THE SOCIAL HEALTH AND HOME CARE SECTOR, IN PORTUGAL AND IN ALENTEJO REGION

Contents

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1. Introduction

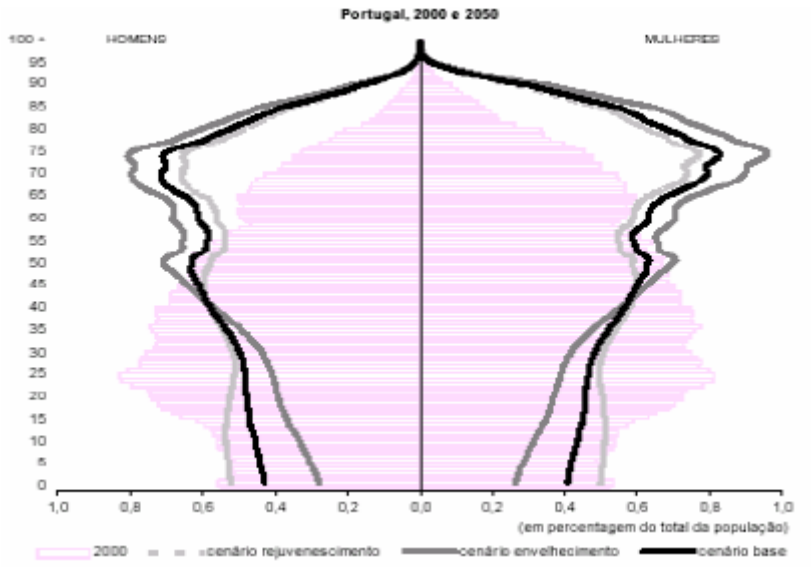
Each partner will provide a general view of the social health sector in their country. A description of the context of social health sector in each partner region is required, together with a clear determination of the social aspect (e.g. workers) in the area.

The demographic situation

Ageing as a demographic phenomenon in Portugal became significant during the 20th century and increasingly relevant in the last decades. The ageing index[1], which is currently at 130, can reach a value between 231 and 321, depending on the scenarios considered in the official population forecasts[2]. This index is particularly high in the Centre and the Alentejo regions, respectively 164 and 179, where the "Interior" territories are plagued by depopulation and rural abandonment.

Since the beginning of the nineties, population over 65 increased 35%, while population up to 25 years old decreased almost 21%. The corresponding change in the age pyramid reflects a twofold process, as ageing is accompanied by a decrease of the young population (Figure 1). Elderly represent currently 19% of total population in Portugal, corresponding to nearly two million persons.

Figure 1. Age pyramid for three scenarios, Portugal, 2000-2050



Source: INE (2003). Projecções de população residente em Portugal 2000-2050

[1] Number of persons over 65 per100 persons under 15 years

[2] Source: INE (2010). Indicadores sociais (Social Indicators)

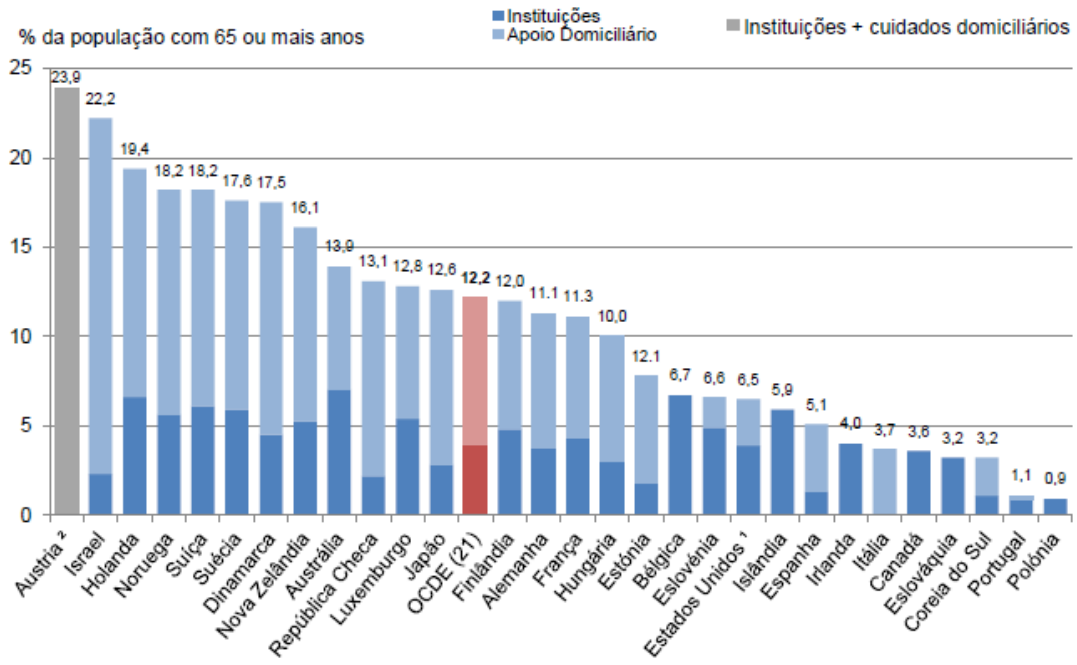
An additional concern is progressive ageing of the elderly group, referred as the "ageing of the elderly", reflecting the increase of the number of individuals in the oldest segments of the population. This phenomenon is becoming increasingly relevant in the most developed countries[3] and induces a gender imbalance, as women have longer life expectancy.

According to OECD data, Portugal is currently the second EU member state with a larger proportion of elderly and the sixth OECD country with higher elderly dependency ratio.

These trends are challenging home care to dependent elderly, traditionally provided by an informal network where families, and specially women, played a central role. Consequently, the demand for institutionalized care is increasing and the system is already struggling to supply the quantity and quality of services needed. Considering the steadiness of the last decade growth rate of service coverage, institutionalized elderly are estimated to be 145 thousand by 2020, requiring an increase of 74,000 openings in the formal network (+103%).

