

STUDY TO ADDRESS THE NEEDS OF SENIOR PEOPLE IN PORTUGAL



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Aga Khan Foundation Portugal



The Study does not reflect the opinions of Aga Khan Foundation. Its contents are of the exclusive responsibility of the authors.

Credits

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Authors: CEDRU - Centro de Estudos e Desenvolvimento Regional e Urbano, in collaboration with BCG
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INTRODUCTION

The study was commissioned by Aga Khan Foundation Portugal to a consortium composed of **CEDRU - Centro de Estudos e Desenvolvimento Regional e Urbano, Lda** and **BCG - Boston Consulting Group**. Its main objective is to help understand the trends and needs of the senior people in Portugal. "Senior population" is to be understood as "individuals 55 years old or above", being this the target-population of the study in question. However, throughout the report the expression "elderly population" is frequently used and it refers to individuals 65 years old or above, as established by the National Institute of Statistics. In fact, the "senior" and "elderly" designations, although simultaneously mentioned, refer to different sample populations.

The study was conducted during the period from September 2007 and April 2008 by a team of 15 investigators/consultants: Carlos Ferreira as the General Coordinator and CEDRU team leader; Nuno Monteiro as BCG Team leader, and the following foreign researchers: Anthony Warnes from SISA - Sheffield Institute for Studies on Ageing / University of Sheffield, Allan Williams from ISET - The Institute for the Study of European Transformation and Klaus Friedrich from the Institut für Geographie / Martin-Luther-Universität Halle-Wittenberg.

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ACRONYMS

ACIDI	High Commission for Immigration and Intercultural Dialogue
PCA	Principle Component Analysis
ADIV	Association for Development and Research of Viseu
ADL	Activities of Daily Living
AFCM	Multiple Correspondences Factor Analysis
AIHW	Australian Institute of Health and Welfare
ALIP	Assisted Living Innovation Platform
AMI	International Medical Assistance
AMU	Medium Urban Areas
AO	Ageing Observatory
APN	Advanced Primary Nurses
APR	Predominantly Rural Areas
APU	Predominantly Urban Areas
BCG	Boston Consulting Group
CACP	Community Aged Care Package
CAD	Support Centers for Dependent People / Multidisciplinary Resource Centers
CAPEX	Capital Expenditure
CCRC	Continuing Care Retirement Community
CGA	Comprehensive Geriatric Assessment
CLAS	Local Social Action Councils
CMHC	Canada Mortgage and Housing Corporation
CNPV	National Council for the Promotion of Voluntary Work
COPD	Chronic obstructive pulmonary disease
CSF	Civil Parish Social Commissions
CSI	Solidarity Complement for Senior People
DEEP	Statistics, Studies and Planning Department
DGEEP	Directorate-General for Studies, Statistics and Planning
DGS	Directorate-General for Health
DPP	Prospective and Planning Department
DWP	Department of Work and Pensions
EACH	Extended Aged Care at Home
EAP	Economically Active Population
EC	European Community
ECR	Regional Coordination Teams
EEC	European Economic Community
EHIC	European Health Insurance Card
EIPDA	Amadora's Intercultural School of Professions and Sports
ESEV	Education School of Viseu
ESF	European Science Foundation
EU	European Union
FORHUM	Human Resources Training
FTE	Full-Time Equivalent
GDP	Gross Domestic Product
GH	Group Homes
GNR	Republican National Guard
IADLs	Instrumental Activities of Daily Living
IARN	Support Institute for the Return of National Citizens
IAS	Social Supports Index
ICS	Social Sciences Institute
ICT	Information and Communication Technology
IMSERCO	Instituto de Migraciones y Servicios Sociales
INATEL	Leisure Time National Institute
INE	National Statistics Institute
IOM	International Organization for Migration
IP	Portugal's National Tourism Organization
IPPR	Institute for Public Policy Research
IPS	International Passenger Survey
IPSS	Private Institutions of Social Solidarity
IRM	International Retirement Migration
ISCED	International Standard Classification of Education
ISET	Institute for the Study of European Transformation
ISS	National Institute of Social Security
LBS	Landesbausparkassen

JMRS	José de Mello Residências e Serviços
MdM	Doctors of The World
MIPAA	Madrid International Plan of Action on Ageing
MIPEX	Migrant Integration Policy Index
MTSS	Ministry of Labor and Social Solidarity
NGO	Non Governmental Organizations
NHS	National Health Service
NSF	National Service Framework
NUTS	Nomenclature of Territorial Units for Statistics
NYSE	New York Stock Exchange
OECD	Organization for Economic Cooperation and Development
OEFP	Employment and Professional Training Observatory
OI	Immigration Observatory
ONS	National Office of Statistics:
PADE	Foreign Patients Support Programme
PAIES	Support for Investment in Social Equipments Programme
PAII	Integrated Support Programme for Senior People
PALOP	Portuguese-Speaking African Countries
PARES	Network Expansion of Social Equipments Programme
PARES	Social Equipments Network Enlargement Programme
PCAAC	Food Aid Community Programme
PCHI	Home Comfort Programme for Elderly people
PER	Special Rehousing Programme
PIDDAC	Central Administration's Development Investments and Expenses Programme
PNAI	National Action Plan for Inclusion
PPP	Public Private Partnerships
PROGRIDE	Inclusion and Development Programme
PSP	Public Security Police
PT	Portugal Telecom
QREN	National Strategic Reference Framework
QUALYS	Quality Adjusted Life Years
RMG	Guaranteed Minimum Income
RNCCI	National Network of Integrated and Continuous Care
RSI	Social Integration Income
RUTIS	Third Age Universities Network
SAAP	Supported Accommodation Assistance Program
SAD	Integrated Domiciliary Support
SCML	Lisbon Holy House of Mercy
SEF	Borders and Foreigns Department
SIG	Sistema de Informação Geográfico
SISA	Sheffield Institute for Studies on Ageing
STA	Remote Alarm Service
TAB	Technical Assistance Bank
TAU	Urban Areas Type
TIDE	Trim Initiative for Development and Enterprise
TSB	Technology Strategy Board
UK	United Kingdom
UMP	Union of Portuguese Charitable Organizations
UNO	United Nations Organization
USA	United States of America
WHO	World Health Organization

EXECUTIVE SUMMARY

This is the final report on the research project entitled "Study to Address the Needs of Senior People in Portugal" undertaken by CEDRU - Centro de Estudos e Desenvolvimento Regional e Urbano - and BCG - The Boston Consulting Group - for the Aga Khan Foundation Portugal.

OBJECTIVES

- ▶ The main purpose of the study was to ascertain the needs of the resident population aged over 55 in Portugal.
- ▶ Three main areas of analysis were considered:
 - Part I.** Assessing the senior market in Portugal in terms of the supply and demand for social services providing support for this age group;
 - Part II.** Finding out about policies, strategies and activities for seniors at international level to serve as benchmarks for work in Portugal using practical, successful measures or projects showing potential to be replicated;
 - Part III.** Understanding the international market when it comes to international retirement migrations, its impact on Portugal and the role of multinational companies in the senior-citizen service sector.

DESCRIPTION

PART I. THE SENIOR MARKET IN PORTUGAL

DEMAND SIDE ANALYSIS

- ▶ The phenomenon of demographic ageing extends practically to all regions of the world, and projections forecast a total of 2 billion people aged over 60 by 2050, representing more than 20% of the world population. According to these projections, in 2045 the number of people aged over 60 will exceed the number aged 15 or under for the first time.
- ▶ In the second half of the 20th century, the history of European demographics began to be marked by a gradual ageing of the population resulting from a transition to low fertility and mortality rates and an increase in life expectancy.
- ▶ Some important characteristics of the ageing population are: a higher number of women, progressive loneliness, isolation and "super-ageing", resulting from a considerable increase in older age groups.
- ▶ As in the rest of the world, the population in Portugal has shown considerable ageing. The proportion of elderly people grew from 8% in 1960 to 16.4% in 2000. The ageing of the Portuguese population is a trend that will continue in the next few decades and estimates are that the elderly will represent almost 1/3 of the population by 2050.
- ▶ The age structure of the Portuguese population has been changing rapidly and, today, Portugal is among the countries in the world with the oldest population (10th in percentage of elderly people and 14th in the ageing index).
- ▶ In Portugal, there are regional disparities as a result of different behaviors in terms of fertility and migratory flows. In recent decades, the central Portugal and Alentejo have been faced with high

population ageing, closely associated with a large exodus of young people and those of working age.

- ▶ According to a survey to a (representative) sample of 1,324 people aged 55 or over residing across the country, the senior population in Portugal is: predominantly married (63%); predominantly aged between 65 and 74 (38%), with a low level of education (61% have only completed primary school) and with low income, retired (77%) and without any other occupation.
- ▶ The analysis of the needs of the senior immigrant population residing in Portugal is confronted with Portugal's short history as an immigration country, with the characteristics of the immigration process (mostly carried out by young working age population), and a strong spatial concentration in the Lisbon Metropolitan Area, which explain this segment's minimum importance in the whole of the senior population. It is important to emphasize the fact that many of the needs of the immigrant senior population living in Portugal are the same as those of the Portuguese senior population, while others are specific to their status as immigrants. The priority areas of intervention in fostering greater social inclusion and active ageing for immigrant seniors are health, the labour market, housing, justice and citizenship.
- ▶ According to recent studies, the elderly population is the group most affected by poverty, and that condition is more accentuated in households with seniors. Government statistics show that around 30% of the senior population lives in a state of poverty in Portugal, although considerable progress has been made in recent years (the figure went down from 38% in 1995 to 28% in 2005, according to Eurostat).
- ▶ The phenomenon of poverty among the elderly is found all over the country, especially in poor, ageing, rural areas and in the main cities (in shanty towns and social housing or in old quarters in city centers).
- ▶ The overall analysis of the main needs affecting the senior population in Portugal (resulting from the survey carried out for the study) indicates that the greater problems occur in terms of housing, namely in relation to repair and preservation work. Notwithstanding, other needs must also be pointed out, such as (in a decreasing order of importance): housework, particularly cleaning; leisure activities shortage, namely the lack of socialization spaces; mobility and, finally, the needs for personal care (particularly hygiene care) and, at the same level of importance, health care, specially when it comes to accessibility needs, whether in terms of time or geographically.
- ▶ Although the population of over 55 years old presents, overall, a multiplicity of vulnerabilities and needs, there are particularly more vulnerable segments that are important to point out and understand. In fact, five segments of the senior Portuguese population were identified, which concentrate innumerable frailties, conferring them a greater degree of vulnerability. These are the "older seniors" (85+ years old), "the poorer" (that have average monthly income equal or lower than 300€, living thus below the poverty threshold), those "who live alone" (the household typology "senior living alone"), "women" and finally, "those who live in Predominantly Urban Areas". The concentration of vulnerabilities when it comes to housing, economic profile, intra-family relationships, help dependency, health state, leisure time activities and equipments lack of use, grants each of these segments with specific needs.

SUPPLY SIDE ANALYSIS

- ▶ In recent years, there has been a considerable increase in available care and services for the senior population from formal and informal providers. This is not only the result of accentuated

demographic ageing, but also of a decrease in families' involvement in caring for older members. They tend to be more willing to bear the cost of services provided by third parties.

- ▶ In the European context, Portugal is among the countries in which family values are still important, which explains the lower penetration of the senior care and service industry, in spite of substantial growth in recent years. In fact, the public sector is responsible for around 80% of care and services. The State and non-profit-making organizations respond mainly to the most vulnerable populations, while private sector operators cater to those with more means. This results in a market gap in terms of services for the elderly with medium and medium-low incomes.
- ▶ There have recently been important reforms not only in State social protection, marked by a sustainability crisis in the social security system and growing attention to the principle of social justice, but also in Local Government. These concerted changes have had significant impacts on the social responses provided to this segment of the population, reflected in the reinforcement of the network of facilities and growing diversification of services provided. Within the scope of the role played by the Central Administration, the innumerable and important Programmes and Projects developed must be highlighted. One of them is the National Network of Integrated and Continuous Care, a multidimensional integrated intervention that allows an effective response to those who simultaneously need health and social care. It is also important to mention the Social Integration Income, for it is a new social policy, due to its innovative characteristics. The Age Friendly Cities Project is also quite innovative, for it seeks to intervene in the scope of health determinants, in detriment of a focused intervention in the state of health as it has been usual within the health area. It is also important to mention that is based on public consultation methodologies.
- ▶ Portugal has a long tradition of Third Sector intervention in providing care and services to the senior population, involving a wide range of institutions, which include religious organizations, such as the Holy Houses of Mercy and Parish and Social Centers. These Third Sector organizations are characterized by being concentrated in the most densely populated areas, having few financial resources and services limited essentially to the fields of social work, health and leisure.
- ▶ The Private Institutions of Social Solidarity assume a crucial role in the Third Sector in Portugal. However, activities are still financially dependent on State support. In 2007, of the amount allocated by the Social Security Institute to the Private Institutions of Social Solidarity, significant financial amounts are channeled for Private Institutions of Social Solidarity dedicated to providing to elderly people: 39.5% within the scope of the current management; 31.9% regarding Programmes; 100% in eventual subsidies and 16% in Programmes/Projects.
- ▶ Volunteer work has registered a significant growth, although it is a recent activity in Portugal, it already assumes magnitude in the non-profit sector. In 2005 it was estimated that the activity was carried out by about 1.6 million individuals. It is in the religious institutions that volunteer work has a more significant presence. There is a considerable connection between the socio-economic profile and voluntary work: the higher the individual/family economic capacity, the easier it is to spend time doing non-compulsory tasks, such as volunteer work.
- ▶ The private sector, which includes formal and informal operators, still plays a lesser role in providing care to the elderly:
 - Less than 20% of the capacity of key elderly care services - day care and residential and home care is in the hands of the private sector;
 - The informal sector, mainly involving home care, is thought to be the principal private service provider, mostly performed by untrained immigrant women, who also perform other housing tasks like cleaning;

- The formal sector, which focuses on residential care, is dominated by small-scale operators.
- ▶ Four main factors explain the lesser role of the formal sector in providing care services to the elderly:
 - The existence of much cheaper elderly care services provided by the informal sector (e.g. immigrants), which also enable the elderly to remain in their own homes for a longer period of time;
 - The central role of the Holy Houses of Mercy and Parish and Social Centers that, through their status as Private Institutions of Social Solidarity, ensure the delivery of care services to elderly people financed by the Government and aimed at elderly people with low incomes;
 - The high operating costs of elderly care services, which make it difficult for the private sector to charge accessible prices to the low-income segment (for example, residential care operating costs are around ~850€ a month);
 - A shortage of Government Programmes co-funding investment in and/or the operating costs of care services for medium and high-income elderly people.
- ▶ Large-scale operators still participate very little in the elderly care sector:
 - Only four large operators currently provide elderly care services (José Mello Residências e Serviços, Espírito Santo Health, Carlton Life and Montepio Residências e Serviços).
 - The capacity of large operators of residential elderly care services represents less than 1% of private capacity and is currently limited to the Lisbon region, whereas their home care services are provided mainly in the Lisbon and Oporto regions.
 - In general, these operators began by providing home clinical care and moved on to offering residential care.
- ▶ The participation of the elderly care services sector is unlikely to increase drastically in the near future:
 - The high costs of the elderly care sector are dissuading small-scale operators from expanding their business;
 - Although some large operators (e.g. Montepio Residências e Serviços) are planning to expand or enter the business, their weight is not expected to increase significantly in the next few years.
- ▶ The family's role as caregivers has changed significantly in recent years, due to the progressive changes in family structures and dynamics and standards of living. This has resulted in a gradual replacement of the family by formal and informal entities. However, care within the family is still one of the cultural values of Portuguese society and the family is still the primary caregiver. There is no doubt as to the importance of seniors remaining in their family environment or in close, frequent contact in proper, more harmonious, active ageing, with positive impacts on seniors' perception of their health, well-being and quality of life (especially the most vulnerable).
- ▶ In care for the elderly, the focus should be on inter-generational relations, which play a key role for both generations, as they contribute considerably not only to active ageing but also to young people's learning process.

