (...) No, this starts with a contradiction. Nursing homes are not considered health facilities, but perhaps they need to be, just like long-term care (...) The evolution of current nursing homes and the operating rules of current nursing homes to the point where they can operate on a par with nursing homes is very expensive for the state or for the elderly.

Interviewee Code: DRN_1209

A third topic that emerged in interviews relates to the sector where professionals work. LTC workers are in a peculiar position since they are working in a field that is seen as part of what would be State's responsibility, so their work is perceived as equivalent to the work carried out by professionals employed as public servants. But they are employed by the private sector (the majority in non-profits) and therefore are paid lower salaries. This affects all careers in both the social care and the RNCCI.

Adding to this, there is still a dominant perception of non-profits as organisations that are guided by a spirit of mission (quite likely explained by their proximity to the Catholic Church apparatus) and therefore workers are sometimes discursively described as persons embedded with that spirit of mission. Some stakeholders were quite critical about this and accused sector representatives of not doing a good job looking after the interests of care workers, especially during negotiations with the State regarding funding of service provision.

We have a Union of Mutualities, which is an organisation that is a bit in tow, so to speak, of CNIS and the Union of Misericórdias. We have a CNIS leader with a miserabilist discourse, in which he thinks we all have to be poor and honourable. The honourable part I agree with, the poor part I don't. He even plays this role a lot in public speeches. And in meetings with the government, he doesn't make any demands. We have a representative of the Misericórdias who, for example, at a meeting with the government last month, the representative of the Confederation of Portuguese Cooperatives said exactly what I say, which is that salaries in this sector must be equal to those in the civil service. And the president of the Misericórdias doesn't think so. When the president of the Misericórdias tells the government this, the government rubs its hands in glee, because it realises that there is no unity between the representatives, and it realises that, after all, there is a representative of a very strong sector, such as the Misericórdias, who thinks that they also have to have miserable salaries and that they don't have to have salaries equal to the civil servants. When this happens, it's obvious that the sector is doing badly and that it can't actually achieve its goals. And yes, the sector, often these representatives, are all... not on the same page.

Interviewee Code: DRN_1009

3. Resources, Infrastructure and Regulation

The regulations regarding the criteria for licensing a care provider include dispositions about the professionals that must be included in the staff and the ratios of staff to users. This is one of the aspects regarding the labour force that generates more discontent among the representatives of non-profit care providers since they see these ratios as insufficient to meet the real needs of service users. Care providers consider they are forced to either lower the quality standards of care provided or hire additional workers risking the financial sustainability of the organisation (see more on this topic in the report on meanings of sustainability). Table 3 below and table 4 below display information about the ratios workers/users as set in applicable regulations for the RNCCI and for the social care sector. The tables also include information about salaries for the different professionals. To facilitate interpretation of figures for salaries, we share some contextual data. In 2024 the national minimum wage in Portugal was set at 820 euros. Based on data for 2023, the National Statistics Office sets the average gross earnings per worker at 1,507 euros for all sectors of activity, 1,365 euros for the sales sector, and 1,525 euros for the health and social support activities. The national average gross salary in the public sector, also for 2023, was set at 2,078 euros and at 1,396 euros in the private sector. The average gross salary in the specific domain of health and social support activities was set at 2,212 euros in the public sector and at 1,179 in the private sector (INE, 2024, available at <https://www.ine.pt>, last access on the 30th of January 2025).

Table 3. Ratios workers/users in the RNCCI, and reference salaries for equivalent professionals working in public provision and in facilities run by non-profits, for 2024

PROFESSIONALS ^(*)	RATIO WORKERS/ 30 USERS ^(a)			REFERENCE SALARY IN THE PUBLIC SECTOR (GROSS MONTHLY)	REFERENCE SALARY IN THE NON-PROFIT SECTOR (GROSS MONTHLY)
	UC	UMDR	ULDM		
Medical doctors^(b)	1	0,75	0,5	2,843.05 € - 3,464.38 €	1,126.00 € – 1,179.00 €
Nurses^(c)	12	9	6	1 547,83 € (Chief nurse: 2,568.39 €)	1 100,00 € (Chief nurse: 1,249.00 €)
Physiotherapists	2	2	0,5	1 389,93 €	888,00 €
Speech Therapists	0,2	0,2	0	1 389,93 €	888,00 €
Occupational Therapists	1	1	0,5	1 389,93 €	888,00 €
Social workers	1	1	1	1 442,57 €	1 100,00 €
Nutritionists	0,125	0,125	0,1	1 442,57 €	1 100,00 €
Psychologists	0,5	0,5	0,5	1 442,57 €	1 100,00 €
Socio-cultural animators	0,5	0,5	1	979,05 € - 1 442,57 €	888,00 €N
Healthcare assistants	14	12	8	926,42 €	832,00 €

Source: Ratios staff/workers as stipulated in Ordinance no. 50/2017, 2nd February 2017; Salary levels for workers in non-profit provision as stipulated in the Bulletin of Labour and Employment no. 21, 8th June 2024; Salary levels for workers in public provision as stipulated in the Civil Service Remuneration System 2025.