However, institutionalized care covers only a very small percentage of the population over 65 years: 1.1% in Portugal, comparing to 5.1% in Spain, 11.3% in France, 6.7% in Belgium.[4]

Figure 2. Percentage of population over 65 receiving continued formal care, 2009 (or nearest date)



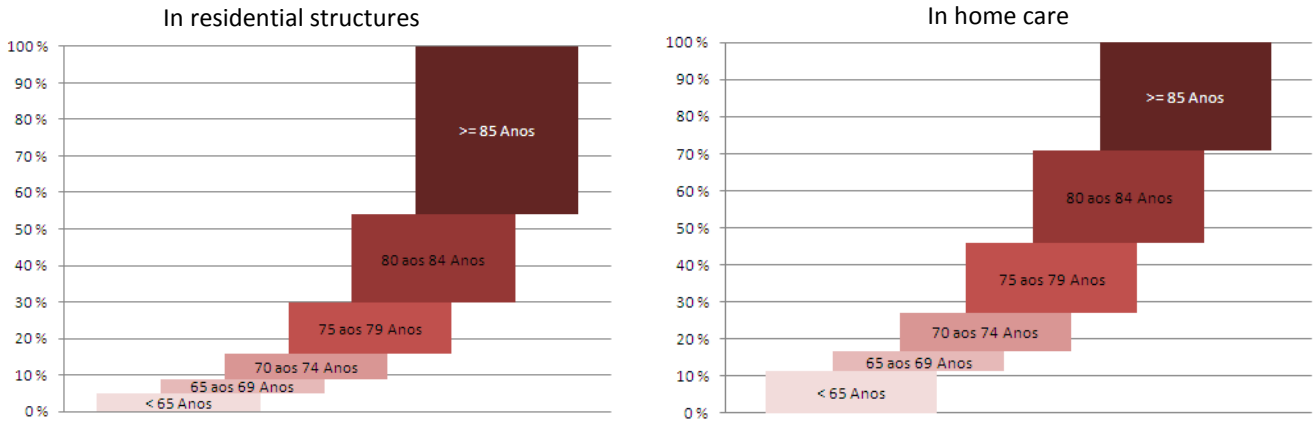
Source: OECD Health Data 2011 *in* Pego (2012)

[3] Giddens, A. (2004). Sociologia (4ª ed.). Lisboa. Fundação Calouste Gulbenkian (Sociology)

[4] Source:OECD Health Data 2011

The age structure of the dependent elderly shows the importance of the group over 80 years, both among institutionalised persons (70%) and those receiving formal home care (>50%).

Figure 3. Age structure of elderly on social care, 2012



Source: GEP-MSSS (2012). Carta Social, Rede de Equipamentos e Serviços. Relatório 2012

Recent data on the National Network for Integrated Continuous Care (RNCCI) indicate that families (informal care) are the main care givers for 63% of the referrals in the system, while formal home care accounts for 13%[5]. Thus, in Portugal, home care (both informal and formal) is, and will continue to be for the next decades, the major social response for the dependent elderly.

The elderly care sector

The current paradigm of social policy for the elderly in Portugal, with a focus on retaining the person at home for as long as possible, can be drawn back to 1976. Home care services (SAD) emerge intensely during the eighties and are enlarged to health care in the nineties with the creation of Integrated Home Care Services (ADI). Simultaneously, integrated care in institution was started for people in need of hospital services.

Formal providers of home care services are mostly independent private organisations over which government control regards only general and sector legislation and regulations, as well as commitment and responsibilities arising from contractual arrangements with governmental agencies. The Portuguese community care sector is characterized by a highly fragmented and diversified system, in terms of size of operators and variety of organisational types, ownership and range of services provided.

There is little penetration of the central, regional and local state in the direct provision of social care services and high utilisation of collaborative partnerships between public and

[5] Source:UMCCI (2012). Relatório de Monitorização do Desenvolvimento e da Actividade da RNCCI (Monitoring Report)

private players. The majority of operators are legally established as Social Solidarity Private Institutions (IPPS), a status that covers a wide range of non-profit organizations, such as humanitarian and religious organizations, charities, mutualities and other private social associations. The non-profit sector is by far the main provider of care services for the elderly, although the profit sector is rapidly increasing in recent years.[6]

A small portion of services is owned and can be directly operated by some public agencies that pursue social goals, namely the Social Security Institute (ISS), the Regional Health Authorities (ARS) and local government agencies.

The organisational model and the range of services offered have little regional differentiation, as they relate to the national policy and follow centralised orientations. Regional or local variation comes mostly from the number and type of IPSS that exist in every region, their intrinsic capacities and aims.

A set of collaborative platforms, the Social Network (Rede Social), was started in 1997/98[7] to perform a bottom-up approach under the guidance of the Social Security Institute (ISS) aiming at planning and coordinating the activities of private and public social care operators at local, municipal and regional level. These platforms are governance instruments that promote a shared vision of the social problems in the territory and allow for private and public participants to jointly agree on objectives, priorities, strategies and actions and to optimise the use of available resources. As collaborative mechanisms these platforms do not provide any care or other service. Each organisation bears its own participation costs (meetings, preparation of planning and reporting documents).

In 2006, a new organizational model was created, the RNCCI, as a response to population ageing and the need for integrated health care. Although not restricted to elderly care, the aim of RNCCI is to provide continuity of care through complementary levels of integrated care, as well as palliative care for the elderly and for those living in situations of dependence, with a strong focus on home care.

RNCCI combines social support and health care based on the co-operation of the Ministry of Health and the Ministry of Labour and Social Solidarity. It provides 4 major responses: institutionalized integrated care, home care, ambulatory care and hospital teams. The total number of places/beds allocated to RNCCI was 12,912 in June 2012, counting institutionalised and home care. This represents a coverage ratio of 662 per 100 thousand persons over 65 years.