- ▶ Qualifications in elderly care services are being recognized as essential, especially for family carers, volunteers and all providers in the informal non-profit sector, who play an essential role but very often do not offer the minimum quality.

MARKET ASSESSMENT

- ▶ The demand for paid elderly care services is expected to grow in future, as a result of four main factors:
 - The ageing of the population and subsequent increase of the weight of elderly in Portugal.
 - Changes in family dynamics, such as more working women, an increase in the average retirement age, a gradual predominance of smaller size families and the increase of time-demanding jobs;
 - Cultural changes, such as the acceptance of the younger generation, as future seniors and family care providers, of elderly care services (reduced prejudice towards paid services for elderly);
 - Economic growth, which will lead to an increase in the incomes of seniors and families and make elderly care services more accessible.
- ▶ The level of dependency of the elderly population is unlikely to go down significantly. Albeit the increase of life expectancy years that has been occurring, it was followed by the fact that people are healthier for a longer period of time. Although people are reaching older ages healthier, the weight of (highly dependent) elderly people will increase.
- ▶ In qualitative terms, as the level of seniors' education and income rises, there will be a demand for better quality services (e.g. special care, qualified personnel and more frequent care).
- ▶ The private sector, Non Governmental Organizations and informal sector are not expected to drive the evolution of care supply:
 - The private sector will probably not expand the services targeted at higher income elderly nor develop services for lower income segments due to the high investment and operating costs of the industry;
 - Non Governmental Organizations will continue to have a minor role in the elderly care industry as Non Governmental Organizations already operating in Portugal have not announced capacity expansions and the entry of new Non Governmental Organizations is not projected;
 - The informal sector has historically developed in response to imbalances between demand and supply.
- ▶ Supply of elderly care services will be determined by the direction taken by public policies in two areas:
 - Coverage of services by public funding;
 - Promotion of participation by the private sector. There are four possible scenarios for the future: 1) "continuity"; 2) "social aid"; 3) "privatization" and 4) "privatization and expansion".
- ▶ Over the short term, the most likely scenario is "continuity".
 - Coverage of elderly care services is unlikely to increase:

- Government priority for the next few years is investment in social facilities for children;
 - In terms of senior policy, poverty eradication is the priority for the near future;
 - The present government feels that the family has the duty to care for the elderly.
- The sector is also unlikely to be privatized:
- The Government continues to trust Private Institutions of Social Solidarity to enlarge their capacity to provide care for the elderly;
 - The privatization of other care services (such as health) is progressing slowly.
- ▶ Over the long term, the “privatization” or “privatization and expansion” scenarios seem more likely to happen:
- Following elderly care service trends in Europe and the Portuguese trend in other public services, the involvement of private elderly care service operators can be expected to increase;
 - Also, there may be a rise in coverage of public elderly care services as the importance of elderly voters increases, specially in services that do not involve too high an investment or costs (in the form of home care, for example). However, the social security budget may come under pressure in upcoming years. Additionally, in recent policies, Portugal has not advanced steadily and continually towards becoming a more social State, as in Northern Europe.

PART II. DRAWING FROM GOOD PRACTICES

LITERATURE REVIEW OF RELEVANT INTERNATIONAL SUCCESSFUL CASE STUDIES

- ▶ Although social and health services are specific to each country’s values, customs and history, it is possible to identify similarities among those with comparable levels of economic development. Their common trajectory shows that, at first, Governments give priority to dealing with situations of greatest need in the elderly population, introducing measures to increase their income and improve their housing conditions. Later they progress to more differentiated, non-elementary care and services (e.g. access to medication).
- ▶ In the 21st century, the unsatisfied needs of the elderly population given most attention in more developed countries are social participation, personal security and safety (e.g. solitude and mobility), and the care of seniors with dementia and chronic limitations. These changes generate ample opportunities in all sectors of society and the economy in terms of elderly care services.
- ▶ Some examples of successful services to address the needs of senior people are:
 - Assistive Technologies are being actively promoted by many national governments of the Organization for Economic Cooperation and Development. It is widely believed that they can simultaneously promote health and wellbeing, retard the increase in healthcare costs, and will have employment and economic stimulation effects. The assistive technology service that has been most widely adopted is telecare, being the “Senior Help Line” in Ireland one successful example to learn from. An evaluation of the service concluded that “The Senior Help Line” has made a major contribution to the health and well being of older people in Ireland at relatively low cost. The service is run by older people for older people and demonstrates the value of peer-to-peer communication (O’Shea, 2006);

- For older people with Instrumental Activities of Daily Living limitations, the alternative to remaining in their own homes with support from informal carers, paid carers or assistive technology, is to move to more “supportive” accommodation. This is likely to be some form of “congregate” housing, from a small block of four or six apartments to extensive retirement communities with thousands of residents. Such “assisted-living housing” has been very successful in Australia, Canada and the United States of America. The schemes range from up-market housing that is funded entirely by the occupiers, through non-profit housing managed by religious organizations (such as United Methodist Homes in the United States of America), to “social housing” schemes for disadvantaged and vulnerable groups including older people that is built with substantial public funding of the capital costs. A particularly instructive national case study is the development of Age Care services over the last 10 years in Australia. According to published review of the Programme, “the goal of the Australian aged care service system has been the provision of a cohesive framework of high quality and cost-effective care services for frail older people and their carers”;
- There is a much smaller number of people, most of them in advanced old age, who have multiple disabling conditions and more severe limitations in both the instrumental and the physical Activities of Daily Living - what is called multiple chronic conditions. Both private-sector health providers (health-care insurers and health management organizations in the United States of America) and State managed national health systems have shown for two decades increasing interest in “intermediate care schemes”. These are nurse-led multidisciplinary teams of clinicians and social care staff that focus on “high-risk” patients and on particular objectives. The Evercare model of intermediate care in the United Kingdom is one interesting case. An assessment showed that Evercare pilot projects provided support for a policy of promoting preventive primary care for vulnerable older people at risk of unplanned hospital admissions and other deteriorations in health. The project has provided a stimulus to the development of new models of care and reappraisal of some existing aspects of primary care practice;
- The care of older people with dementia: individuals with moderate and severe dementia require intensive supervision, support and care. There are two models of care regarding people with dementia: the biomedical and the psychosocial models. Sometimes they are presented as antagonistic or alternatives, but it is argued that the two have complementary roles and that both are required. All those who are involved in dementia care should recognize that they have a common objective, to expand and improve treatment, care and support for both the sufferers and their families, and that this requires the expansion and improvement of both medical and social care. End-of-life care for the elderly is now recognized as a major problem in Japan, so since the late 1980s, there has been a rapid development of group homes for people with dementia in Japan. A group home is a small, home-style facility funded by public insurance. The law stipulates that each group home must provide specialized, in-home care services with mutual support for the elderly person with dementia. Thus, it assumes the roles of both institution and home, drawing from both biomedical and psychosocial models. The method helps stimulate and activate the patients’ functions that are still alive by focusing on reality and eventually it can guide them to regain a positive attitude as well as strengthening self-esteem. The model has been rapidly growing in recent years and has been adopted enthusiastically by non-profit and for-profit organizations and by medical and non-medical institutions.

DESCRIPTION OF INTERNATIONAL POLICIES AND LEGISLATION FOR THE ELDERLY

- ▶ In terms of international policies and legislation for the elderly, several generalizations can be made from the experience of not only the United Kingdom and Japan but also many others. The first intervention is invariably to provide a limited and means-tested income benefit or pension, with the objective of reducing indigence or destitution among the very old, particularly widowed women. History shows that the following phase is to establish the basics of social protection and more universal access to health care based on need. It is also apparent that acute hospital services tend to attract the earliest investment, followed by the establishment of a comprehensive network of primary care health centers (including rural clinics). After these services have been well established, attention turned to the development of community-health services that are delivered to the homes of older people with mobility limitations.
- ▶ The United Kingdom, the United States of America, Canada, France and Australia have focused on the intractable problem of preventing low standards of care, neglect and abuse in residential and long-term care. Governments have made huge efforts to regulate and define quality standards to prevent these problems but have often failed. The perennial difficulties of maintaining good standards of care in residential settings and in hospital wards reflects a pervasive weakness of health and social care services for older people: they have low prestige and tend to attract minimal funding, and are often the first target for cuts. The least popular career option among medical students is geriatric medicine (surgery is the most prestigious); the least desired work placement for trainee nurses is a nursing home for older people (the most popular is an intensive-care paediatric team); and most professional social workers are interested in child protection or in working with people with learning disabilities. The problem is acknowledged worldwide. It can only be fought by changes in medical, nursing and social work education and training. Any nation that seeks a radical improvement in its elderly care services must introduce prior and parallel changes in professional education and raise the financial and promote the work with frail older people.
- ▶ In more deprived societies, before the State takes on a responsibility for funding and managing welfare services, family members are key providers of accommodation, income and instrumental support to older people of reduced capacities. On the contrary, in countries with the highest standards of living and extensive State welfare, an older person's housing and income are largely independent of their family's help, but the closest same-generation and descendent relatives are predominant providers of emotional and affirmational support to the majority, and of personal and intimate care to older people with functional limitations (although not of nursing and medical care). The result in the richest countries is that the boundaries and complementary roles of informal and formal carers become a contentious and fiscally important public policy arena. Policy debates can become charged with opposing ideologies of the normative role of the family in caring for its frail members. Proposals to improve the welfare of older people through new personal social services should include new ways of supporting informal carers.
- ▶ The United Nations Organization has actively promoted constructive national policy approaches to population ageing that seek to raise the health and welfare of older people. The Madrid International Plan of Action on Ageing sets out a typology of the range of older people's needs and relates these to the kinds of programmes and services that address those needs. The Plan proposes actions for its implementation and follow-up in a country and specifies that Governments have the primary responsibility for implementing its recommendations at the national level, while underscoring the need for effective partnership between Governments, all parts of civil society and the private sector.

PART III. THE INTERNATIONAL MARKET

MARKET ANALYSIS OF THE ELDERLY IN SELECTED COUNTRIES

- ▶ International retirement migration and the concentration in countries like Portugal are an important factor in analyzing the demand for social services for the elderly population, as their numbers and specificities make these residents a segment with special needs compared to other seniors.
- ▶ Portugal is an important destination for international retirement migration, and the flows come mostly from Central Europe countries, such as the United Kingdom and Germany. Currently, the estimates suggest a total of 49,000 British citizens residing in Portugal and around 50,000 German citizens. The majority of these are more than 50 years old. According to estimates from the Public Policy Research Institute, of English people living abroad, in 2006, Portugal is in the 18th of the ranking of the 20 more popular destinations by the British citizens. This will tend to increase in the future, as a result of greater mobility and the growing attraction of the country as a temporary or permanent residence for retired foreigners.
- ▶ Senior migrants come to Portugal mainly because of the climate, which is why they settle in areas with the mildest weather, such as the Algarve, Costa do Estoril and Madeira.
- ▶ The evaluation of the integration of this segment of the elderly population in their host region is generally positive, though it shows some needs, particularly access to health care.
- ▶ As Portugal is a recent destination for international retirement migration, it is only now that these cohorts are progressing to more advanced ages and greater fragility. Given that a substantial number (around 1/3) choose to live in the country in this stage of their lives, this poses major questions for the provision of specialized housing, care and nursing homes, and geriatric health care services in future - both for those with considerable personal resources, and those who are relatively impoverished. However, some segments of this group are more vulnerable. The risk factors occur when individuals remain in the foster countries, do not have residence in their home countries, present weak language knowledge, have low incomes, do not own a private health insurance, reside in peripheral areas or in unstable neighborhoods, present weak social contacts and have no relationship whatsoever with their relatives. Nonetheless, three aspects can be outlined as the three more relevant risk factors when seniors residing abroad are faced with problems related to age: first, living in a foreign culture and society; secondly, not having the possibility to use the German social support like their fellow-countryman and third, the motivations oriented towards a more comfortable life style when they move to the destination country.

THE ROLE OF MULTINATIONAL COMPANIES

- ▶ The role of the private sector in providing elderly care services varies from one country to another. For example, while in Sweden only 15% of elderly care services are provided by the private sector, in the UK the private sector is responsible for more than 70% of service provision.
- ▶ Public policy seems to be one of the key catalysts in the development of the private sector, as it has an impact on:
 - The availability of public services and the balance between national and regional supply and demand;
 - The quality and scope of services with public funding, the frequency with which services are provided and the qualifications of personnel;

- Incentives to private enterprise, such as tax benefits, funding or co-funding schemes for the initial investment or services that private operators provide and special loan terms;
- Incentives for clients, such as tax benefits when buying or co-paying for elderly care services, are examples.
- ▶ Monetary aspects also seem to influence the private sector's participation in elderly care services, including the income of the seniors (pensions and pension supplements) and their families (conditioned by average income and unemployment rates).
- ▶ In most countries, the private sector remains fragmented, though there are exceptions. It is more concentrated in the Northern European countries, where the aim of developing private operators was to increase the efficiency and effectiveness of the sector. Today, the main operators are consolidating the sector worldwide in aggressive growth plans.
- ▶ In 2005, the world's five largest operators were in the United States of America and had residential care capacities ranging from 32,500 to 51,000 beds. Until then the largest European operator was Southern Cross, a British company offering around 30,000 beds.
- ▶ Due to the sector's large finance needs, most operators are quoted on the stock exchange and their main shareholders are financial service companies (such as investment funds and private equity companies). The main elderly care service operators are generally specific to the country and their core business is residential. However, some operators have gone international, like Sunrise Senior Living, which operates not only in the United States of America but also in Canada, the United Kingdom and Germany.

PART I

THE SENIOR MARKET IN PORTUGAL

MODULE 1

DEMAND SIDE ANALYSIS

1. Recent and future megatrends

1.1. An overview of ageing

The phenomenon of demographic ageing extends practically to all regions of the world, and projections forecast a total of 2 billion people aged over 60 by 2050, representing more than 20% of the world population. According to these projections, in 2045 the number of people aged over 60 will exceed the number aged 15 or under for the first time.

The baby-boomer generation, which has shaped the demographic structures of most of the developed countries, is essentially the contingent of old people for the forthcoming four decades and is now starting to enter the age brackets that are defined as senior. By the end of the first quarter of this new century, the overwhelming majority of those born in the post-war period will have entered old age and by 2025-2030, should the current birth and death rates remain unchanged, the age pyramid will be completely inverted, giving rise to a new and substantial absolute and relative increase of the elderly population.

Throughout the second half of the 20th century, the European demography history has become associated with population ageing, in both absolute and relative terms, as well as to its wide-scale globalization. The twenty-first century should now cater for the significance, profile and needs of an elderly population undergoing profound changes.

There is a consensus in several studies undertaken on the elderly population in regard to the need to consider this age group as a composite unit, of a heterogeneous nature, with more and more lags between “young” seniors and “old” seniors, which some authors call the “fourth age”.