(*) The list of professionals only contemplates those that are specified in legislation that regulates the RNCCI. Pharmacists are not included in applicable regulations but due to general dispositions about usage of medication in healthcare units, many of the providers must include a pharmacist in their staff.

(a) Applicable legislation stipulates minimums for different staff categories for a unit with capacity for 30 users. Ratios staff/users were therefore computed for 30 users.

(b) Medical doctors hired by non-profits often do not work exclusively for the non-profit employer. Some are already retired from the SNS. The diversity of situations makes it difficult to estimate salaries for this specific group. We use as reference values at entry in the career and for non-exclusivity contracts.

(c) The ratios for nurses includes the personnel that takes coordination responsibilities.

Table 4. Ratios workers/users in the social care sector for residential care for older persons and for homecare services for older persons, and reference salaries as stipulated in labour agreements for the IPSS, for 2024

PROFESSIONALS ^(*)	RATIO WORKERS/USERS		REFERENCE SALARY IN THE NON-PROFIT SECTOR (GROSS MONTHLY)
	ERPI ^(a)	SAD ^(b)	
Technical director ^(c)	1	0,5	1,337.00 €
Socio-cultural animator	1	-	888,00 €
Nurse	1	-	1,126.00 € - 1,179.00 €
Direct action assistants ^(d)	7	10	862,00€
Domestic work coordinator	1	-	882,00 €
Cook	1	1	862,00 €
Cook assistant	2	2	832,00 €
Auxiliary workers	2	2	842,00 €
Driver	-	1	852,00 €

Source: Ratios for ERPI as defined in Ordinance no. 349/2023, 13th November 2023; Ratios for SAD as defined in Technical manual of the Social Security, December 1996; Salary levels as defined in the Bulletin of Labour and Employment no. 21, 8th June 2024

^(*) Presence of certain professionals and ratios can be adjusted in special circumstances. For example, if the users of a service are severely dependent, ratios can be redefined in accordance with redefinition of payments from the State that are also adjusted in such circumstances. Values presented are for the standard scenario as defined in applicable regulations.

^(a) Applicable legislation takes as reference a unit for 40 residents. Ratios workers/users are therefore computed per 40 residents.

^(b) Applicable legislation takes as reference a service for 60 users. Ratios workers/users are therefore computed per 60 users (daily visits).

^(c) Technical directors can be imputed half time to the role in both ERPI and SAD. The most common arrangement is to have one technical director full-time securing the role in both services.

^(d) Regulations define ratios for these workers for day and night shifts. We offer the global ratio. The day Shift stipulates 1 worker per 8 residents. The night shift stipulates 1 worker per 20 residents.

Regarding the actual **size of the workforce engaged in LTC** it is very hard to get accurate information since available data is aggregated by broad sectors of the economy and by broad professional groups. Census data from the National Statistics Office puts the entire healthcare activities and social services activities sector, in 2021, accounting for a bit over 400,000 employed workers (source: INE, available at <https://www.ine.pt>, last access on the 30th of January 2025). This number, however, includes a very broad range of workers and therefore is of very limited use to estimate the size of the LTC workforce. A report on LTC in Europe by the OECD estimated that LTC accounted for 0,4% of total employment in the country, in 2021 (OECD, 2023), which would be something around 18,000 workers. This corresponds to a ratio of 0.8 workers per 100 persons aged 65+, a value significantly lower than the OECD24 average set, for that same year, at 5.7 workers per 100 persons aged 65+.

Irrespective of the final number, there is a shared view that there is shortage of care workers. Difficulties in hiring and retaining workers is a topic that was mentioned several times in the interviews.