For its aims, organization, methods and results RNCCI qualifies as one of the most relevant developments of the health care sector in Portugal. RNCCI implementation had also a major

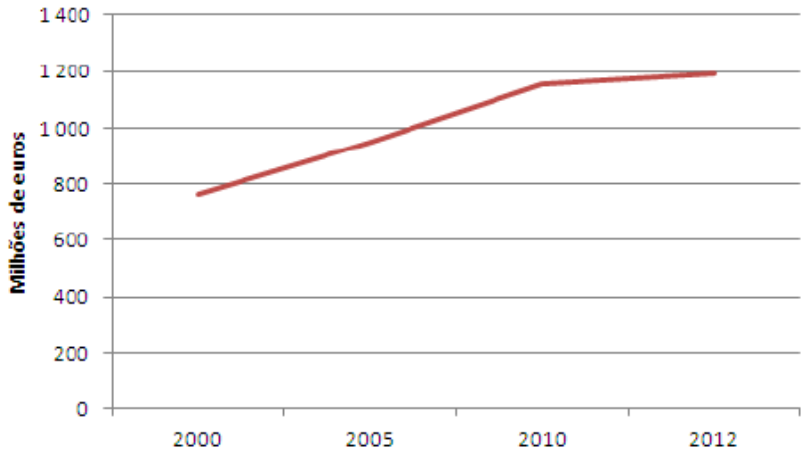
[6] Although there is no date restricted to elderly care, the number of profit organisations in social care (all population groups) increased 72% since 2002, while the number of non-profit organisations increased only 24%. (source:www.cartasocial.pt, *accessed March 2014*)

[7] Cabinet Resolution no. 197/1997 (18 November), Normative Order no. 8/2002 (12 February) and Decree-Law no. 115/2006 (14 June)

impact on the sector labour market, as it provided the first job for 36.6% of the workers admitted in the initial years[8].

Funding of social care services comes from three main sources: (i) financial participation of government agencies through contractual arrangements with IPSS, (ii) financial contribution of the users and (iii) the organisations' revenue. Public expense regarding contractual arrangements for social care has increased 56% since 2000, decelerating in recent years as a result of the national debt crisis (Figure 4). This evolution reflects not only the growth of the number and capacity of responses, as previously mentioned, but also a consequent evolution in employment.

Figure 4. Evolution of public expense with contractual arrangements for social care



Source: GEP-MSSS (2012). Carta Social, Rede de Equipamentos e Serviços. Relatório 2012

Current social policy tends to favour community-based approaches to social care, with a focus on private institutions and a concentration on the non-profit sector as these approaches prove to be more responsive and efficient than the public agencies. Also, this is in line with the tradition of social care services in Portugal.

The labour market

The overall employment of the social economy sector is estimated in the range of 227,000 jobs[9]. Despite the high diversity of activities in this sector, social action represents 48.6 % of the paid jobs in the sector and 41.4% of the Gross Value Added (GVA). In terms of employers, 64.9% of total paid employment is provided by non-profit charity and humanitarian associations, 14.4% and 14.1% is allocated respectively to the main religious organizations (*Misericordias*) and cooperatives, 4.7% to foundations and 2% to mutualities.

[8] Source: INA (2009). Estudo de caracterização dos utentes da Rede Nacional de Cuidados Continuados Integrados (Characterisation of the users of RNCCI)

[9] INE (2010). Conta Satélite da Economia Social (social economy statistics)

These jobs include a vast range of highly qualified personnel (such as clinical director, dietist, specialist doctor, psychologist, occupational therapist, social scientist, pharmacist, teacher, master nurse, social educator, social mediator, etc.), semi-qualified and specialised (physiotherapist, analyst, audiometrist, ortopedist, pharmacy assistant, vocational nurse, practical nurse, house supervisor, care assistant, care technician, home assistant, etc.) and low qualified general purpose jobs (cafeteria worker, day centre worker, residential & home care support worker, social work assistant, supported housing worker, etc.)

Apparently, there is no shortage of workers in care and social support services in Portugal, a country with an unemployment rate over 15%. At the higher end of the qualification range there should be no shortage of staff, as the currently unemployment of higher education graduates is more than 100,000 and many of them majored in fields relevant to the social sector. The lower and by far the largest part of the range, where unqualified and low qualified people predominate, is likely to suffer some shortages that in some regions may be sizable. Though, there is no information available in the country to quantify these shortages.

There is also a large amount of voluntary work that is organised and supervised by the care institutions on an individual basis. The volunteers are usually allocated to secondary jobs such as house help, animation, entertainment, shopping for the elderly, etc., which they perform after minimal training provided by the responsible institution.

Due to the organisation of the elderly care sector, specific employment data is not readily available. Operating through a multitude of IPSS, with a high diversity of institutional forms and sizes, and strongly dependent on community-based approaches, elderly care employment covers a variety of situations, from voluntary work to internships and to formal jobs reckoned in different political sectors (health, social action, labour, education…). In spite of this, a tentative estimation is presented in the next section, concerning the situation analysis.

The current government is placing emphasis in the social economy sector as a major resource for the implementation of social policies with less government intervention in the field, the role of the central state being reinforced on regulation and funding. The on-going “Social Emergency Programme” includes increased funding to support community-based care services to the elderly such as home care, night centres, detection of isolation situations and enhanced facilities to accede health care. Simplification of the base legislation and regulation of private organisations of social solidarity (IPSS) and simplification of the licensing procedures for social care facilities are also relevant measures of the Programme. An effort to increase and diversify funding opportunities for the IPSS, such as enhanced subsidising rates, special credit facilities, special funds to support social innovation is another concern in the Programme.

The deployment of the governmental policies in the employment and training area is IEFP, the National Institute for Employment and Professional Training (Instituto do Emprego e

Formação Profissional). The institute was established in 1979[10] as a public body responsible for executing the employment and professional training policies of the government. Its head offices are located in Lisbon and its management system, which includes a Governing Board, an Executive Board and a Supervisory Commission, has tripartite governance made up of representatives of the government, the trade unions and employer's confederations. At regional level there are 5 Advisory Committees also with tripartite representation.