Mainstream key issues of ageing are:

- ▶ The demographic shifts;
- ▶ Transition from the active senior to frail elderly stage of the life course. How do needs and resources change, in particular considering that there are growing proportions of frail elderly people;
- ▶ How are these changing needs affected by demographic changes, social changes in how people expect to live their lives more actively and independently as they age biologically, and others such as families being geographically dispersed;
- ▶ How are resources changing in terms of the income available to individuals (from the State, from employment pensions and from other sources), wealth available (whether they own homes or other assets), the levels and types of State provision, growing voluntary sector provision, the emergence of new types of housing (e.g. sheltered), changes in how social and health care is delivered;
- ▶ How is the scale of these challenges magnified by a) the growing proportion of older people in the population and b) the increasing geographical mobility of population both within Portugal and in terms of international migration, which leads to the concentration of older people in some places and regions;
- ▶ To what extent are the needs and resources of the later stages of the life cycle dependent on income, gender, previous mobility, social networks, geographical location (especially urban *vs* rural);

- ▶ What influences whether people move in later life - locally, regionally or internationally - in response to changes in their needs and resources;
- ▶ How are individuals responding to longevity and changes in needs/resources? Is it by seeking to work longer? Moreover, what are the characteristics of this work - part *vs* full time, changes of status or sector;
- ▶ What support do families provide, whether they live locally or at a distance? This support may be financial, housing, emotional, or care;
- ▶ How are new technologies influencing resources - for example, in terms of helping the frail elderly to stay in their own homes, or in terms of internet and web-based services and information.

1.2. An overview of welfare: complexity and dimensions

The welfare of the population is primarily a result of their material resources, physical states of health, and mental wellbeing. Each of these constructs is complex.

Material resources refer not only to current income (and the standard of day-to-day living that can be afforded), but also to savings, assets, pension entitlements and the sense of income security. In most of the richest countries of the world, house ownership increased substantially during the second half of the 20th century, from less than 1/5 of all households in 1950, to a clear majority today. This change has reflected both rising affluence and the powerful encouragement by many governments of the principle of “a property owning democracy”, not least because the policy is strongly supported by large majorities of the population. It also means that over the coming decades, an increasing share of the older population will possess substantial “housing equity”. This may be “coveted” by the children and wider families, but it represents a growing resource that older people will draw upon to raise their current welfare. There is clear evidence from many countries that private expenditures are already rising as a proportion of total welfare spending.

Physical states of health have improved significantly in affluent countries over the last century, as most clearly indicated by the marked increases in average life expectancy and the substantial decrease in infant mortality. This “epidemiological transition” has come about for two very different sets of reasons and their respective contributions remain controversial and can never be accurately determined. Firstly, multi-faceted improvements in the standards of living, from personal nutrition and hygiene to exposure to pathogens, toxins and injury at work and in the environment; and secondly, rapid advances in the biomedical sciences and the development of a multitude of new treatment therapies - in other words, more and better health care.

Much less is understood about temporal change in the population's *mental wellbeing*, partly because of scarce data and partly because there are contradictory trends. The overall distribution of “life satisfaction” or even “happiness” may not have changed substantially in centuries, as even eminent welfare economists and public health analysts accept (Layard, 2006; Marmot, 2004). Similarly, the prevalence of clinical depression, anxiety, other affective disorders and psychoses have not followed consistent trends over time. They may be relatively constant across societies, or their oscillations may fluctuate more with a shared national sense of pessimism or optimism, as engendered by wars, ensuring peace, foreign occupations and the rapidity of social and occupational change. The only clear temporal trend is that the prevalence of cognitive disorders in advanced old age has increased, which is associated with irreversible brain and nervous (psychomotor) system damage, notably the various dementias and Parkinson's disease.

The main types of welfare services

The scope of public-welfare interventions therefore ranges from income support, through personal health-care and social-care services and the support of family carers, to specialist “social housing” provision. The study focuses on what are sometimes called the human services: that is, the provision of advice, counseling, care, support and treatment, including that provided along with accommodation. In short, this review is concerned with three types of welfare service or intervention:

- Accommodation, including specialist housing and housing-plus-care settings;
- Personal care services;
- Health services: primary care, community health services, hospital services.

The mixed economy of contemporary welfare provision

In no Western country is the provision of welfare services the exclusive preserve of any agency or sector of the economy. Even in the United States of America (USA), which by reputation has a “private” health-care system, the Federal Government is the main founder of clinical education and training and basic biomedical research, and makes substantial contributions to the health-care costs of older people and of those on low incomes respectively through Medicare and Medicaid (see <http://www.medicare.gov/> and <http://www.cms.hhs.gov/MedicaidGenInfo/>). The USA federal government also repeatedly makes available capital grant programmes for building hospitals and other medical facilities (as in rural and deprived areas and following natural disasters).

Even in the United States of America, then, the supply and even more the development of innovative health and social care programmes and social housing comes about through disparate efforts by many sectors. As in all OECD countries, numerous agencies and organizations (individuals, companies, organizations and agencies) are involved in promoting (or retarding) welfare through the supply and development of human services. It is useful to be clear about the respective roles of the principal groups of agents.

Table 1 summarizes the roles of each of the main groups of agents in welfare service provision and development. There are of course innumerable inter-dependencies among the main actors. Many welfare advances are initially led by one of the agent groups, but to become enduring and widespread they require the sanction or practical support of other groups. Many complementarities and inter-dependencies will become evident in the later sections that focus on specific types of services.

Table 1. The principal agencies involved in delivering and developing welfare services for older people

Agents	Roles	Methods
1. Central Government	Regulation of practitioners and provider organizations. National planning, <i>i.e.</i> set welfare development priorities. Provide funding for demonstrations and trials, and in the longer term, part funding for provision with high welfare returns.	Legislate to create regulatory (including inspection and closure) agencies and powers, which may be devolved wholly or in part to lower tiers of government, professional bodies or independent agencies. Set up inquiries and commissions to build a consensus on new, technically feasible and affordable priorities. Promote priority goals through grants, subsidies and, more rarely, State ownership and management.
2. Local Government and State agencies	Top-down roles (from State to Local Government level) Bottom-up roles (from local to State government level)	Agencies for implementing Central Government policy, with adaptations to local circumstances. Synthesize welfare priorities of local populations, businesses and non-profit organizations, and advocate with Government for responsive action.
3. Practitioners and their associations, e.g. physicians' societies, federations of nursing home proprietors	Deliver appropriate and competent treatment, care and support. Self-regulation of practice and professional standards.	Determine basic, specialist and updating training syllabuses and accreditation requirements. Set standards of competence, and establish quality control procedures to identify incompetence and negligence.
4. For-profit companies	To supply welfare goods and services, from specialist housing to surgery. To create new services, by demonstrating the profitability of their provision.	Create efficient systems to supply reliable, effective and appropriate goods and services. For unprofitable services of demonstrated welfare value, work responsibly with public sector and non-profit organizations to establish efficient delivery systems.
5. Non-profit organizations, including religious and charitable organizations	To develop services that meet unmet needs (gaps). To challenge inefficient and unethical features of welfare provision. By their advocacy and enterprise, to improve the range and quality of welfare provision.	Through innovative action projects, demonstrate that gaps can be filled in and obliquities removed. Raise philanthropic funds, professional effort and altruistic contributions. Persuade for-profit companies to enter new fields. Persuade Governments to legislate for or to adopt new priorities, through regulation or funding.
6. Consumers, or the population	To reveal the population's welfare priorities by service and expenditure choices, and by evaluative comments and expressions of needs and wants.	Feedback to existing providers, through political channels and the media. Demonstrate through expenditure the demand for particular products and services, <i>e.g.</i> specialist housing, mobility scooters, off-the-shelf (non-prescribed) medications.
7. Scientists and inventors	Develop new products and services, as with pharmaceuticals, prosthetics (<i>e.g.</i> artificial hips) and assistive technologies.	Pursuit of scientific and technological agendas. Persuade public and philanthropic research funders to support new priorities.

1.3. Ageing: from world to intra-national dynamics

Ageing is a worldwide phenomenon that is undergoing profound transformations in every country's current and future population structure. The magnitude of such a shift calls for a "demographic transition", with increasing life expectancy and reduced lifetime fertility as the key driving forces. Demographic transition is a sequential three-staged process:

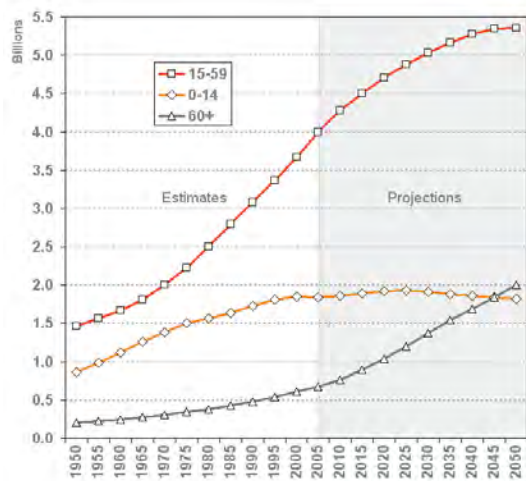
- ▶ Stage 1: rejuvenation due to increased survival rates at younger aged groups;
- ▶ Stage 2: decline in the fertility rates which reduces the proportion of younger aged groups while, at the same time, the bulk of newborns in Stage 1 moves up to the adult/working age groups;

- Stage 3: due to the continuous reduced fertility and mortality rates, the proportion of children and adult age groups decline, while increased life expectancy enlarges the upper part of the age pyramid.

International

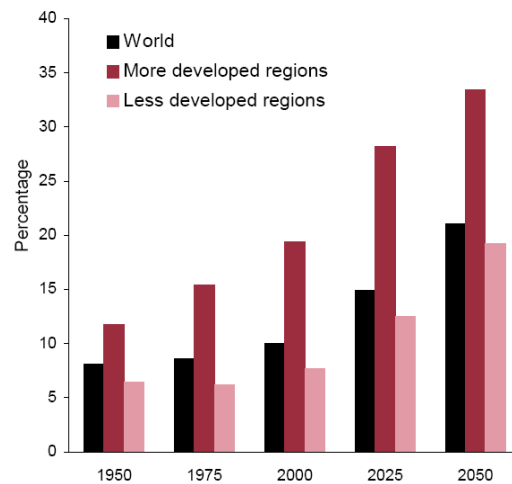
The demographic studies carried out by the United Nations Organization (UNO) in 2006 (“World Population Prospects, the 2006 revision”) confirm that the world population is undergoing major transformations, marked by a clear transition from a regime of high death and fertility rates to a period of low death and birth rates. This demographic trend is largely responsible for the swift growth of the world population that took place in the last few years. Nonetheless, it is also the leitmotiv of the slowdown in this growth over the medium-long term, given the changes in the age structure associated to it (reduction/stagnation of the young population and a strong rise in the older age groups) (*Figure 1*).

Figure 1. World population by age groups, 1950-2050 (N.)



Source: World Population Prospects, the 2006 revision, United Nations Population Division.

Figure 2. Proportion of population aged 60 or over world and development regions, 1950-2050 (%)

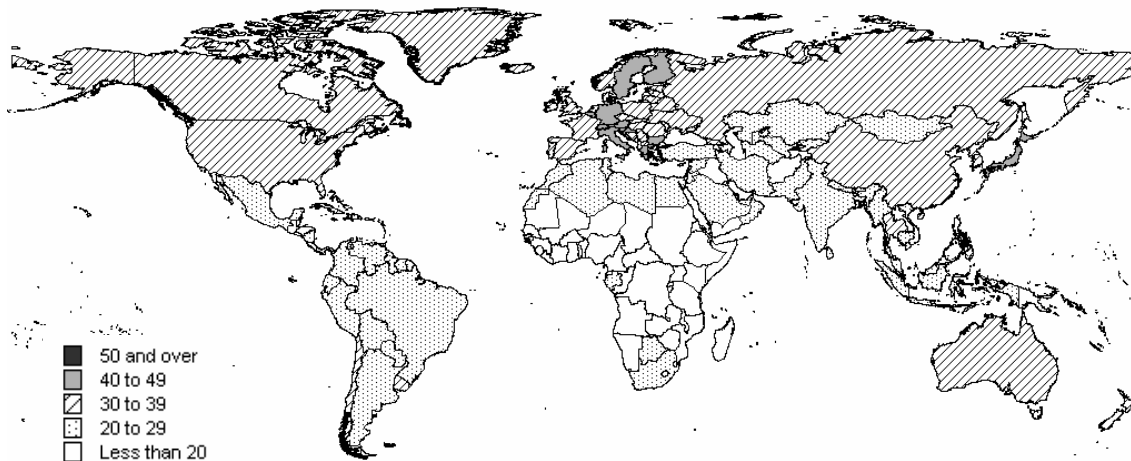


Source: World Population Ageing 1950-2050, United Nations Organization, 2002.

By 2050, both developed and developing regions are projected to age significantly (*Figure 2*). Currently, the bulk of population is concentrated in the age bracket between 30 and 50 years old in developed countries and between 0 and 20 years old for developing countries. By 2050, this is expected to change to the age bracket between 50 and 70 years old in developed countries and to the age bracket of 15 to 35 years old in developing countries.

Two main demographic factors - the increase in life expectancy and the decline in fertility rates - are driving population ageing. People around the world are living longer (*Figure 3* and *Figure 4*). Life expectancy has been growing steadily in all continents over the last 50 years. This has led to an increase in global life expectancy from 47 to 65 years. By 2050, experts predict that life expectancies will converge to 80 years (except in the case of Africa). The increase in life expectancy has made centenarians the fastest growing age group since 1970. In the last 50 years, this age group experienced a 40% increase and reached 265,000 people.

Figure 3. Median age in 2005, medium variant (years)



Source: World Population Prospects, the 2006 revision, United Nations Population Division.

Figure 4. Median age in 2050, medium variant (years)

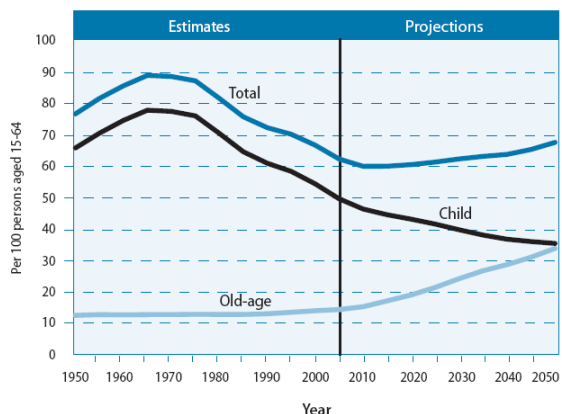


Source: World Population Prospects, the 2006 revision, United Nations Population Division.

Due to the relatively young demographic structures in developing countries, the world's total dependency ratio has been declining, not only because of the reduction in child dependency (lower fertility rates), but also because of the recent boost in the adult population. However, this trend will stop in the near future (within a decade) and then reverse as adults move on to the older age groups (*Figure 5*). Within 50 years, the old-age dependency ratio in less developed countries will rise from 8.2 to 21.8.

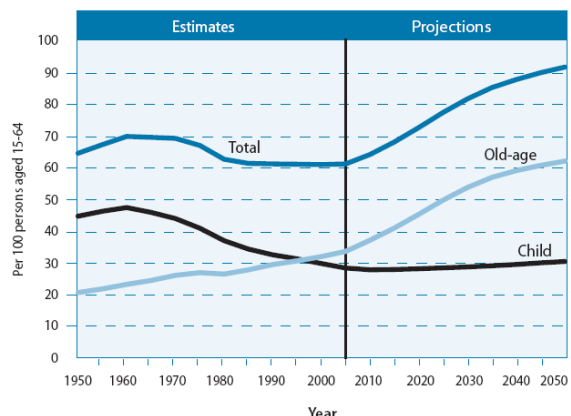
In developed countries, total dependency ratios are on an upward trend for the next decades, due to the growing population of aged citizens (*Figure 6*). The old-age dependency ratio in developed countries will rise from 21.2 in 2000 to 46.5 by 2050.

Figure 5. Child and old-age dependency ratios, 1950-2050, developing countries



Source: World Economic and Social Survey, United Nations Organization, 2007.