And then there's the question of valuing these workers. Because what we see in the sector is that we have qualified workers, we have workers who are committed to the work they do, but then, given the working conditions, which are, excuse the term, terrible, given the precariousness and the lack of pay, many workers with good conditions, with skills acquired in the workplace, end up leaving the sector. And right now the sector is facing immense difficulty in hiring workers. We're now getting to the point where we have some support structures for the elderly in the social and solidarity sector, and even for children, which is another field, that are resorting to temporary work companies

Interviewee Code: STN_1410

Every day we hear from nursing homes that can't hire staff because they're short-staffed. They have turnover, and turnover isn't just in the auxiliary staff. It's in the technical staff.

Interviewee Code: MPN_0310

The age and gender composition of the workforce in healthcare and social care activities displays trends that are likely common to the specific subgroup engaged in LTC. The figures available are for the full sector of healthcare and social care activities, without any possibility of identifying the specific sub-group of LTC workers. The figures available are shown in table 4 and concern 2021 census data.

Table 4. Age and gender composition of the workforce in the healthcare and social care activities sector, in 2021 (census data)

	TOTAL NUMBER OF WORKERS IN THE COUNTRY	WORKERS IN HEALTHCARE ACTIVITIES	WORKERS IN SOCIAL CARE ACTIVITIES WITH RESIDENTIAL CARE	WORKERS IN SOCIAL CARE ACTIVITIES WITH NO RESIDENTIAL CARE	DOMESTIC WORKERS EMPLOYED BY FAMILIES
Total	4,426,461	276,617	119,670	49,168	62,774
Males	2,256,526	64,630	11,737	4,696	7,196
Females	2,169,935	211,987	107,933	44,472	55,578
15 to 34	1,125,662	85,774	23,997	10,803	6,060
35 to 44	1,148,631	78,269	29,263	13,443	20,177
45 to 54	1,207,715	59,270	35,197	13,720	20,177
55 to 64	812,776	43,064	28,196	10,089	22,605
65+	1,316,677	9,416	2,915	1,040	3,286

Source: INE, Census 2021, available at <https://www.ine.pt> (last access on the 30th of January 2025)

The main trends as shown in table 4 align with global trends thoroughly discussed in the international literature. The care sector globally is a females' domain (females account for close to 83% of the total number of workers). The gender gradient is less pronounced in the healthcare sector and peaks among domestic workers. Despite a general ageing of the Portuguese workforce, the social care sector has a higher share of older workers when compared with the healthcare sector.

Regarding **domestic workers**, there is no available data on how many of these would also be engaged in care provision. Additionally, there is a lot of undeclared domestic work, which means the figures in the table may be underestimating the actual number of persons engaged in this activity.

Data on **informal carers** is limited. National estimates, issued for 2019 by the National Statistics Office, pointed to a total of 1,059,000 persons aged 15+ regularly providing informal care to someone, 85% of which to relatives. This represents around 12% of the total resident population in the country. 65% of informal carers were identified as females (INE, 2019, available at ine.pt, last access on the 30th of January 2025). Regarding informal carers that are officially recognised as such, the most recent data, extracted up to September 2024 from the Social Security records, show a total of 9,420 persons with the status of primary informal carer, and a total of 5,843 with the status of secondary informal carer. 58% of primary informal carers were receiving, at that date, a carer's allowance, with an average value of 352 euros per month (Source: Statistics Bulletin of the Ministry of Labour, Solidarity and Social Security, September 2024).

The system is very fragmented in terms of the **regulatory framework** that applies to the different professions that operate in the LTC sector, with some overlapping of instances of regulation. Different regulatory frameworks apply to different professions. Wages and other benefits are a topic negotiated separately but also with varied instances of representation.

Nurses are a professional group that has a self-regulatory body (*Ordem dos Enfermeiros*) that regulates access to the profession and participates in all instances of negotiation regarding content of work and description of tasks, career pathways, nature of work contracts and other aspects of the profession of nurse. This body, although it is not a union, often participates in negotiations and protests concerning wages and remunerations. Healthcare professions are *very clearly regulated and national dispositions apply to the LTC sector on an equal basis to any other area of healthcare provision*.

Social workers are a professional group that also has a self-regulatory body (*Ordem dos Assistentes Sociais*). Their influence is more marginal, and their activities are more focused on training and access to the profession. Social workers typically take the lead in LTC services as general coordinators and main responsible for the supervision of other workers.

Other qualified social care workers include a variety of professions that do not have self-regulatory bodies but that are still represented by national associations of professionals. That is the case of social animators, gerontologists, occupational therapists and others of the same kind. These associations have very limited influence in any aspect of regulation of LTC.