IEFP comprises a structure of decentralised services (organised into 5 Regional Offices, and local executive facilities: 86 Employment Centres, 31 own Training Centres, 1 Rehabilitation Centre and 8 Enterprise Creation Centres). The institute also participates jointly with the industry sector organisations in 23 specialised Training Centres.

IEFP's role in the recruitment and retention of care workers is carried on mostly through:

- The official employment office providing a national mechanism for employers to recruit new staff members;
- The training centres that provide general and customised training programmes that can be used to enhance the capabilities and skills of existing staff thus contributing to their retention;
- The various active employment and occupational measures that provide financing to recruitment and training of employees.

[10] In 1979 three main organisations were merged to create IEFP: the Directorate-General for Employment, the Directorate-General for the Promotion of Employment and the Workforce Unemployment Fund.

2. Situation Analysis

Development of an analytical situation analysis adopting as main methodogical tool the preparation of a SWOT analysis for the social health sector in the partner regions. The SWOT analysis should provide clear evidence and conclusions about basic aspects. Particularly the SWOT analysis will provide significant input concerning

a) Existing employment and training status

Specific employment data on elderly care is not readily available. The most recent statistics of the Ministry of Labour and Social Solidarity[11] indicate that overall employment in social care activities was 114,979 in 2010, paid jobs representing 99% (113,864). These numbers allow an estimation of social jobs in the elderly care sector in the range of 77,000 [12]. Alentejo has approximately 30% of the national employment in the social care sector.

Jobs in the health sector are not included in this estimation. Employment in RNCCI is mostly in the health sector and allocated to elderly care. A broad estimation based on the number of operational teams points to nearly 3,000 jobs. These include doctors, nurses, care assistants and psychologists in the payroll of organisations with contractual arrangements with the Ministry of Health. According to recent data from the national coordination unit, the residential structures of RNCCI have a total of 199 doctors and 1814 nurses (full time equivalent). Information on additional jobs in secondary activities are not available.

Education and training for the social care sector is provided by many different institutions. Formal higher education is offered by the major national universities at graduate level and some have master programmes on social service that may include thesis on elderly care. Regional universities and polytechnics located inland (in the so-called “Interior”) also offer specific courses on elderly care. However, these university graduates are usually allocated in the IPSS to directive and coordination functions (although they are not really prepared for it), while the operational personnel have only basic education (qualification level[13] 1 or 2 at the most).

A search of the university offer at undergraduate level for 2014 yielded the results presented in the table below: in the health area, two programmes in gerontology, one in social gerontology; in the social area, 19 programmes in social service (not necessarily for the elderly). The total capacity (*numerus clausus*) offered in 2014 is nearly 1100.

[11] Source: GEP-MSSS – Quadros de Pessoal 2010 (employment statistics)

[12] RCDI estimation based on the assumption that the three main responses for the elderly represent 67% of the total number of social responses.

[13] According to the National Qualification System defined by the Normative Oder n.782/2009 (23 July).

Table 1. University and Polytechnic offer at undergraduate level for 2014

Major	Institution	Numerus clausus in 2013[14]
Gerontology	Instituto Politécnico de Bragança - Escola Superior de Saúde de Bragança	71
	Universidade de Aveiro - Escola Superior de Saúde de Aveiro	22
Social Gerontology	Universidade de Aveiro - Escola Superior de Saúde de Aveiro	47
	Instituto Superior de Serviço Social do Porto	40
	Escola Superior de Educação de João de Deus	40
Social Service	ISCTE - Instituto Universitário de Lisboa	40
	Universidade de Coimbra - Faculdade de Psicologia e de Ciências da Educação	38
	Universidade de Lisboa - Instituto Superior de Ciências Sociais e Políticas	67
	Universidade de Trás-os-Montes e Alto Douro - Escola de Ciências Humanas e Sociais	56
	Instituto Politécnico de Beja - Escola Superior de Educação	69
	Instituto Politécnico de Castelo Branco - Escola Superior de Educação de Castelo Branco	45
	Instituto Politécnico de Leiria - Escola Superior de Educação e Ciências Sociais	49
	Instituto Politécnico de Portalegre - Escola Superior de Educação	45
	Instituto Politécnico de Viseu - Escola Superior de Tecnologia e Gestão de Lamego	43
	Instituto Superior Miguel Torga	45
	Instituto Superior de Serviço Social do Porto	90
	Universidade Católica Portuguesa - Centro Regional das Beiras	67
	Universidade Católica Portuguesa - Faculdade de Ciências Humanas	Not available
	Universidade Católica Portuguesa - Faculdade de Ciências Sociais	Not available
	Universidade Fernando Pessoa	25
	Universidade Lusíada	30
	Universidade Lusófona de Humanidades e Tecnologias	55
	Universidade Lusófona do Porto	25
	Instituto Superior Politécnico Gaya - Escola Superior de Desenvolvimento Social e Comunitário	30

Source: Ministry of Education (http://www.acessoensinosuperior.pt/indmain.asp , accessed March 2014)

There are no competent training and development institutions in the country specialised in the social economy, making it difficult to enhance professionalism of senior officers and managers. A few initiatives have emerged recently, some of which induced by modern public and private higher education institutions, such as IES - Centro de Formação e Investigação

[14] Number of places available in 2014 is not yet announced.

em Empreendedorismo Social (Centre for Training, and Research in Social Entrepreneurship)[15].

A major critique most care organisations make to the higher education system is the inapplicability of the courses to the real needs of the elderly care sector. Although this is true in many sectors and not only on elderly care, the complaint is that courses are too theoretical and lack effective practice. When leaving school, graduates are not ready to perform the tasks required and there is a lot of *on the job learning* that saddles the institutions. This is one of the major recruitment drawbacks in the sector.

Another very significant problem is the lack of middle level education and technical training. In the Portuguese education system this training level is consigned to CET - Cursos de Especialização Tecnológica[16] (Specialised Technological Courses). CET are technological courses delivered by registered education and training organisations as post high school education with a strong technical and practical component, providing qualification level 5. In 2006, a reform of the CET system aimed at increasing the access to this qualification level widened the type of institutions that could deliver CET and changed enrolment preconditions. A total of 623 courses are currently registered, 43 of which are in the social service area.