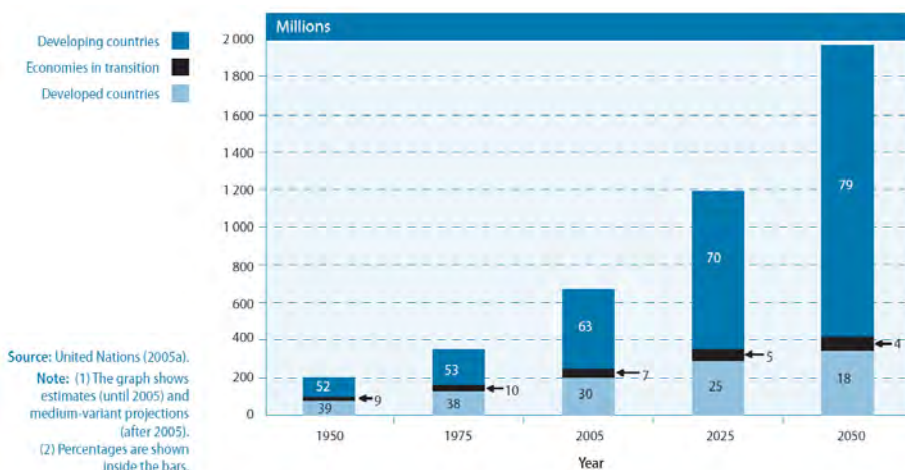
Figure 6. Child and old-age dependency ratios, 1950-2050, developed countries



Source: World Economic and Social Survey, United Nations Organization, 2007.

Although most of the developing countries are in Stage 2 of the demographic transition, one must take into account the quantitative issue: the majority of the world population lives in these countries and their demographic vitality will reinforce these figures (1.6 billion people aged 60 or over in 2050) (Figure 7); in areas like East Asia/Pacific and Latin America/Caribbean, demographic transition is taking place at a fast pace (rapid fertility reduction).

Figure 7. Size and distribution of world population aged 60 or over by groups of countries, 1950, 1975, 2005, 2025 and 2050 (N.)

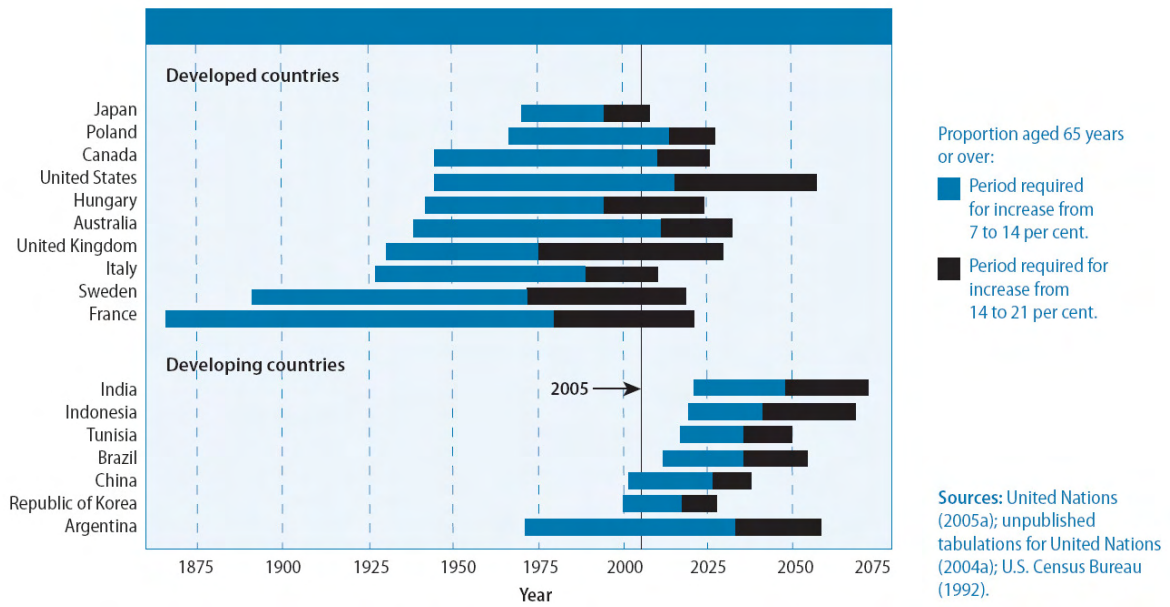


Source: United Nations (2005a).
 Note: (1) The graph shows estimates (until 2005) and medium-variant projections (after 2005).
 (2) Percentages are shown inside the bars.

Source: World Economic and Social Survey, United Nations Organization, 2007.

Those two realities combined will be responsible for an even more rapid ageing process than developed countries have experienced in the last decades (Figure 7). By 2050, 4 in every 5 of the world population aged 60+ will reside in a developing country.

Figure 8. Time period required for the proportion of the population aged 65 years or over to increase from 7 to 14% and from 14 to 21%, selected countries

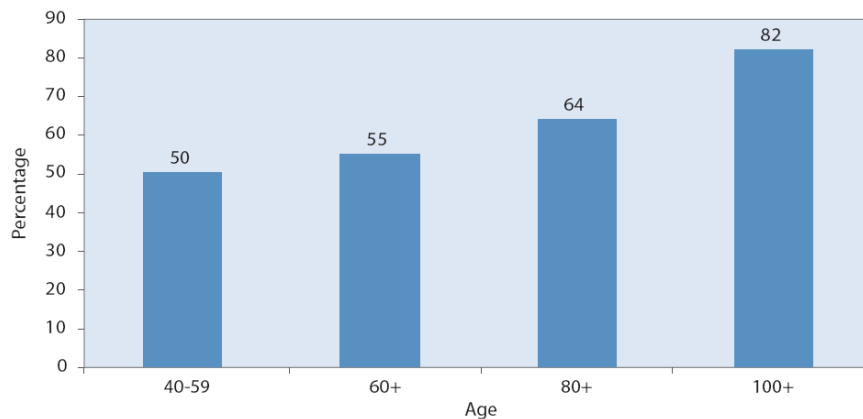


Source: World Economic and Social Survey, United Nations Organization, 2007.

Thus, in accordance with the demographic projections for the forthcoming years by UNO, in 2045 the number of old people in the world (people over the age of 60) will outstrip the number of young people (people under the age of 15) for the first time, as a result of the reduction in the birth rate and the increase in the average life expectancy.

From a global perspective to a more detailed analysis, ageing is a gender imbalanced process. Female life expectancy is higher than male and, therefore, as we move up in the age pyramids, the number and proportion of women rises and significantly outnumbers men (*Figure 9*).

Figure 9. Proportion of women among people aged 40-59, 60+, 80+ and 100+ years, world, 2007

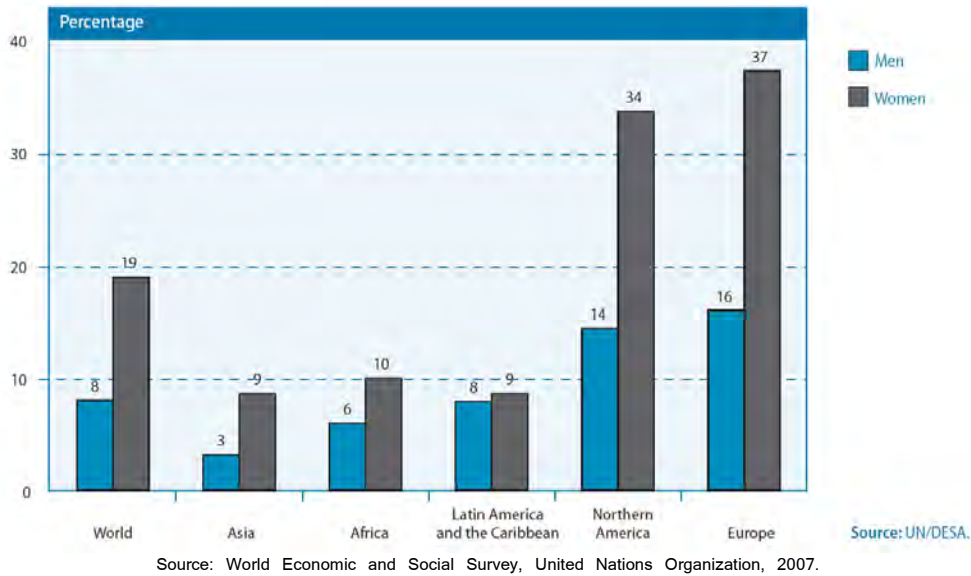


Source: World Population Ageing 1950-2050, United Nations Organization, 2007.

Solitude and isolation in the older population is a status mostly affecting developed countries. In developing countries, older people still rely on the family and community for support. However, the increase in the proportion of elderly facing solitude will take place in both developed and developing countries. In the latter, due to demographic shifts and social trends (eg. women's labour participation),

this situation will raise more dramatic challenges as formal services are not prepared to support and care for isolated elderly (*Figure 10*).

Figure 10. Proportion of population aged 60 or over living alone, by region and sex, 2005 (%)



Looking at the ageing process more closely, one should highlight the fact that the older population is also ageing: the 80 years or older group is the fastest growing segment of the older population and by 2050 their share of the 60 years old or above population will reach 20%, with 379 million individuals in the so-called “fourth age” (*Figure 11* and *Figure 12*).

Figure 11. Distribution of population aged 60 or over by age groups: world, 1950-2050 (%)

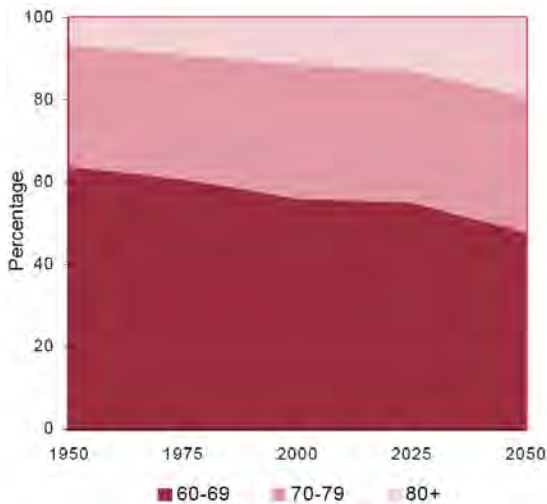
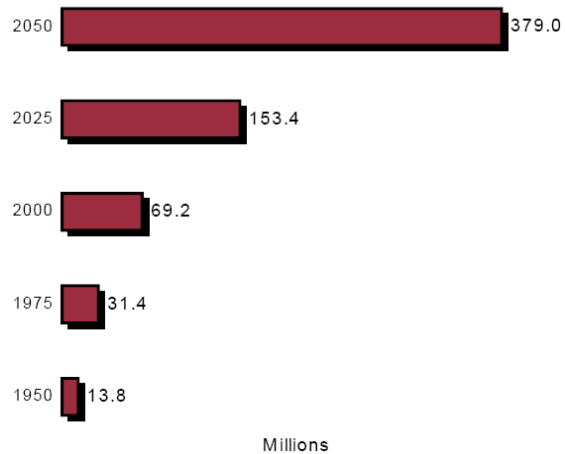


Figure 12. Population aged 80 or over: world, 1950-2050 (%)

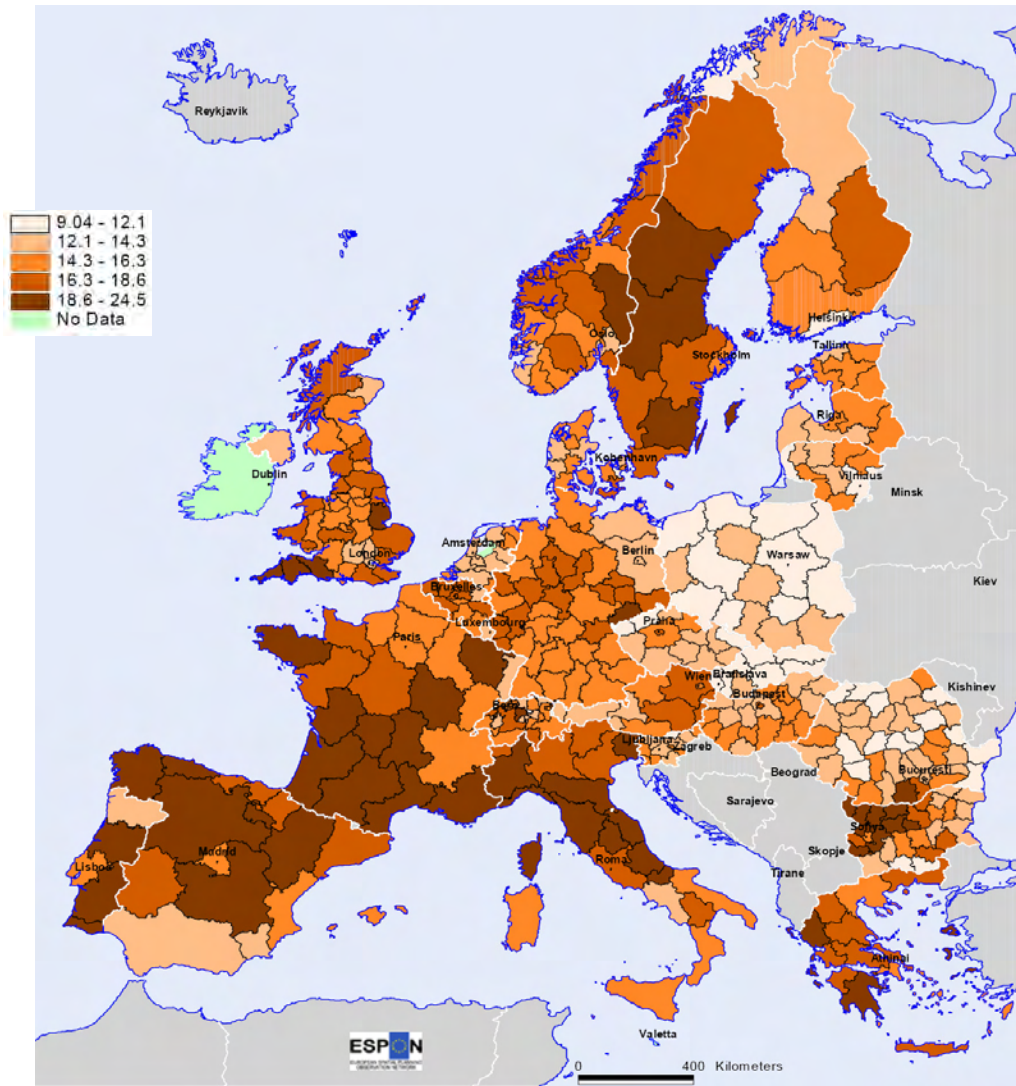


Throughout the second half of the 20th century, the death rates of the various European countries have come closer together, while the life expectancy has grown at progressively slower paces: between 1950 and 1980, the rise in OECD countries was on average 8.5 years more for women and an additional 5.9 years for men. In the 1980^{ies} and 1990^{ies}, the on-going dynamic made it possible to increase the

life expectancy by a number of years. It should be noted that the European elderly population is not only expanding in terms of the effective number but that it is also living longer. In the first years of the 21st century, the life span for the new senior generations (when reaching 60 years old) is another 18 or 25 years of life expectancy, depending on the gender (male and female).

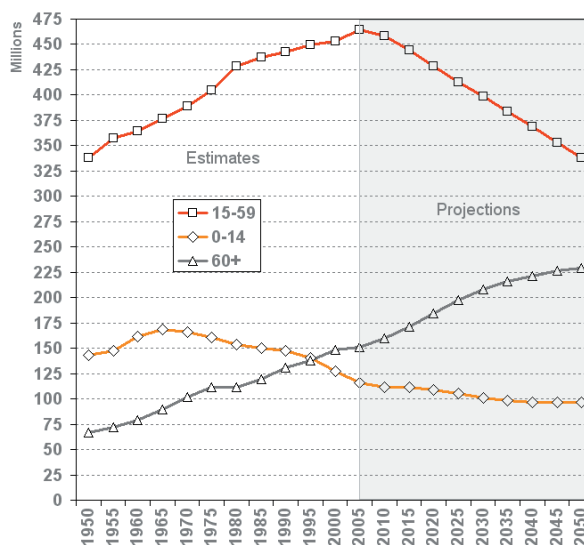
Focusing the analysis on the European contingent, this reality becomes even more acute (**Figure 13**), insofar as the elderly population has outstripped the young population since 1995, and it is anticipated that in 2050 the population over the age of 60 will be practically double that under the age of 15 (**Figure 14**). In fact, according to UNO projections, only the age groups at the top of the European age structure will grow in the forthcoming decades.