Non-qualified workers are not formally represented. There are unions that include these workers, and they are the ones who sit at the negotiations table when wages and contractual aspects are discussed.

4. Stakeholders and Governance

Since the system is quite fragmented in terms of LTC providers (some public provision, especially in healthcare; non-profits and private commercial providers in the social care sector), there is fragmentation in aspects related to formal aspects of work, including contracts, wages, social protection, and other benefits. This fragmentation leading to different labour dynamics was perceived by some interviewees as a source of competition in the sector, as already discussed, with negative results primarily to non-profits.

LTC provided as public provision (healthcare and some social care in healthcare units) generates employment that is covered by dispositions applicable to public servants. Professionals are therefore employed by the State, and they have wages that are defined for the careers in the public sector, on top of other benefits such as access to the public servants' healthcare insurance. Workhours are also specific of the public sector (typically less than those in the private sector) and days off are more generous. LTC provided by non-profits is covered by dispositions applicable to the private sector as a whole and follows private sector labour legislation. Aspects regarding contractual aspects, wages, extra benefits, work hours, task lists and other aspects of work are negotiated by the sectorial bodies that represent non-profit providers and unions. These negotiations in turn are embedded in bi-annual negotiations that the same sectorial bodies have with the central government to define the amount of money the state will transfer to the providers, by type of service and by user. These negotiations and their results are binding to all non-profit providers that sign cooperation agreements with the central government. This aspect is seen as posing some conflict of interests that are detrimental to the interests of workers.

There are four very influential sectorial bodies representing the non-profit sector: one is the representative of Holy Houses of Mercy, one is the representative of Private Institutions of Social Solidarity, one is the representative of Mutuality organisations, and the last is the confederation of social cooperatives. These are the stakeholders that negotiate directly with the central government all aspects of regulation, funding and operations of LTC, both social care and RNCCI. But their nature is peculiar because they take upon themselves roles that can be seen as conflicting. On the one hand they represent the interests of the sector and are interested in securing the best deals with the central government, namely in aspects of funding. In negotiations with the central government, one of the arguments they commonly use refers to the low wages and hard-working conditions of workers, demanding from government representatives more funding so that they can, as employers, improve salaries and hire more workers. On the other hand, these sectorial bodies also act as the representatives of the employers. In other words, they are also the ones who sit with unions and representatives of workers to negotiate salaries, working hours and other aspects of work. In that role they tend to prioritise the financial interests of the organisations and not the interests of workers. There is an intrinsic duality in the system that typically does not favour the interests of LTC workers.

LTC provided by private commercial providers operates in a more flexible framework that is only conditioned by dispositions in the general labour legislation. Private providers use monetary incentives to attract workers and compete with non-profits.

5. Territorial Differentiation

Distribution of care workers across the territory will mirror the distribution of care facilities. Available data is not disaggregated by territorial units, so it is not possible to go further on the topic.

There is a general view that some regions of the country struggle to hire care workers more than others, which is related to territorial dynamics that affect the economy as a whole. Low-density areas struggle in particular to hire healthcare professionals and often have to resort to additional incentives to be able to fill-in available positions. The social care sector has difficulties everywhere since it depends more on low-qualified workers who often consider working in LTC as a temporary solution until something better shows up. In smaller territories, for example, the opening of a manufacturing unit or of a big supermarket is likely to have significant impacts in the availability of workers for the local care facilities. Some stakeholders mentioned this with concrete examples.

And I can tell you that a few years ago, when Mercadona opened, a lot of people went to Mercadona because they earned more in the supermarket.

Interviewee Code: DPL_1309

And then there's no appreciation, there are very low salaries, which means that if you don't really enjoy working in this area, you'll quickly be taken to another area, whether it's tourism or supermarkets. Because the pay is similar, and so reconciling work and family life is almost impossible for many of these women, who are mainly women, who are also formal carers, and so there is also an overload, a lack of training and, above all, a career that is neither planned nor recognised.

Interviewee Code: PIN_2709

And they don't have a single nurse on staff. None. None. They are nurses who work in hospitals, in clinics, in other places and they go there to do what are called extra shifts and are paid on a green slip. And they get paid a lot, they get paid very well, so they get paid very well. Why is that? This also happens in the interior of the country and in various regions. There are nurses who travel 100, 200 kilometres or more to work a shift. And that has to be reflected in the price, of course. It's the shift itself, it's the travelling.

And so they have brutally high costs with these kinds of situations, because they don't have any staff.