There are 22 CET focused specifically on elderly care, of which 18 regard Techniques of Gerontology and 4 are in the Psycho-gerontology area, accounting for a total of nearly 600 admissions every year. Most of the offer is concentrated in the large cities (Lisbon, Porto, Coimbra, Braga and Leiria) and in three cities of the Interior – Viseu, Bragança and Beja.

Despite the aims underlying the design of CET and the inclusion of a 4-month on the job apprenticeship, the critique of the care institutions on the field remains the same: trainees are not ready to deal with the concrete tasks they should be assigned to.

To overcome the lack of technical education and operational training specific for elderly care, most IPSS organise short training actions for their own staff. Almost all social care operators prepare annual training plans and organise or contract professional training.

Some relevant stakeholders, for instance the National Association for Palliative Care (APCP), offer professional training to care workers and to people seeking jobs in the sector. The ACPAC is a professional association seeking the qualification of professional in palliative care. The association works with several higher education institutions and with the relevant public bodies responsible for the health care. On a casual basis the association is requested by care institutions to organise training actions and advise for the workers on the field.

A few private consulting or training firms also offer professional training on elderly care (some are also included in the CET system), thus responding to an opportunity identified as a

[15] http://www.ies.org.pt/ , accessed March 2014

[16] Decree-law n.88/2006 (23 May)

growing market.

A major problem for the workers in the institutions to enrol in short training actions is the difficulty to conciliate a full time job with the training schedules. The institutions are not prepared to provide free off work license and the workers are not willing to sacrifice their revenue by requiring non paid leave (also, the workers have no guarantee that this would entail any job promotion). No doubt, there is here a lack of regulation allowing employed persons to be paid while in temporary training.

The official agency for employment and professional training, IEFP, is not particularly concerned with training in elderly care. Most of the training programmes are oriented to registered unemployed and are pre-defined according to the agency's trainer pool and only a few focus elderly care[17]. Again, the critique of the institutions in the field points to a most theoretical approach of the training contents.

IEFP also has an apprenticeship programme oriented to young professionals seeking the first job. Through this programme, the agency assumes part the wage of the employee for a maximum of one year (depending on the qualification level). However not many institutions use this programme, in part because they do not find qualified professionals, and when they do, they are not willing to take the financial commitment after the co-financing period. The proportion of apprenticeships in total employment in the social care sector is only 0.2%.

b) Types/categories of services offered

Under the supervision of the Ministry of Labour and Social Solidarity, the existing social responses for the elderly comprise 7 types of services:

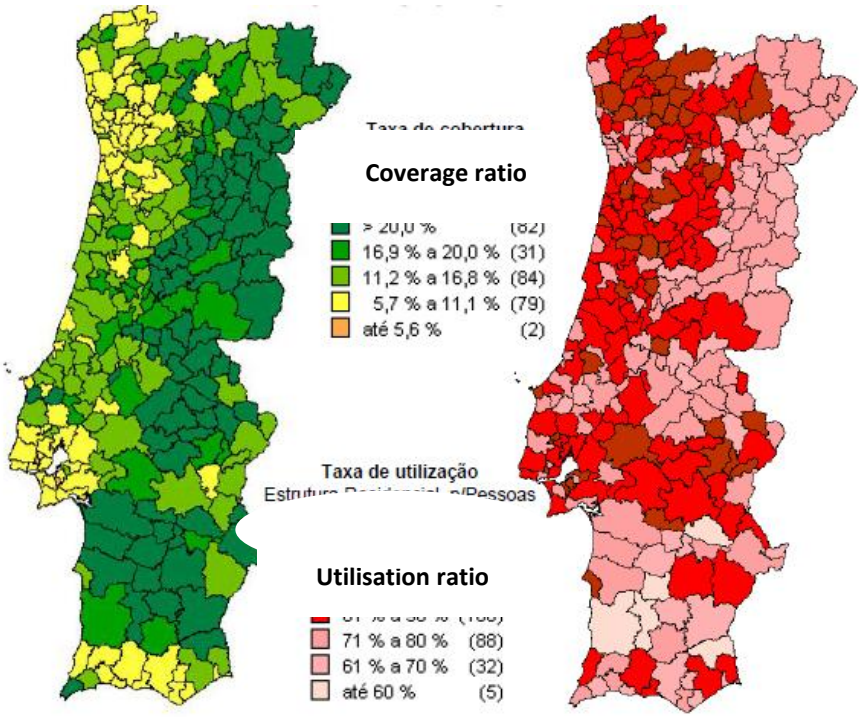
- Home care (SAD) – comprises a wide range of personal care and home services, including hygiene, sanitation, meals and medication, laundry, occupational activities, psychological support, home repair, shopping and, if necessary, training for family members. Tele-assistance can also be provided under SAD.
- Recreational centre – aims at preventing solitude and promoting social interaction as a form of delaying/avoiding institutionalisation.
- Day centre (CD) – provides the services necessary to ensure daily routines, promotes autonomy, interpersonal relationships, aiming at delaying/avoiding institutionalisation.

[17] A search of 50 training actions offered by IEFP revealed 11 actions on elderly assistance, all level 2, but most were on animation and only three included on the job training.
(http://www.iefp.pt/FORMACAO/Paginas/Home.aspx,*accessed March 2014*)

- Night centre – for autonomous elderly remaining at home during the day but in need of night assistance.
- Family foster care – temporary or permanent integration in a family household capable of providing a safe and stable environment.
- Residential structure (ERPI) – collective housing for dependent elderly, providing all services necessary.
- Holiday centre – not restricted to elderly, these centres provide a change in the daily routines of families and individuals, socialisation with different groups and social interaction.