Figure 13. Proportion of population aged 65 and over in 2000 (% of total population)



Source: EUROSTAT

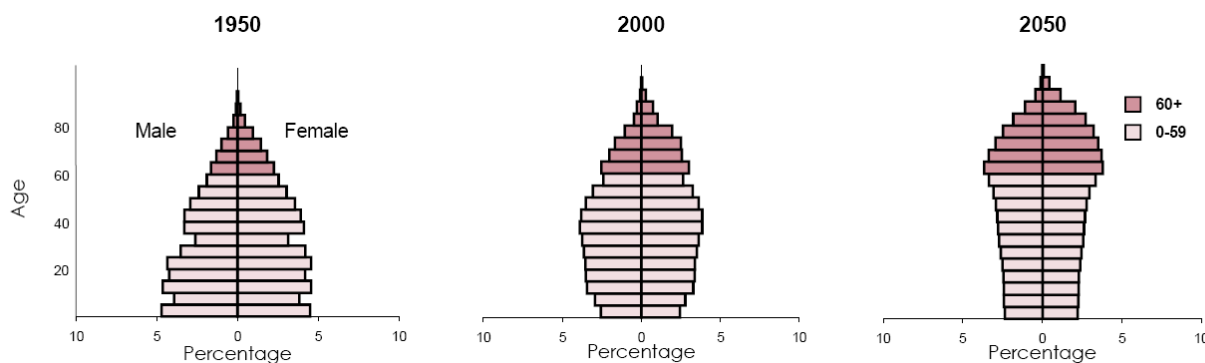
Figure 14. Europe's population by age group, 1950-2050 (N.)



Source: World Population Prospects, the 2006 revision, United Nations Population Division.

A comparative analysis of the age structures in 1950 and in 2000 for the European Union (EU) highlights the stall in this structure, simultaneously eroded at the base and extended in the last age groups (*Figure 15*). The progression of the baby-boomers in this structure also stands out: in 1950, they were still at the base of the pyramid; in 2000, they appear in full adult life. Over the next four decades, this generation will essentially comprise the contingents of European seniors (Ferreira, 2007).

Figure 15. European age pyramid 1950, 2000 and 2050 (%)



Source: World Economic and Social Survey, United Nations Organization, 2007.

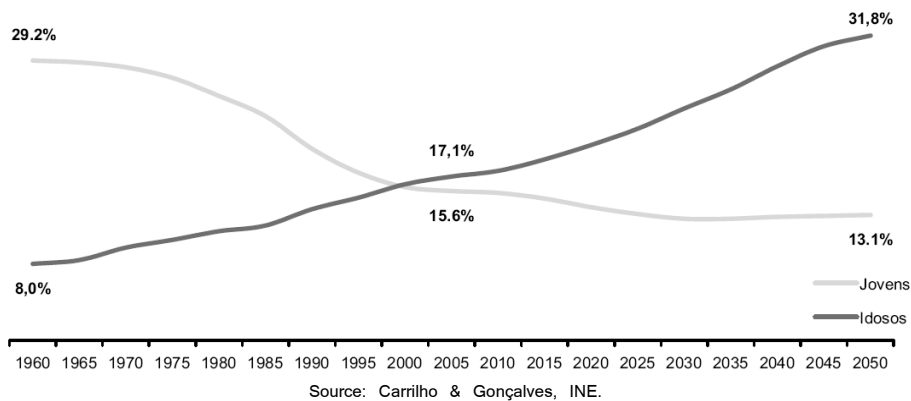
As far as the “very senior” segment is concerned, the projections indicate an even more pronounced evolution in this segment, which will lead to its growing weight in the total effective number of old people. The weight of this sub-group will be all the greater the more significant the progress in reducing the death rate in more advanced age groups becomes (a fact that has been confirmed in the last years).

National

Similarly to what occurs at world level, the Portuguese society has also suffered from demographical ageing. In the course of the last four decades, the Portuguese elderly population has unquestionably increased, from 8.0% of the population in 1960 to 16.4% in 2000, while the young population has evolved in the opposite direction, having decreased from 29.1% in 1960 to 16.0% in 2000.

This ageing phenomenon of the Portuguese population has revealed itself to be not only consistent since at least the 1960^{ies}, but also a process that is constantly on the rise: in the medium scenario of *Instituto Nacional de Estatística* (INE) - (National Statistics Institute) demographic projections, aged population will double its proportion in the total population from 2000 to 2050, reaching nearly 32% (*Figure 16*).

Figure 16. Proportion of young (<15 years) and old (>65 years) population, 1960-2050 (%)



The rapid ageing process that took place in the last years places Portugal among the more aged countries in the world: ranked 10th in the proportion of population aged 60 or over (*Figure 17*); ranked 14th in the ageing index (older vs youth population) (*Figure 18*). In the EU context, it ranks as the 7th most aged country (*Figure 19*).

Figure 17. Country ranking by percentage of population aged 60 or over, 2007

Country	60 or over	Rank
Japan	27.9	1
Italy	26.4	2
Germany	25.3	3
Sweden	24.1	4
Greece	23.4	5
Austria	23.3	6
Bulgaria	22.9	7
Belgium	22.9	8
Latvia	22.8	9
Portugal	22.8	10

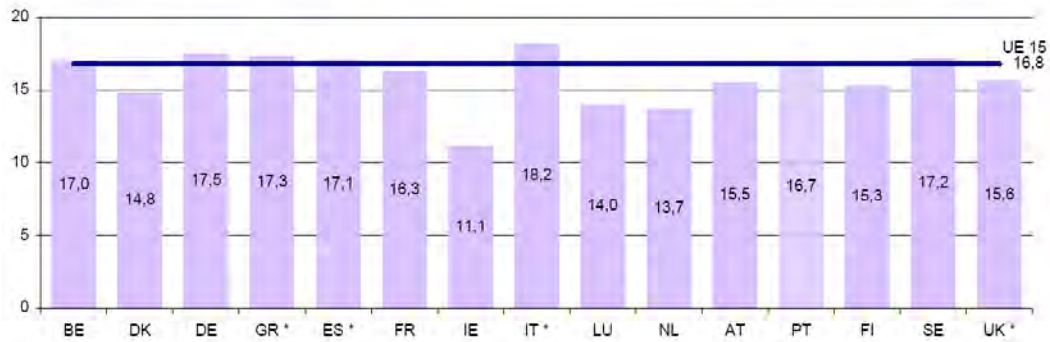
Source: World Population Ageing 1950-2050, United Nations Organization, 2007.

Figure 18. Country ranking by ageing index, 2007

Country	Ageing index	Rank
Japan	201.0	1
Italy	189.8	2
Germany	182.3	3
Bulgaria	172.5	4
Greece	166.0	5
Latvia	164.4	6
Austria	156.1	7
Slovenia	155.9	8
Czech Republic	150.7	9
Croatia	150.0	10
Ukraine	149.5	11
Spain	149.2	12
Estonia	148.3	13
Portugal	144.3	14

Source: World Population Ageing 1950-2050, United Nations Organization, 2007.

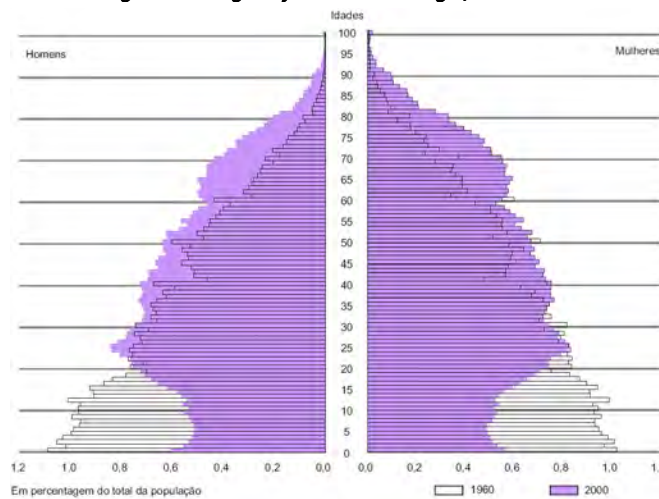
Figure 19. Population aged 65 years or over in the European Union (EU-15), 2002 (% of the total population)



Source: *Dinâmicas territoriais do envelhecimento*, INE, 2002.

The age evolution of the resident population in the period between the Census of 1960 and that of 2001 was marked by the simultaneous ageing at the top and at the bottom of the age structure (double ageing) (Figure 20). This combination led to the fact that for the first time the ageing index supplanted 100, i.e. the entrance to the 2nd millennium saw the existence of more old people than young people in Portugal.

Figure 20. Age Pyramid in Portugal, 1960-2000



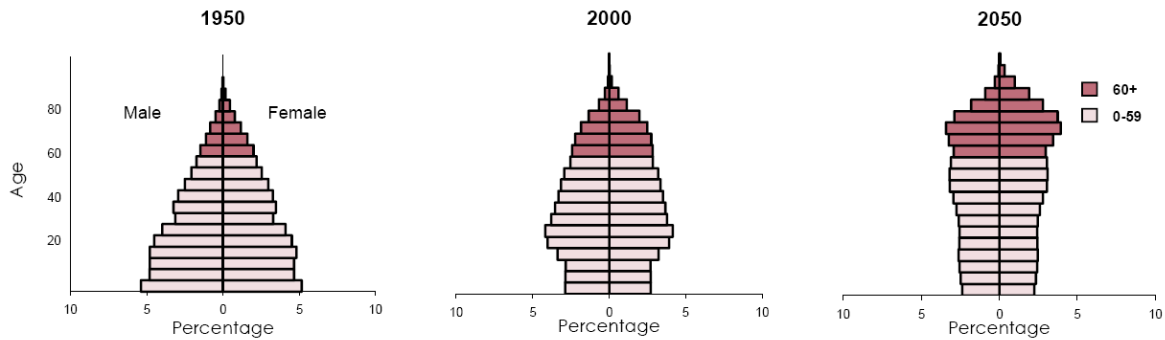
Source: *O Envelhecimento em Portugal*, INE, 2002.

In Portugal, population growth between 1991 and 2001 was due largely to immigration (it is estimated that the migratory phenomena accounts for approximately 80% of this growth) and less to the natural balance. The persistence of this differentiated dynamic between the natural balance and the migratory balance is translated into a growing number of foreign people living in Portugal, which at present should represent approximately 4% of the total population (around 400,000 people). The creation of an European Space for the free circulation of citizens contributed greatly to this, which has fostered international travel that is not strictly related to work.

The predictable increase in the average life expectancy and the maintenance of the low levels of fertility (already below the minimum threshold for generational replacement: 2006 - 1.4) in the coming years, which will not compensate the possibility of keeping up positive migratory balances, are reflected in the demographic projections made by the National Statistics Institute (INE) for the horizon year of 2050. These projections reveal a significant reduction in the population (1/4 of the population may be lost in 50 years) and a pronounced and alarming double ageing of the Portuguese population: more old people

(old-age dependency ratios will rise from 23.1 in 2000 to 53.5 in 2050) and less young people (youth dependency ratios will rise from 24.7 in 2000 to 25.8 in 2050) (*Figure 21*).

Figure 21. Portuguese age pyramid in 1950, 2000 and 2050 (%)

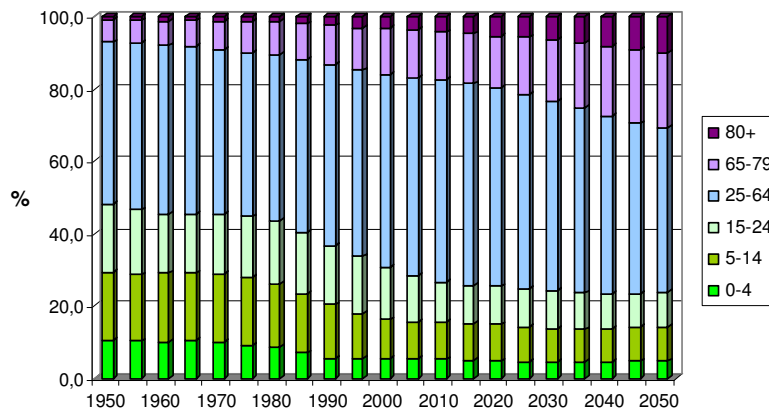


Source: World Economic and Social Survey, United Nations Organization, 2007.

One of the striking characteristics of this demographic ageing in Portugal is a discrepancy in terms of gender, with a growing over-representation of women in correlation to the age progression: in 2001, the ratio of men in the senior population over the age of 65 was 72/100, an amount which drops to 46/100 when limited to individuals over the age of 85. This difference will tend to tone down as the average life expectancy between men and women comes closer together.

The growth rate of the elderly and very elderly population is relatively higher than the remaining age groups, whether in the retrospective period or in the projection period (*Figure 22*): the elderly population (65 years or over) has a somewhat higher average growth rate (2.1%); however, the 85-years-or-over age group presents the fastest growth rate (almost 3% of the annual average), whereas the younger population, (15 years or less) shows a decrease of -0.9%, annual average.

Figure 22. Medium variant by age group, 1950-2050 (%)

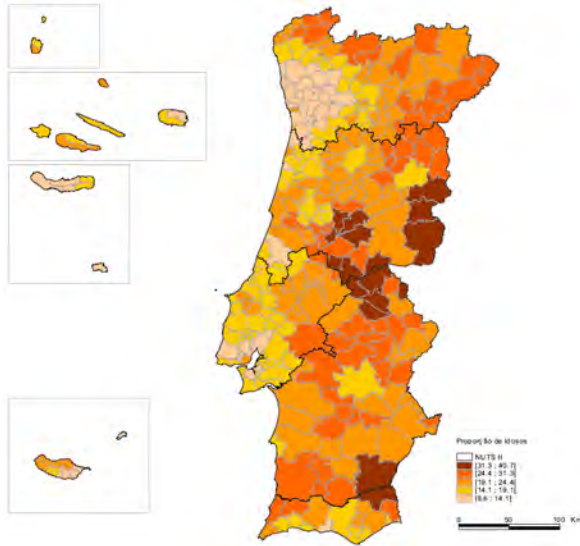


Source: INE, General Population Census (1960-2001) and projections for the resident population (2010-2050).

The increase in the average life expectancy and the consequent rise in the longevity of the Portuguese population, in conjunction with the reduced fertility rates and the increment in the emigration flows, will be responsible for the population break in Portugal in the forthcoming years and for an intensification of the demographic ageing phenomenon in all of Portugal's regions (including the Autonomous Regions).