Interviewee Code: DRN_1009

Both the healthcare and the social care sectors of LTC follow national dispositions in all aspects that concern regulations applicable to the workforce so there is no expectation of observing significant territorial variation besides the natural differences associated to the distribution of the population in general. In some regions of the country, namely smaller villages with weak economic dynamics, the social care sector may be the main employer in the region. This reduces the power on the workers' side to claim higher salaries and better working conditions.

6. Debates and Strategies

The main topics that appear in national debates, in the literature and in the interviews addressing care work are primarily focused on aspects of availability of workers. As already discussed in a previous section of this report, there is a shared view that there is shortage of workers in the LTC sector. This coupled with the low qualifications of many of the workers is seen as one of the main factors of pressure on the social care sector and one of the main sources of quality problems in care provision. Shortage of workers is also discussed as one of the main factors impacting coverage rates of LTC, with some stakeholders expressing some pessimism in regards the possibility of expanding coverage in sequence of recently approved funding for building new care facilities (both under the RRP and with national funds). They argue that care provision does not involve just building facilities. It requires qualified workers that are simply not there.

I look at it with concern. Because it all ties together, doesn't it? Because we know that this sector is the one that's going to grow the most in our country, isn't it? And the one that's going to need the most human resources. We need people. And there would also have to be a labour and employment policy, that's now it isn't here, is it? And when I say that, there are several things here. We need to be able to prevent qualified people from leaving, and to do this we need to review careers, we need to compensate them. People leave because it's not possible here in this country, they're not given the conditions they need and this also creates the need for a salary revision. And then there's the other issue, the issue of employees who are less differentiated, but who also wanted to... this is a difficult area, of care, but we also need to attract them to this area. And in order to attract them to this area we also need... the question of careers. I think it would be important to create a career here, to make these people have a career with progression to attract them.

Interviewee Code: DPN_0212

One other theme that shows in the political arena concerns the high level of emigration of healthcare workers, especially nurses. This is a phenomenon that has been consistently discussed in Portugal for the last decade and a half and that is commonly mentioned as a source of pressure on national healthcare arrangements, affecting the capacity of expansion of the RNCCI.

Debates on care work also bring about the topic of integration of migrant care workers in the LTC sector. The public perceptions about immigrants and their contribution oscillate between acknowledging that the national economy needs migrant workers and some sort of nationalist closure that is hostile to migrants, as indeed seen in most countries of the EU. This has led to some recent changes in migration policies, following the election of a right-wing coalition that currently sits in government. The topic is one that generates heated debates, and the trend seems to go in the direction of regulating entry of migrants in a stricter manner which is likely to impact soon the availability of workers for the LTC sector, particularly for the social care domain that is more dependent of this foreign labour force.

One last topic that also takes space in both the literature and in the policy arena concerns informal carers. Insufficient support for informal carers is the most common issue raised by both representatives of informal carers and by researchers. Recently, in late 2024, the Carer's Act that had been approved in 2019 was revised precisely to accommodate some of the pressures that had been accumulating pushing towards less strict requirements to be recognised as an informal carer and to more generous arrangements in the definition of the carer's allowance. The current arrangements are still seen as insufficient by informal carers' representatives.

In early 2024, it was approved in the national parliament a National Plan for the Promotion of Active and Healthy Ageing. It included some brief references to care workers stating that one line of action

under the plan would be training workers to improve their skills and therefore the quality of the care provision. This extended to informal carers as well. The plan, and the respective coordinator, were dismissed in late 2024 after the change of government and therefore the dispositions it contained are on hold pending the drafting of what the current government has announced to be a new strategy for longevity. It is still unclear what that will entail and the first signs, namely with the appointment of a medical doctor to lead the process, suggest it may remain something very much focused on a purely biomedical approach to ageing.

In 2022, the Ministry of Labour, Solidarity and Social Security created the first training centre in the country specifically focused on training workers and assisting the management of social economy organisations. This included the ones engaged in LTC provision. The centre, located in Guarda, a region that is not in the big urban centres, initiated its activities under a partnership with the local higher education institutions. Very recently, in early January 2025, the current government announced the closure of the training centre and the dismissal of its director. It is unclear what will follow.

This sequence of events, irrespective of the merit of the basis for the decisions and the evaluation that may have been done on the performance of the entities, to which we do not have access, reflect a *modus operandi* that has been common in the policy making process: when governments change, there is a tendency to interrupt ongoing processes and this prevents any programme to have lasting effects.

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