Residential structures (ERPI) are the most demanded service (93.4% utilisation ratio in 2012), followed by SAD (78.5%) and day centres (67.2%). These 3 types of services cover the whole territory, with higher incidence in the less developed regions of the "Interior" (Figure 5). There are currently 6,672 units providing these three types of services with a total capacity for 240,226 persons[18]. The average coverage ratio is 12.2%, but 64% of the total number of municipalities is above average.

Figure 5. Coverage and utilisation ratios of the 3 main social responses for the elderly (ERPI, SAD, CD), Portugal, 2012

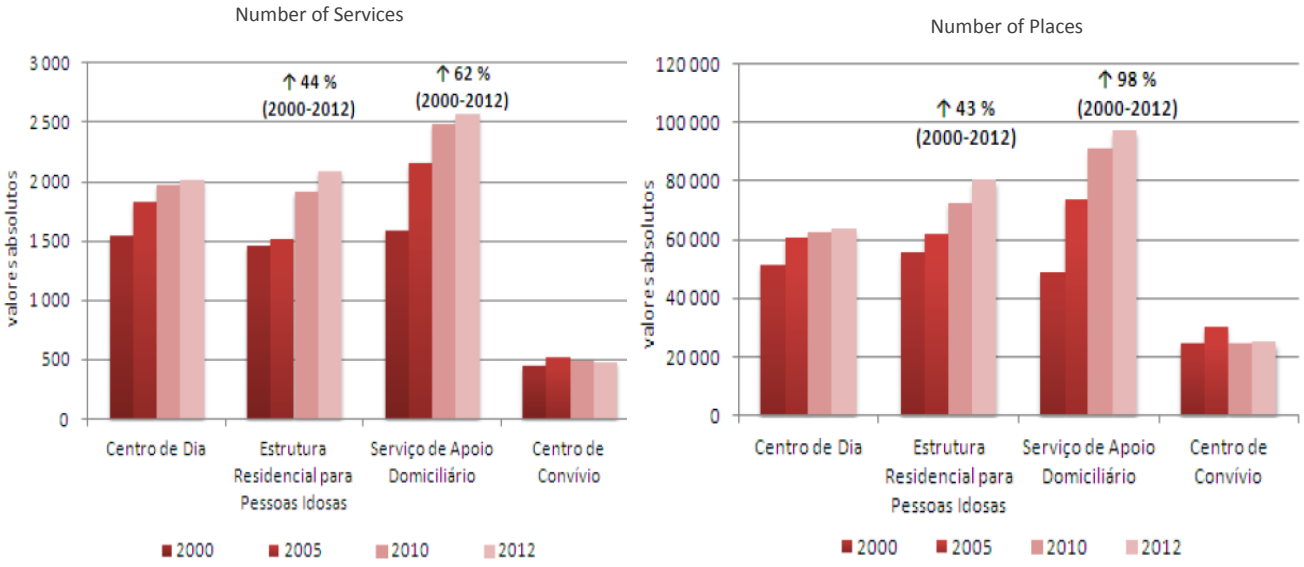


Source: GEP – MSSS (2013) - Carta Social. Folha Informativa n.º11, Junho 2013.

[18] Source: Carta Social, 2012 (www.cartasocial.pt, *accessed March 2014) (social map)*

In the 2000-2012 period, home care services (SAD) had the highest growth (62%), followed by residential structures (44%) and day centres (31%). This general increase in the number of services was followed by an even higher increase in capacity, which reached 98% in the case of SAD (Figure 6). These growth values enhance the strong focus of the social care policy on home care services.

Figure 6. Evolution of social responses for the elderly in Portugal



Source: GEP-MSSS (2012). Carta Social, Rede de Equipamentos e Serviços. Relatório 2012

The current supply of the three main social responses for the elderly in Portugal amounts to 6,672 services, with a balanced distribution of the three types (Table 2). In terms of capacity, SAD holds 40% of the total supply.

Table 2. Main social responses for dependent elderly, Portugal, 2012

	Day centre (CD)	Residential structures (ERPI)	Home care (SAD)
Number of units	2 013	2 093	2 566
Total capacity	63 444	79 997	96 785
Average capacity	31.5	38.2	37.7

Source: Carta Social, 2012 (www.cartasocial.pt, *acessed March 2014)*

These social responses are disseminated all over the national territory, as already mentioned, more concentrated in the municipalities with higher ageing index and in the metropolitan areas of Lisbon and Porto. In 2012, 241 of the 278 municipalities of Mainland

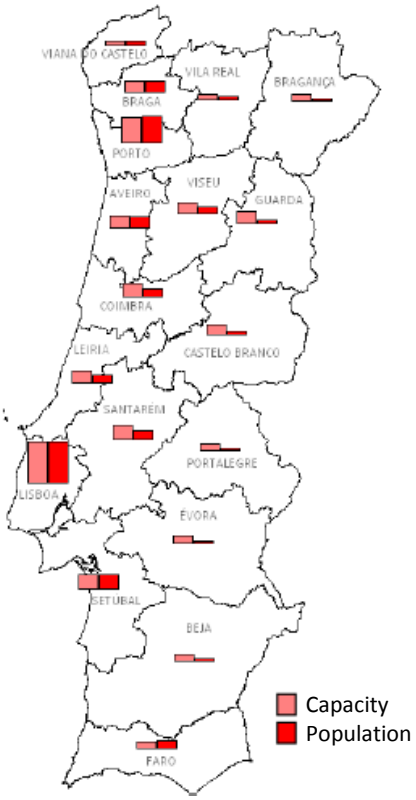
Portugal offered at least 10 services for the elderly, and 128 municipalities offered at least 20 services each.

The share of Alentejo in the total number of the three main types of responses ranges from 8% in SAD to 11% in ERPI, with similar shares in capacity. The regional share of the population over 65 is 9.4% (182,988 persons).

The correlation of the percent distribution of the capacity offered in the three main types of responses and the regional distribution of the population over 65 (Figure 7) enhances a positive balance in almost all districts, with the exception of the metropolitan areas of Lisbon and Porto and the Algarve. This is due to the fact that these territories have a higher number of elderly, in absolute values, resulting in increased demand over installed capacity.