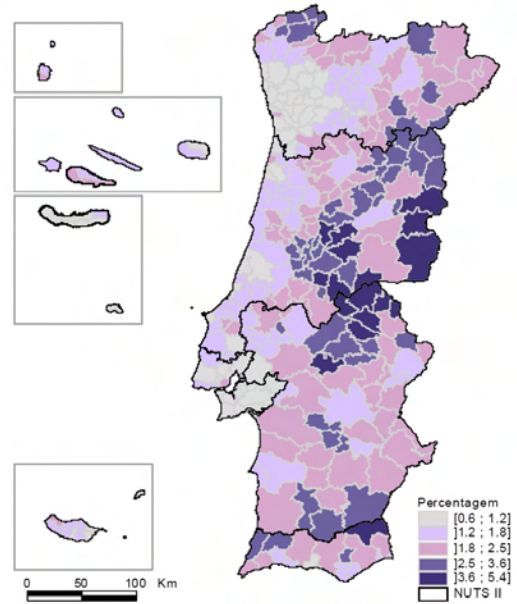
Regional mosaic of ageing in Portugal

Figure 23. Population aged 65 years or over, by municipality, 2001 (%)



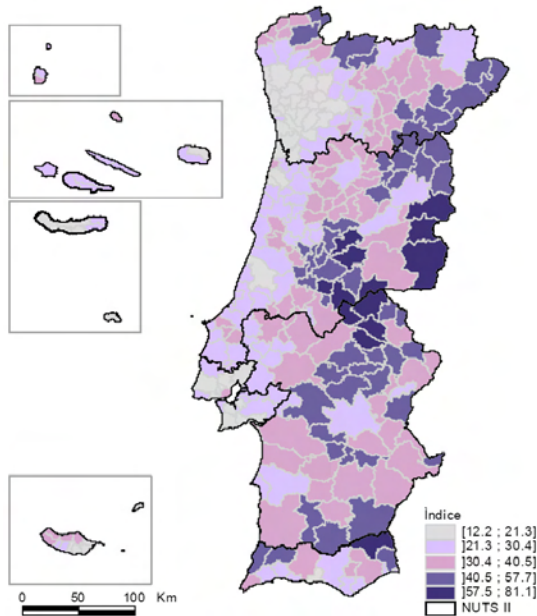
Source: *O Envelhecimento em Portugal*, INE, 2002.

Figure 24. Population aged 85 years or over, by municipality, 2001 (%)



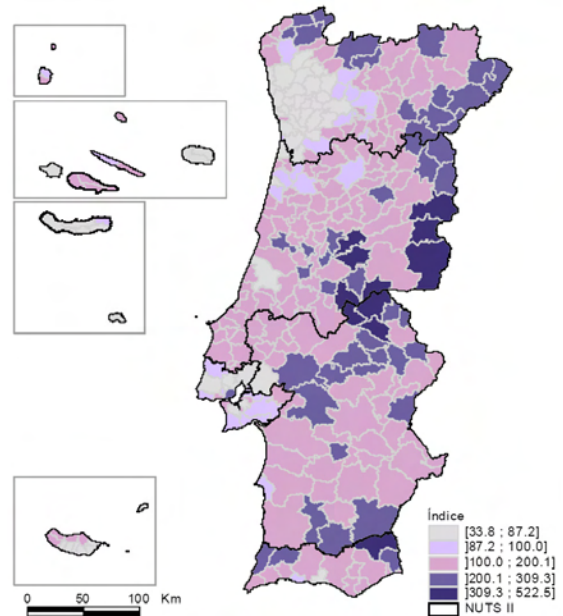
Source: *Dinâmicas territoriais do envelhecimento*, INE, 2002.

Figure 25. Elderly dependency ratio, by municipality, 2001 (%)



Source: *Dinâmicas territoriais do envelhecimento*, INE, 2002.

Figure 26. Ageing index, by municipality, 2001 (%)



Source: *Dinâmicas territoriais do envelhecimento*, INE, 2002.

The characteristics and dynamic of this ageing phenomenon does however reveal regional differences resulting from the different behavior of variables such as fertility and migratory flows.

Over the last decades, the inland regions of the country (Centre, Alentejo and Algarve) have been confronted with high indexes of ageing population, explained above all by the constant emigration movements (internal and external), namely of the active population, which directly influences the drop in

birth rates, progressively leading to the population depletion of these territories. In other regions (such as the North, Madeira and Azores), on the other hand, there are still high levels of fertility, which has enabled them to experience population growths.

Nonetheless, over the last years, the elderly population has continued to grow in all of the regions (including the Autonomous Regions of Madeira and the Azores and the North Region, which have recently no longer been able to substitute generations) and it is expected that the ageing will be extended to the rest of the country in the coming years, albeit at different rhythms and at specific moments. In other words, the increase in the proportion between the elderly population and the young population will become a reality in all of the Portuguese regions in the near future.

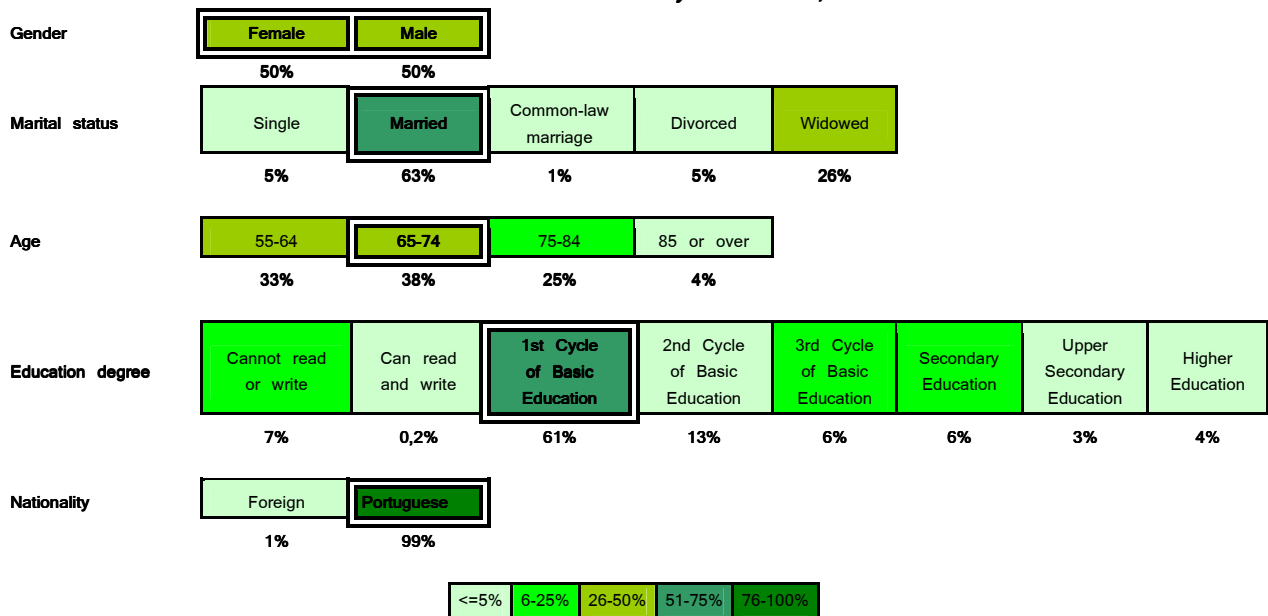
2. Segmentation of the portuguese senior population

2.1. Socio-demographic characterization (the sample and the 2001 Census).

Based on a CEDRU survey to 1,324 individuals aged 55 years or over (see Annex A - for survey Methodological Notes and see Annex B - for questionnaire used), it is possible to present an approximate and quite safe portrait of the main socio-demographic characteristics of the senior Portuguese population. This profile is described in this chapter and, whenever possible, a comparative analysis of the results obtained with other documental or statistical references will be made.

The following table, which translates the basic profile of the individuals, concludes that the sample is made up of a similar partition of men and women, the majority of which are married, belong to the 65-74 age group and have a basic level of education.

Table 2. Profile of the surveyed individuals, 2007



Source: CEDRU Survey, 2007.

In comparison to the national reality, an approximation to the characteristics of the sample is observed in some indicators. Nevertheless, in terms of gender, the prevalence of the female gender - a reflection of a higher average life expectation for women - is not properly represented in the results obtained from the sample.

Table 3. Resident population aged 55 years and over, by gender, 2007 (%)

Gender	Census 2001 (%)	Survey (%)
Men	44	50
Women	56	50

Source: CEDRU Survey, 2007.

In a regionalized analysis of the sample, it was observed that among the surveyed individuals - native Portuguese - the regions of Lisbon, Centre and Alentejo prevail. Whereas in an analysis by *Nomenclatura das Unidades Territoriais para fins Estatísticos* (NUTS) - (Nomenclature of Territorial Units for Statistics); the overwhelming majority is from the Greater Lisbon area (24%), Serra da Estrela and Beira Interior Sul (10% each). On the other hand, foreign seniors come mostly from Portuguese speaking countries, namely from ex-African overseas colonies: Cape Verde, Guinea-Bissau, Angola, Mozambique and S. Tomé and Príncipe. However, it is important to point out the considerable weight that Spain already represents, in terms of seniors in Portugal (6%).

Table 4. Portuguese natives surveyed, by region, 2007 (%)

Origin (NUTS II)	%
Alentejo	24
Algarve	6
Centre Region	31
Lisbon	31
Northern Region	9
Madeira	0.2

Source: CEDRU Survey, 2007.

Table 5. Foreign people surveyed, by country, 2007 (%)

Origin (Country)	Sample (%)	SEF 2001 (%) ¹
Cape Verde	31	18
Guinea-Bissau	22	2
Angola	18	4
Mozambique	10	2
Spain	6	13
South Africa	2	0
Germany	2	9
Australia	2	0
Brazil	2	4
USA	2	5
Congo	2	0.1
S. Tomé and Príncipe	2	1
Others	-	41

Source: CEDRU Survey, 2007.

The retirement situation of the majority of the individuals (77%) is above all a reflection of the age condition itself and even of the discontinuation of the professional activities previously pursued, due to ageing and related physical debilities. Notwithstanding, the proportion of the active population surveyed is overrepresented when compared with the country, since in 2001, active individuals aged over 55 represented 11.6%. In both cases, it is evident that inactivity *vis-à-vis* employment is a common point for most of the elderly, namely those retired and housekeepers.

In a recent study by INE, the education levels of the population over the age of 65 were based on the classification categories used by the United Nations, the International Standard Classification of Education (ISCED). It was concluded that in Portugal about half of the population (55.1%) is illiterate.

¹ Foreign population living in Portugal, by nationality and gender, according to the age group, 2001.

Concerning the elderly population, 37.0% had the 1st and 2nd levels of the basic education while only 3.4% had the 3rd level. From the 3rd level to higher education, only 7.9% of the Portuguese elderly population was considered². In the following sample, this is also a reality.

Table 6. Work situation of the surveyed individuals, 2007

Conditions Regarding Work	No.	%
Active	213	16.1
Unemployed	22	1.7
Domestic	59	4.5
Retired	1,019	77.0
Others	3	0.2
Did not answer / Not applicable	8	0.6
Total	1,324	100

Source: CEDRU Survey, 2007.

Table 7. Education levels of the sample, 2007 (%)

Education Level	%
Knows how to read and write	0.2
Illiterate	7
1 st level of Basic Education	61
2 nd level of Basic Education	13
3 rd level of Basic Education	6
Secondary Education	6
Upper-Secondary Education	3
Higher Education	4
Total	100

Source: CEDRU Survey, 2007.

When comparing the work situation with the education level, it can be concluded that the illiterate individuals are all retired (86%) and that the education level increases in tandem with the period of time in the labour market. Consequently, it is possible to conclude that, among other factors, the majority of pensioners keep up some type of activity (9% of the valid answers).

Table 8. Work situation of the surveyed individuals according to the education level, 2007 (%)

Work Situation	Illiterate	Knows How to Read and Write	Basic Education (1 st level)	Basic Education (2 nd level)	Basic Education (3 rd level)	Upper Secondary Education	Secondary Education	Higher Education
Active	6	0	12	28	33	11	26	44
Unemployed	0	0	2	1	3	0	4	0
Housewife	8	0	4	5	7	3	6	0
Others	0	0	0	1	0	0	0	0
Retired	86	50	81	66	58	86	64	56
Did not answer/ Not applicable	0	50	1	0	0	0	0	0

Source: CEDRU Survey, 2007.

Among the retired seniors that still carry out some sort of activity, and based on the valid answers obtained, about 68% of the individuals work for others (employees), 30% are self-employed and a lower percentage are non-paid family workers and employers.

² Adapeted from: "O envelhecimento em Portugal, situação sócio-demográfica", INE, 2002.

In 38% of the cases, the household income does not exceed 750 euros/month and in the sample the maximum number of members comprising the household is 8. However, the larger families/households are not the ones with higher incomes, which might reveal economic difficulties and hidden poverty (about 2% of the surveyed individuals live by themselves and have monthly incomes below 150€).

Table 9. Professional situation, 2007

Professional Situation	N.	%
Employee	169	57.7
Self-employed	87	29.7
Non-paid family worker	16	5.5
Employer	15	5.1
Unemployed	3	1.0
Others	2	0.7
Housewife	1	0.3
Sub-total	293	100
Did not answer/Not applicable	1,031	-
Total	1,324	-

Source: CEDRU Survey, 2007.

Table 10. Individuals in the household (in %), according to monthly income (euros), 2007

Monthly Income	No. of Individuals Per Household							Total
	0	1	2	3	4	5	8	
Up to 150	2	1	1	0	0	0	0	1
151-300	17	10	9	11	13	20	100	13
301-500	17	15	9	10	26	20	0	15
501-750	10	11	6	14	4	20	0	10
751-1000	5	8	14	13	9	0	0	8
1001-1,500	2	6	8	8	13	0	0	5
1,501-2,500	1	1	6	1.6	0	0	0	2
2,501-5,000	1	0	1	8	4	0	0	0.9
> a 5,001	0	0.9	1	3	0	0	0	0.8
Did not answer/Not applicable	44	45	45	32	30	40	0	43
Total	100	100	100	100	100	100	100	100

Source: CEDRU Surve, 2007.

According to some recent studies developed by INE, in Portugal the poverty indexes in households with elderly people are higher when compared to those without elderly people. Senior couples and those in which at least one of the members is an elderly are (in this order) the second and third groups that most experience poverty, according to income. If the poverty indexes are considered according to life conditions (goods deprivation by household), the situation remains the same.

Table 11. A few characteristics of the elderly population (65+ years old) and the poorer 10%, Portugal, 2000 (%)

Variables Analysis		Population aged 65 or over, in the poorer 10%	Population aged 65 or over, in the total population
Gender	Male	37.4	40.9
	Female	62.6	59.1
Health State	Very Good	0.0	0.2
	Good	4.3	7.0
	Reasonable	38.9	39.0
	Poor	48.0	42.4
	Very Poor	8.8	11.4
Instruction Level	None	72.1	54.4
	1st level of Basic Education	25.1	34.8
	2nd level of Basic Education	1.5	2.2
	3rd level of Basic Education	1.3	3.9
	Secondary Education	0.0	3.1
	Higher Education	0.0	1.6

Source: "Pobreza e exclusão social nas famílias com idosos em Portugal", Revista de Estudos Demográficos, n.º 35, INE.

Furthermore, the disparity in the structure of household incomes with and without elderly people is equally evident, because in the former the weight of the pensions is highly significant.

Table 12. Structure of the average annual net revenues per equivalent adult, according to the type of private domestic household (ADP), Portugal, 2000 (%)

Type of Income	Total ADP	ADP without elderly	ADP with Elderly					
			Total	Single Elderly	Elderly Couple	Couple with an Elderly	Rep Elderly+ others	Others with Elderly
TOTAL INCOME	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total of Money Income	85.9	86.2	85.2	81.5	83.3	85.8	88.4	88.5
Work Income	54.6	70.3	22.1	2.3	8.0	20.0	38.6	52.7
Pensions	23.4	7.5	55.2	71.8	69.9	58.0	42.8	28.5
Social benefits	2.5	3.0	1.4	0.8	0.2	2.3	2.0	2.5
Other monetary Income	5.4	5.3	5.5	6.7	5.1	5.5	5.0	4.8
Non-monetary Income	14.1	13.8	14.8	18.5	16.7	14.2	11.6	11.5

Source: "Pobreza e exclusão social nas famílias com idosos em Portugal", Revista de Estudos Demográficos, n.º 35, INE.