A new social response is being prepared by the current government: Senior Space (*Espaço Sénior*). This new service will merge the current functions of day centres, recreational centres and senior citizens academies. A flexible bottom-up approach will allow for a local-specific organisation model of this service. The rationale for this new solution is, again, to increase responsiveness to new social challenges and to rationalise human and logistic resources.

Figure 7. Regional percentual distribution of existing capacity and population over 65, in 2012



Source: GEP-MSSS (2012). Carta Social, Rede de Equipamentos e Serviços.

In the health sector, the most relevant system is the National Network for Integrated Continuous Care (RNCCI), mentioned in section 1. RNCCI aims at providing integrated care (social and health) to all persons in dependence situations, regardless of age. Naturally, dependent elderly are the largest group in the system (80% of total referrals).

The network comprises four types of services:

- Residential units differentiated into convalescence care, rehabilitation care, long term care and palliative care – there are currently 268 contracts with institutions providing 5,916 beds (Table 2);
- Ambulatory assistance (day centre) – this service is planned but not yet implemented because of funding difficulties and lack of specific regulation;
- Hospital assistance, including hospital discharging teams and palliative care teams – every hospital in the National Health System (SNS - Serviço Nacional de Saúde) is

served by a total 80 hospital discharging teams; the palliative care teams are 25, 11 of which in Lisbon, 6 in Algarve, 4 in the North and 4 in Alentejo; the Centre Region is not yet covered.

- Community home care, including primary care and palliative care – primary care is provided through 245 contracts in this service, 32% of which in the North, 22% in Lisbon, 20% in the Centre and 12.7% in Alentejo and the same percentage in Algarve; in palliative care there are only 5 community support teams, 3 of which in Alentejo.

The targets set out for each of these services in the strategic planning of the RNCCI are far from being met, despite the rapid growth of the network: residential units have been increasing on average 3 new units/65 beds per month since 2010. However, the most recent monitoring report acknowledges the services quality improvement and substantial benefits in terms of the users' well-being.

An important issue that deserves more attention from the RNCCI management structure is the need to ensure effective coordination with the social security teams in home care. There is some interaction between social and health teams on the field, but there is no integration of services. In fact, some users are visited by both teams in the same day, causing unnecessary inconvenience as well as cost duplication. There is a lack of real integration that operational management should solve.

c) Basic factors (economic, social) that affect the national context of social-health sector

Current social policies are seriously constrained by the on-going public debt consolidation plan resulting from the memorandum of understanding signed with the European Commission, the International Monetary Fund and the European Central Bank. The plan that has been in force for the last three years determines serious cuts on public spending. This economic constraint is the major conditioning factor of the government social policy.

Impacts are not only the direct effects on public investment and on the financial contributions from the national budget to the social-health sector operators, causing serious operational difficulties. Additional impacts come from the recessive economic environment that emerged in the country, negatively affecting the development strategies of all institutions.

On the other hand, under such conditions a more intense involvement of the civil society is seen by the government as a solution that will enable to pursue social policies, which tend to increase due to the economic decline the country is experiencing.

Regarding the social context two major factors can be identified. The first is demographic and relates to the continuous ageing of the population, as described in section 1. The ageing

index is expected to reach 395 or 231 in 2050[19], depending on the different scenarios. The elderly dependency ratio[20] will probably duplicate until 2050. This trend will put pressure on the social security system and on the existing supply of elderly care.

The second aggravating factor is the economic situation mentioned above that is pushing more families to poverty and social exclusion, putting even more pressure on the social security system, both in terms of services and for financial support.

A positive impact on the sector may come from technology developments that facilitate new solutions such as distance alarm systems, tele-medicine, and other innovative responses.

Recruitment, retention and training of workers in the care sector are thus highly conditioned by this economic and social context. Human capital management at IPSS, most of which are independent of government decisions, is influenced by the general shortage of resources, both financial and human.

d) The existing political/legal environment

The current political orientation of the government tends to favour policies that exploit existing private resources, with emphasis on the non-profit sector, to replace or amplify the action of public owned/managed social services.

The approach relies on community-based care services provided by private organisations and assigns to the state a subsidiarity role of providing funding when and where it is needed and of regulating and encouraging the activities of the civil society. This approach puts emphasis on:

- Strengthening the support to the elderly;
- Increasing efforts to include people with disabilities;
- Providing more support to volunteer's work;
- Resorting to the social economy as the centre of the care services.

In this context, efforts concerning recruitment and retention of care workers are made by the private operators and to a lesser extent by local government (municipalities).

The assessment of the social economy sector made by the government in 2013[21] defends a new paradigm for social policy, based on three major factors:

- Strengthening cooperation and confidence between the government and the social solidarity institutions;

[19] Source: INE, 2010. Indicadores sociais (social indicators)

[20] Number of persons over 65 per 100 persons at the age 15-64

[21] Government, 2013. Carta Comum de Balanço e Compromisso, Comissão Permanente do Sector Social, Junho 2013 (Social Sector – Common assesment and commitment paper)

- Maintaining a permanent dialogue for continuous coordination, in which the government acknowledges the proximity value brought in by the operators in the field and gives real sense to the principle of subsidiarity;
- Increasing the institutions financial sustainability and autonomy.

Within the principles of this new paradigm, the government compromises with a set of future actions, some of which will impact on elderly care:

- European Structural Funds - Allocation of funds to the development of sustainable active ageing and promotion of inter-generation solidarity;
- RNCCI - Reinforcing inter-institutional cooperation for higher service efficiency and promotion of efforts to create more units and to overcome existing constraints;
- RNIS+ - Creation of a national network for social intervention in vulnerable families;
- Senior Space (Espaço Sénior) – Creation of a new social response for the elderly, more flexible, with a local specific configuration, merging three already existing services (day centre, recreational centre and senior academy);
- Specialized care for elderly with a dement condition – specific training of care givers and professionals to deal with dement situations.