Table 13. Work earnings, pensions and social support, 2007 (%)

Work Earnings	%	Pensions	%	Social Support	%
0-250	4	0-150	2	0-150	25
251-500	28	151-300	30	151-300	50
501-750	21	301-500	30	301-500	19
751-1.000	24	501-750	17	> a 501	6
> a 1.001	23	751-1.000	10		
		> 1.001	11		

Source: CEDRU Survey, 2007.

In urban areas, public transports are the second major transport means used by seniors to move around, followed by the use of a private vehicle. In the rural context, apart from the private vehicle (still on top of the list), seniors use family vehicles and only then public (in case it exists) means of transport.

Table 14. Transport means, 2007

Transport	No.	%
Private vehicle	504	38
Public transports	338	26
Family vehicles	127	10
On foot	99	7
Private vehicle and Public transports	43	3
Family vehicles and Public transports	43	3
Other	26	2
Other mix of transport means	22	2
Public transports and on foot	19	1
Family vehicles and taxi	15	1
Taxi	14	1
No answer/Not applicable	74	6
Total	1324	100

Source: CEDRU Survey, 2007.

According to the household typology, a major proportion of seniors live with their spouse (48%), although those who live alone also present a significant share (31%).

When compared with the national survey - INE, 2001 - 32.5% of Portuguese families include an aged member, while the families with just one senior account for 17.5% of the total. Considering just the families of senior(s), 50.5% have only one senior and 48.1% have two seniors.

Table 15. Household typology, 2007 (%)

Typology	%
Senior and spouse	48
Senior only	31
Senior couple with descendents	13
Senior with descendents	5
Other	1
No answer	1
Senior with another aged member	1
Senior couple with another aged member	0.5

Source: CEDRU Survey, 2007

Another perspective points out the fact that although the majority of the surveyed seniors are not taking care of aged people, the percentage of those who do is rather significant. These situations are quite concerning because, in most cases, the dependents are older than the caregivers.

Table 16. Seniors taking care of aged dependents, by age, 2007 (%)

Aged Dependents	55-64	65-74	75-84	85+
Yes	8	4	3	2
No	92	96	97	98

Source: CEDRU Survey, 2007.

As Roman Catholic Christianity is the most representative religion in Portugal, the sample also reflects the following reality: around 89% of seniors profess this religion.

Table 17. Professed religion, 2007

Professed Religion	Total	%
Roman Catholic	1179	89.0
Atheist	74	5.6
Other	53	4.4
Did not answer/Not applicable	18	1.4
Total	1324	100.0

Source: CEDRU Survey, 2007.

2.2. Multiple Correspondence Factor Analysis (MCFA)

2.2.1. Methodological Outline

The survey conducted on behalf of the present study, consisting of eight groups of questions, has made it possible to characterize the target population according to social and demographic features and unmet needs.

The exploitation and description of the results of the survey were supported by the execution of a Multiple Correspondence Factor Analysis (MCFA) from Burt's tables. These tables are a result of the crossing of each question and its several modes, being translated into: n analysis units, surveyed individuals, m variables, each one of the questions and k states, each one of the answer types to each question.

However, at first glance, it suggested a high redundancy of the values, since the descriptors' reduction was considered. For that purpose, the questions related to the description of the individual's social, demographic and economic characteristics were separated from the questions related to the description of their needs and consumer habits.

Next, a Principal Components Analysis (PCA) was applied to these two sets, bearing in mind the reduction of the redundancy, translated in the decrease of the number of variables analyzed. The result of the two analyses made it possible to choose 49 questions, or variables, that best characterize the universe under study: the 1,324 respondents. This was then followed by the application of a MCFA on this set of questions, whose results were analyzed.

2.2.2. Multiple Correspondence Factor Analysis (MCFA) Application

Principal Components Analysis (PCA)

From the survey conducted to the Portuguese senior population, a grid of descriptors was defined, which were separated into two sets of variables and questions. The goal was to obtain a social and economic characterization of the needs and consumer habits of the target population. Subsequently, PCA was applied to these two sets of questions and variables. Its purpose was to reduce redundancy, given the high number of variables used in the survey. Thus, in a first stage, it was immediately possible to obtain a group of principal components to characterize the target population.

↘ As far as the economic, social and demographic characterization is concerned:

- The Portuguese senior population, whose working situation is pensioner, is mostly in a situation of inactive retirement;
- Among the Portuguese senior population that lives in Predominantly Urban Areas (APU), building/apartment housing types prevail;

- It is among the senior population that lives in their own house that the greater number of rooms is observed;
 - Within the target population's profile, the widows prevail;
 - There is a strong correlation between the senior population whose lodgings appear to be in a good state of preservation and those whose household has rather high monthly incomes.
- ↳ In terms of the needs, habits and lifestyles characterization, the following correlations must be emphasized:
- Among the Portuguese senior population that does not have cultural activity habits in their leisure time (such as studying, using the Internet, participating in cultural events, going to libraries, practicing sport or hobbies, participating in recreational activities) with those who do not have volunteering culture habits;
 - There is a strong correlation between the senior population that resides in their own house and those who more often carry out domestic tasks, such as shopping, meals preparation and house cleaning;
 - As far as health care is concerned, there is a strong inverse correlation between the frequency of use of health care, irrespective of it being primary or secondary, and the degree of satisfaction with the provision of these services. In fact, among the Portuguese senior population that most resorts to the health care centre, there is an overall sense of dissatisfaction with both this service and hospitals;
 - There is a strong correlation between the type of occupation regarding leisure time and the senior population's perception of their state of health. The highest degree of dissatisfaction regarding leisure time was observed among the senior population that does not travel frequently. In addition, it is also among this segment of the target population that the most negative perceptions concerning the evaluation of their state of health subsist;
 - The Portuguese senior population presents a considerable degree of autonomy, insofar as it usually does not benefit from support for the execution of their tasks. Consequently, there is a strong correlation between those who do not benefit from support for their domestic tasks, and those who do not benefit from support regarding mobility in the access to health care. This aspect cannot be dissociated from the methodology of the survey (conducted on the street and to a reduced number of individuals in a situation of greater dependency), but also because demographic ageing is a relatively recent trend in the Portuguese society;
 - The Portuguese senior population does not typically use primary and secondary health care services. There is a strong correlation between those who do not use one type of care and who do not use the other. If this factor is somehow associated to a lesser need for health care, on the other hand, it is associated to a weak culture of disease prevention and health promotion, in favour of behavior related to using medical care, mostly in situations of an actual disease.

Multiple Correspondence Factor Analysis (MCFA)

Based on these two PCA, 49 variable/questions were selected, considered those that best described the universe of the study's target population (the 1,324 surveyed seniors). Subsequently, MCFA was applied to this group of variables so as to allow, in a simpler and immediate manner, the identification of the main system of interdependency among the variables, and thus characterize the target population. Consequently, the noise and redundancy are minimized, since the survey offered a large set of data),

thus characterizing the target population. According to the results from the MCFA, a set of strong correlations was identified, making it possible to characterize the Portuguese senior population (into two large groups) with the following aspects standing out.

Leisure Time Occupation

- The Portuguese senior population that is involved in volunteer work during leisure time in general also goes to libraries, studies, uses the Internet, has a hobby and plays sport, participates in cultural events and is a member of recreational associations. The target population that has a greater volunteer culture is the one that is mostly dedicated to associativism that plays sport, values the participation in cultural events, and thus presents an active ageing lifestyle. It should be noted that the senior population that presents this profile usually has a high income, since there is a strong correlation between the practice of these activities in the occupation of leisure time and a household's total average monthly income higher than 1,501€ (the top income tax rate);
- Generally, the execution of domestic tasks (preparing meals, house cleaning and shopping) among the Portuguese senior population is still mainly undertaken by women. In addition, there is a strong correlation between these variables and the fact that male partners in an unmarried union generally have their meals at their relatives' houses.

Accessibility to Health Care

- There is a strong correlation between the level of education of the senior population and the behavior adopted when accessing health care. Particularly, it is among the target population with the highest level of education (mainly regarding secondary school) that there is a specific pattern of use of the health care services: a greater concern with the promotion of health in detriment of health care in an actual situation of disease. This is explained by the strong correlation between the variables level of education with secondary school attendance with a regular frequency of use of the health centre. Furthermore, it is important to point out that the greatest degree of dissatisfaction with primary health care is among this segment of the target population, which is a reflection both of its greater use and the higher levels of education, and thus the demand is greater;
- It is among older individuals (aged 85+ years) that states of health are more vulnerable. Consequently, this is the segment of the target population most frequently in institutionalization situations and that uses hospitals more often. The strong correlation between these three variables illustrates the significant association between ageing and state of health deterioration, loss of autonomy and greater dependency;
- Another strong correlation between the social and demographic components and access to health care is the fact that seniors in an unmarried union and with a working situation of "housewife" are among those who most frequently use the hospital.

Working Situation/Employment Status

- Seniors aged between 55 and 64 years are those whose working situation is most active, which would be expected, insofar as 65 years olds are a turning point in the transition towards retirement. It is also among this age group that the financial situation is more advantageous, since there is a correlation between these two variables and the two pre-defined higher typologies of average monthly income for the household (between 751€ and 1,500€ and higher than 1,501€);
- On the other hand, individuals whose work situation is “unemployed” or who have a precarious working situation are one of the most vulnerable groups when it comes to social and economic terms. This frailty is a result of a set of circumstances, namely: precarious working situation and illiteracy. This reveals a set of limitations, such as living in loan-regime housing;
- As expected, it is among the senior population with higher levels of education (higher education) that the total average monthly income of the household is higher (more than 1,501€), inasmuch as there is a strong correlation between these variables;
- There is a strong correlation between financial income and the working situation, when it comes to pensioners. In fact, the majority of the senior population with a higher total average monthly income (> to 1,501€) is in an active retirement situation;
- Senior individuals whose working situation is housewife are most predominant in Predominantly Rural Areas (APR) and in Medium Urban Areas (AMU).

Housing

- There is a strong correlation between seniors in an unmarried union and the loan-free regime lodging situation. Simultaneously, individuals with this marital status also present a strong correlation with a more degraded state of the lodgings. Additionally, the more degraded lodgings present a strong correlation with precarious working situations or even unemployment. There is also a strong association between the demographic and socio-economic variables, which somehow correspond to more vulnerable realities, with incapability to carry out repair and preservation work in the lodgings;
- Furthermore, seniors in an unmarried situation reside in small lodgings, for there is a strong correlation with one-room lodgings;
- In the working situation with the typology, “other”, unemployed individuals stand out and present a strong correlation with the loan-free occupation regime. The strong connection between these variables is an obvious result of the precarious economic situation and subsequent financial difficulty to buy a house or obtaining a renting situation.

2.3. Analysis of the main sub-groups of the senior population

Bearing in mind the existing reference bibliography (which is focused on the population-ageing theme), the results of the MCFA and the overall results of the national survey made to the population, five variables were selected. These variables were considered of the utmost interest in the characterization process of the senior population, namely: age, income, household composition, gender and *Tipologia das Áreas Urbanas* (TAU) - Urban Area Type. This selection occurs as these are key-variables and allow the segmentation of the senior population, providing thus a global picture of the senior population

residing in Portugal. Each of these variables comprises a target-public and for each one a thorough analysis was carried out, sustained in the crosscut with a set of determinant variables in order to characterize it in its timeliness.

From this individualized analysis, a summarized evaluation template for the sub-group set was developed, indicating the more and less vulnerable, dependant and active ageing segments of the senior population. This template's goal is to validate the heterogeneity of the senior population, to identify the needs and aspects that most influence their well-being and more relevant trends in each one of the segments

2.3.1. 1st sub-group based on age

Age is a rather pertinent variable, for simultaneously to the increase in age, there is a biological process characterized by the decline of the individual's functional capacities, which generates differentiated needs according to age.

Associated to the age factor, there are significant disparities regarding the housing context. It is possible to infer that the younger seniors are the ones who mostly reside in their own homes. This lodging occupation regime tends to decrease as ages increases. The total rent lodging, although not substantially distinct among the several age groups, is a more relevant reality when it comes to older individuals.

As far as the dimension of the lodging is concerned, even though not evidencing many differences based on age, the individuals aged between 55 and 64 years are the ones residing in houses with a larger number of rooms (50.2% lives in houses with 2 to 3 rooms and 46.1% with 4 or more rooms). Only 1.6% lives in smaller houses (between 0 and 1 rooms). On the contrary, older individuals - aged 85+ years - although residing mostly in lodgings with 2 to 3 rooms (52.7%), have the lowest values when compared to the remaining age groups. In addition, the seniors from this age group are the ones who most reside in lodgings with 0 to 1 room (3.6%) and it is important to point out that this group presents the second most significant proportion of residence in large dimension lodgings (40% resides in lodgings with 4 or more rooms), which is related to a higher institutionalization occurrence.

The state of preservation of the lodging is an important indicator, because it illustrates the individuals' housing conditions. Thus, seniors belonging to a younger age group are the ones that benefit from the better conditions in terms of the building's preservation, since 53.7% considers living in lodgings with a good state of preservation (a substantially higher value, when compared to the remaining age groups) and only 3.7% thinks their lodging is in a degraded state and that it needs repairing (this is the lower registered value). In terms of the remaining age groups, although the disparities are not quite relevant, it is worth mentioning that the number of degraded lodgings increases with age, so that 10.9% of the individuals aged 85+ years live in degraded lodgings. Furthermore, the state of preservation of the lodgings in need of repairs presents higher values among the older age groups.

Table 18. Housing context, according to age group, 2007 (%)

Age Groups	Lodging Occupation Regime		Rooms of the Lodging			Lodging's State of Preservation				Total (N.)
	Own house	Total rent	0-1	2-3	> 4	Good	Reasonable	In need of Minor Repairs	Degraded (in need of major repairs)	
55-64	67.7	28.6	1.6	50.2	46.1	53.7	30.4	10.6	3.7	434
65-74	65.0	30.2	1.0	64.0	33.0	36.0	41.6	15.2	4.2	500
75-84	58.0	32.3	2.4	68.9	23.3	29.9	39.9	18.7	6.0	331
85+	58.2	30.9	3.6	52.7	40.0	38.2	32.7	16.4	10.9	55
NR	50.0	50.0	0.0	50.0	50.0	25.0	50.0	25.0	0.0	4
Total	63.8	30.3	1.7	60.2	35.2	40.3	37.2	14.7	4.8	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

The analysis of the economic profile is upheld by three analysis factors considered quite illustrative of the senior population's economic reality. The first corresponds to the situation of individuals regarding work, in case they are already pensioners. In fact, there is a positive and strong correlation between the increase in age and the increase in the proportion of inactive individuals. Seniors aged up to 64 years present the lowest incidence of inactivity (33.4%), as they are in the age group that precedes retirement. In comparison to the following age group, the proportion of those who are not active increases considerably (77.6% of the individuals between aged 65 and 74 years do not work). Notwithstanding, it is in the older age groups that a higher number of individuals ceased to work, and the seniors aged 85+ years (87.3%) are the ones who stand out. Closely associated to this aspect, it is important to take into account the fact that the exclusive source of income of most seniors is their pension, which significantly decreases their financial capacity.

Regarding the structure of the total average monthly incomes, the senior population as a whole mostly has low and reduced incomes. Most of the relevant asymmetries occur in terms of the lower incomes: as age increases, there is a significant rise in the number of individuals who live with incomes lower than 300€ per month. If among individuals aged between 55 and 64 years only 7.8% is in this specific situation, among the very old (85+ years old) that reality is as high as 29.1%. Consequently, the older seniors are the ones who live below the poverty threshold (in Portugal, the poverty threshold is the value indicated by DGEEP's study of 2006, expressed in purchasing power parity, and corresponds to 4,967€ a year).