The on-going 'Social emergency programme' includes some measures that have direct bearing on the community-based social care sector. A major planned reform is the preparation of a new base law of the social economy sector, which may introduce some changes on the balance between public and private actors in this sector, particularly in the health care area, where the penetration of the public sector is dominant.

e) Funding mechanisms

As mentioned in section 1, funding of the social care sector comes from three sources:

1) Government transfers and other public contributions and subsidies are the largest proportion of the sector revenue;
2) The institutions' earnings from sales of goods and services, property income, private transfers (which includes donations and legacies) and various other income items are a second source, although quite variable in the universe of operators as it depends on the nature of the institution;
3) Financial contributions of the users are the third source of income, also quite variable among institutions.

The high dependence on the government transfers introduce some vulnerability in the funding of the institutions as it has been affected by the national debt crisis and the austerity programme. Nevertheless, the government assumed the compromise to increase these transfers by 2,6% between 2011 and 2013. In 2012, an increase of 0.9% was registered.

3. Identification and evaluation

Identification and evaluation of existing problems, obstacles and practices adopted in each partner region. Specifically there should be a research of the existing good practices in each partner region together with the challenges identified to face and implement the skills dimension in White employment sector.

Some of the problems and challenges of the Portuguese elderly care system were already highlighted in the previous sections. Reference was made to:

- Intensity of population ageing in Portugal, increasing pressure on the social care sector;
- Government policy relying on an increased intervention of the private sector and the civil society;
- Unavailability of qualified care assistants in the labour market;
- Lack of technical education and training for care assistants on the field (qualification level 5);
- Ineffective orientation of the higher education and university programmes, lacking focus on the real needs of the institutions;
- Lack of development and business training organisations specialised in the social economy, allowing for the development of management competencies;
- Lack of operational coordination between the health care provided by RNCCI and social care services;
- Financial vulnerability of the care institutions, particularly in the non-profit sector.

Major deficiencies related to human resource management within the institutions can be identified as:

- Lack of programmes aiming at continuously improving the quality of services provided and lack of training in managerial instruments and techniques (these weaknesses result from a generalised lack of qualification of the staff).

- Lack of an entrepreneurial attitude of the managerial bodies that does not facilitate the adoption of new ideas and innovation;
- Inflexibility of the public social security system (the major provider of funds to the sector) to consider funding new innovative initiatives that move away from the established routine activities;
- Insufficient use of the public training programmes offered by IEFP that are not oriented to the real needs of the institutions.

To better understand the situation and the prospects of the elderly care sector in Portugal, a SWOT matrix is presented below, in which the main issues addressed in the previous research are assessed in terms of its strategic importance.

Strengths	Weaknesses
• Large and consolidated system based on private non profit institutions highly responsive. • Good coverage and utilization ratios for the three main social responses (SAD, ERPI and CD). • Services capacity exceeds population needs in rural areas. • Home care is one of the pillars of the system. • On-going implementation of RNCCI, with good results in institutionalized assistance. • No shortage of workers.	• Low qualification skills at all levels of system (management, coordination and care assistants). • Training relies mostly on the institutions' internal actions to qualify their own staff. • Gap between formal education/training and the real needs of the institutions. • Lack of technical education and training. • Institutions are financially dependent on the government budget.
Opportunities	**Threats**
• Growing awareness in the society and inside the sector on the need for effective integrated home care. • Growing demand due to population ageing. • Growing demand of institutions for trained workers at all levels. • High youth unemployment (pool of potential workers available). • Technological development. • Existence of a large scientific and knowledge base (guidelines, reference documents, assessment reports, academic work).	• Growing demand due to population ageing. • Shortage of financial resources both for care activities and for education and training. • Inter-institutional cooperation is difficult to operationalize.

To overcome the shortcomings in the system, institutions create strategies, some of them innovative others just adaptation schemes to make the best of the available resources. A few good practices were identified through interviews with organizations located in the district of Beja, in the Alentejo region. These practices will be further investigated during the course of the project and particularly in the national and regional round-tables that will gather experts and relevant stakeholders.

Although still depending of a more accurate assessment, the research identified some interesting project ideas in Beja, which are intended to foster the elderly care offer in Alentejo. These ideas try to match the existing resources at the Beja Polytechnic Institute (IPB) and the needs of the care institutions. They regard the creation of a regional observatory for active ageing and the implementation of an inter-generation network for active ageing. Although still in an early phase, these ideas are evidence of the sector dynamics.

4. Conclusions and suggestions

Evaluation of the existing policies on the social - health sector with particular emphasis on the labour skills and the needs in each country (e.g. mismatch).

The existing system for home care in Portugal is well developed and seems able to provide the satisfactory responses for the current needs of the ageing population. Strongly supported in the private non-profit social sector, the system is well organized, with good coverage over the territory and sufficient capacity, even in the rural areas. In general, institutions show a fair knowledge of the demographic and social environment in which they operate and are able to provide to the needs of the population.

The most important difficulty that operators face relates to the qualification of human resources. Although there is no shortage of workers, the education and training system does not provide the type of qualification level, particularly the technical skills to assist persons with diverse dependence situations.

There is a gap between the real needs of the institutions on the field and the workers available. This gap is conveyed into the institutions that have to train their own staff, at all levels of operation, a procedure that burdens the institution and reduces efficiency. In addition this creates vulnerability in the system, as training initiatives and quality become much more a casual issue, depending on the institution on an individual basis.

Increasing proximity between the education and training system and the social-health care sector is one of the challenges that need to be met in the near future. The creation of a programme facilitating the leave of workers for training would be a good improvement.

Another important issue that should be addressed at a global operational level is the effective integration of health and social services, particularly in home care. Although, the RNCCI is planned as integrating social and health care, the praxis is far from this objective. Good practices can be found on the field on a case by case basis, depending on the teams and the persons involved. The organization of the system does not guarantee much integration.

Finally, an important shortcoming relates to funding, as this is currently affected by the national financial crisis. New funding solutions should be thought to increase the autonomy of institutions and allow the adoption of more effective human resource management and qualification.

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