As far as the structure of the total average monthly incomes is concerned, in all of the age groups, expenses lower than 300€ per month are paramount. However, it is among the seniors up to the age of 64 years that the higher expenses are recorded (32.7% have monthly expenses ranging from 301€ to 750€ and 10.4% from 751€ to 1,500€), which cannot be detached from the fact that this age group presents an equally higher structure of the total average monthly incomes.

Table 19. Economic profile, according to age group, 2007, (%)

Age Groups	Situation Regarding Work, in the Case Of Pensioners	Structure of the Total Average monthly Income (€)				Structure of the Total Average monthly Expenses (€)				Total (N.)
	Non Active	<300	301-750	751-1,500	>1,501	<300	301-750	751-1,500	>1,501	
55-64	33.4	7.8	22.6	23.3	7.1	34.1	32.7	10.4	0.5	434
65-74	77.6	15.2	27.8	10.4	1.8	41.8	23.6	4.6	0.4	500
75-84	86.1	18.1	25.1	6.9	0.9	39.9	21.5	4.2	0.0	331
85+	87.3	29.1	36.4	5.5	5.5	43.6	10.9	5.5	0.0	55
NR	75.0	25.0	50.0	0.0	25.0	25.0	50.0	0.0	0.0	4
Total	65.6	14.1	25.8	13.5	3.5	38.7	25.6	6.4	0.3	1,324

Source: CEDRU Surveys, 2007

Legend: NR - Did not answer; NSA - Not applicable

Within the scope of family dynamics, the first aspect worth mentioning is the significant dichotomy based on age, highlighting the fact that the family household typology couple living with descendants reveals a higher relevance among the younger seniors (28.6%) and it is quite reduced in the remaining age groups. On the other hand, the senior living alone typology is much more significant among older seniors (58.2% among individuals aged 85+). The family household typology senior living with spouse is more relevant among the intermediate age groups, namely those between 64 and 74 years old and 75 and 84 years old, since they are at a stage in life when their descendants no longer live with them.

The previous conclusion is validated by the analysis of the contact frequency with their children, for it is among younger seniors that the frequency is more regular (68%), decreasing among the older seniors

(in the remaining age groups, it varies between 51.1% and 52.7%). On the contrary, the more infrequent contacts among senior parents and their children present the inverse pattern, i.e., lower among seniors aged up to 64 years and higher in the remaining age groups. However, it is the age group between 75 and 85 years old that the situation is less positive, of more isolation. This happens because at this age generally these individuals no longer have their children living with them, but they are still sufficiently independent, which might generate less contact with direct descendants.

Table 20. Family dynamics, according to age group, 2007

Age Groups	Family Household Typology			Contact Frequency with Children			Total (N.)
	Couple with Descendants	Senior Living with Spouse	Senior Living Alone	Regular	Occasional	Rare	
55-64	28.6	40.8	20.7	68.0	15.9	3.9	434
65-74	7.0	59.8	26.4	52.0	27.6	9.8	500
75-84	2.1	41.4	48.6	51.1	23.9	9.4	331
85+	3.6	27.3	58.2	52.7	27.3	7.3	55
NR/NSA	25.0	25.0	25.0	25.0	25.0	0.0	4
Total	12.8	47.5	31.4	56.9	22.8	7.6	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

The analysis of the assistance and support provided for the accomplishment of a vast series of tasks clearly individualizes the senior sub-group of 85+, for these are the ones mostly in need of the support from family, friends, neighbors, institutions, State and other formal or informal caregivers. Furthermore, this sub-group's need for support becomes more intensified when it comes to basic care, such as domestic tasks (41.8%), personal care (29.1%), health care (25.5%) and mobility (25.5%).

In regard to the sub-group of younger seniors, there is an increase in the assistance provided at all levels as age increases. The group aged between 55 and 64 years is therefore the one that need less help.

As far as the intermediate age groups are concerned, there is a significant difference among them, since individuals between 75 and 84 years old clearly require greater assistance.

Table 21. Support provided, according to age group, 2007 (%)

Age Groups	Support/Assistance Typology from which they benefit						Total (N.)
	Domestic Tasks	Personal Care	Financial Help	Mobility	Health Care	Leisure	
55-64	17.5	5.5	7.4	6.9	10.1	9.0	434
65-74	15.4	7.0	8.0	7.0	12.4	8.2	500
75-84	23.9	12.4	10.9	13.0	14.5	8.8	331
85+	41.8	29.1	10.9	23.6	25.5	12.7	55
NR/NSA	0.0	0.0	0.0	0.0	0.0	0.0	4
Total	19.3	8.8	8.6	9.1	12.7	8.8	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

The population's state of health is strongly influenced by the age variable, since the age increase is closely associated to the loss of functional capacities and a higher occurrence of pathologies. Thus, even if the existence of pathologies is significant in the entire senior population, regardless of their age, in both younger age groups this occurrence does not reach half of the population, while among individuals between 75 and 84 years old, more than half of the population confirms having some pathology (58.9%). This value increases considerably when it comes to the older seniors (63.6% of the population aged 85+ presents a disease).

In articulation with the acknowledgement or not of the disease, the evaluation of the target population's perception of their state of health varies significantly. Consequently, the evaluation of a good state of health is higher among the younger individuals and decreases considerably as age increases, while the evaluation of a poor state of health typifies the opposite trend.

Table 22. State of health, according to age group, 2007 (%)

Age Groups	Pathology Present			State of health Evaluation				Total (N.)
	Yes	No	Did not answer	Good	Reasonable	Poor	Did not answer	
55-64	45.9	53.5	0.7	40.3	52.8	6.2	40.3	434
65-74	47.4	51.2	1.4	36.6	58.0	4.2	36.6	500
75-84	58.9	39.9	1.2	26.9	59.8	11.5	26.9	331
85+	63.6	32.7	3.6	25.5	54.5	16.4	25.5	55
NR/NSA	75.0	25.0	0.0	25.0	75.0	0.0	25.0	4
Total	50.5	48.3	1.2	34.9	56.6	7.2	34.9	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

The manner in which the senior population occupies their leisure time varies according to a multiplicity of variables, such as health, income, education, among others. It is also limited by the age variable, since the younger populations are generally associated to higher levels of mobility and better states of health. In fact, it is among the younger senior population that there is a greater habit of traveling and higher associativism, contrasting with the extremes of the age pyramid under analysis. At this level, the intermediate age groups present more homogenous behaviors.

Notwithstanding, and regarding the degree of satisfaction with leisure time, the intermediate age groups are precisely the ones that reveal a more complete satisfaction, while those between 55 and 64 years old, as well as those aged 85+, display similar realities as those who are less "totally satisfied", more "unsatisfied" and "totally satisfied".

Table 23. Leisure time, according to age group, 2007 (%)

Age Groups	Travels often	Degree of Associativism		Leisure Time Satisfaction				Total (N.)
	Yes	Significant	Null	Totally Satisfied	Satisfied	Unsatisfied	Totally Unsatisfied	
55-64	58.3	6.7	67.3	7.4	68.7	9.4	1.4	434
65-74	44.6	4.2	66.0	10.4	73.2	8.0	0.6	500
75-84	38.4	4.5	69.5	11.5	72.8	8.8	0.3	331
85+	14.5	3.6	61.8	7.3	74.5	10.9	1.8	55
NR/NSA	50.0	0.0	75.0	25.0	75.0	0.0	0.0	4
Total	46.3	5.1	67.1	9.6	71.7	8.8	0.8	1,324

Source: CEDRU Surveys, 2007

Legend: NR - Did not answer; NSA - Not applicable

The analysis of the use of health and social collective infrastructures is essential for the assessment of the needs and dependency of individuals.

As far as health infrastructures are concerned, primary health care is mostly used by intermediate age groups, with quite similar realities, while differentiated health care is generally used by older seniors (61.8% of individuals aged 85+ uses this form of health care). This occurs as result of the younger age groups' demand for prevention medical services, going to routine doctor's appointments, whereas the older age groups look for these services mainly in emergencies, which explains the higher use of hospitals.

The frequency of use of health care on a monthly basis is consistent with the previous analysis (the monthly frequency was selected because it is the most relevant for the analysis, since lower and higher usage frequencies could not so markedly display the disparities among the various sub-groups). Thus, individuals aged 85+ are the ones who mostly resort to hospitals as well as to health centers on a monthly basis, which proves that they do not use these services in routine situations. Younger seniors are effectively those who use health care less.

As far as social infrastructures are concerned, two social responses were selected for the analysis (the day care centre and the socialization centre, for being the most used at a national level). The use of both of these social responses tends to increase as age increases, displaying a remarkable contrast between younger and older age groups. Among the younger age groups, although the disparities are not striking, the 85+ age group is rather well individualized when compared to the upper uses.

Table 24. Health and social use of collective infrastructures, according to age group, 2007 (%)

Age Groups	Often uses		Monthly usage frequency		Often uses		Total (N.)
	Health Centre	Hospital	Health Centre	Hospital	Day Care Centre	Socialization Centre	
55-64	78.3	54.8	12.9	3.0	2.1	2.1	434
65-74	85.2	55.8	15.4	1.2	1.2	2.0	500
75-84	86.7	54.1	18.1	2.1	4.2	2.1	331
85+	72.7	61.8	27.3	5.5	7.3	5.5	55
NR/NSA	75.0	50.0	0.0	0.0	0.0	0.0	4
Total	82.8	55.3	15.7	2.2	2.5	2.2	1,324

Source: CEDRU Surveys, 2007

Legend: NR - Did not answer; NSA - Not applicable

2.3.2. 2nd sub-group based on income

Income was the second variable considered, for it considerably restricts a wide set of aspects in the life of individuals.

The senior population's housing context is one of the spheres more strongly influenced by the target population's economic capacity. Consequently, although there is a global tendency for the acquisition of own house in detriment of other forms of occupation, it is among the seniors with the lower average monthly incomes (lower than 300€) that the own house occupation regime is less expressive (50.8%) and the total rent lodging is more significant (39%). With the increase in income, there is an inversion of this pattern of lodging occupation, i.e., there is a higher tendency among the senior population to reside in their own house and less incidence in total rent situations.

The individuals' economic capacity is also closely associated to the size of the smaller lodgings (between 0 and 1 room) are less frequent as the structure of the average monthly income rises, while larger lodgings (with 4 or more rooms) depict an inverse profile, since it increases as the individuals' economic capacity also increases.

In addition, the lodging's state of preservation portrays a strong correlation with the target population's economic capacity. This can be demonstrated by the fact that 80% of the individuals with average monthly incomes higher than 1,500€ have their own lodgings in a good state, and there are no records of degradation situations. On the opposite side, those who live in the poverty threshold (with average monthly incomes equal to or lower than 300€), are the sub-groups with less lodgings in a good state and more lodgings in need of minor repairs and degraded state of preservation (needing major repair work).

Table 25. Housing context, according to income structure, 2007 (%)

Structure of the Total Average monthly income (€)	Lodging Occupation Regime		Rooms of the Lodging			Lodging's State of Preservation				Total (N.)
	Own House	Total Rent	0-1	2-3	>4	Good	Reasonable	In need of minor repairs	Degraded (in need of major repairs)	
Up to 300	50.8	39.0	3.7	65.2	26.7	26.2	36.9	24.6	7.5	187
301-750	66.1	26.6	2.3	63.2	31.0	33.9	40.4	17.3	4.7	342
751-1,500	82.1	15.6	1.1	48.0	49.7	58.7	32.4	6.1	1.7	179
> to 1,501	83.0	14.9	0.0	27.7	68.1	80.9	14.9	4.3	0.0	47
NR	59.4	35.5	0.9	63.3	33.2	39.7	38.7	13.4	5.3	569
Total	63.8	30.3	1.7	60.2	35.2	40.3	37.2	14.7	4.8	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

It is important to point out that among the target population, as the economic capacity increases, so do the situations in terms of active work, even when it comes to pensioners. In fact, it is among those with average monthly incomes equal to or lower than 300€ that there are less individuals working after retirement (6.3%); and it is among those with incomes equal to or higher than 1,501€ that there is a larger proportion of active people (33.3%). Hence, it is concluded that individuals with poorer financial resources are also those who most exclusively depend on retirement pensions to survive, which deteriorates their poverty situation.

Unsurprisingly, it is easy to conclude that the higher the income, the higher the purchasing power and therefore the expenses.

Table 26. Economic profile, according to income structure, 2007 (%)

Structure of the Total Average Monthly Income (€)	Situation in terms of work, in the case of pensioners	Structure of the total average monthly expenses (€)				Total (N.)
	Active	< 300	301-750	751-1,500	> 1,501	
Up to 300	6.3	56.1	10.7	0.5	0.0	187
301-750	10.0	48.5	31.9	0.6	0.0	342
751-1,500	17.0	24.6	51.4	9.5	1.7	179
> to 1,501	33.3	14.9	29.8	46.8	0.0	47
NR	6.3	16.2	19.5	0.0	0.0	569
Total	8.9	4.6	5.4	0.0	0.0	1,324

Source: CEDRU surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

With regard to family dynamics, the household typologies of couple with descendants are more common among seniors that receive higher average monthly incomes (24% receive between 751€ and 1,500€ and 36.2% receive 1,500€ or more), whereas economically more deprived individuals are also those who generally live alone (46.5% of the individuals whose average monthly incomes are equal to or lower than 300€ live alone). Simultaneously, the more economically deprived the senior, the less regular the contact frequency with the children. In fact, it is among the poorer senior population that lives in isolation and has less contact with their direct descendants, as the economic capacity increases, that there is a larger proportion of those who live with someone and have regular contact with their children.

Table 27. Family dynamics according to income structure, 2007 (%)

Structure of the Total Average monthly income (€)	Household Typology			Contact Frequency with Children			Total (N.)
	Couple with Descendants	Senior Living with Spouse	Senior alone	Regular	Occasional	Rare	
Up to 300	4.3	37.4	46.5	51.9	23.0	9.6	187
301-750	7.9	48.2	33.9	61.1	21.9	6.7	342
751-1,500	24.0	50.3	18.4	68.7	13.4	3.9	179
> to 1,501	36.2	36.2	19.1	70.2	14.9	2.1	47
NR / NSA	13.0	50.4	30.1	51.3	26.9	9.1	569
Total	12.8	47.5	31.4	56.9	22.8	7.6	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

The assistance and support provided is greater overall among the more financially deprived senior population, with the individuals' financial capacity determining their dependency level in many aspects. However, as far as the health care typology is concerned, there are no striking disparities in terms of income. Regarding leisure, the most deprived individuals are those who less benefit, since they live below the poverty threshold and therefore only a few can afford leisure activities.

Table 28. Support from which benefits, according to income structure, 2007 (%)

Structure of the Total Average Monthly Income (€)	Support/Assistance Typology from which they benefit						Total (N.)
	Domestic Tasks	Personal Care	Financial Help	Mobility	Health Care	Leisure	
Up to 300	25.7	13.9	19.3	15.0	15.5	9.6	187
301-750	21.9	12.3	8.5	12.0	19.0	14.6	342
751-1,500	19.6	8.9	3.9	7.3	16.8	8.9	179
> to 1,501	19.1	4.3	0.0	6.4	14.9	10.6	47
NR	15.5	5.3	20.2	6.3	6.5	4.7	569
Total	19.3	8.8	5.4	9.1	12.7	8.8	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

Poor housing conditions, nutrition, work and life in general are associated to low economic income, as well as to lower education levels. Consequently, there is less information, particularly when it comes to health care and healthier lifestyles. The combination of these factors ends up causing negative impacts on the individuals' health, mainly evident when they are in an older stage in life. It is therefore plain that the seniors living in poverty situations are those who present a higher occurrence of pathologies (63.1% with average monthly incomes equal to or lower than 300€ declares having a disease).

Notwithstanding, if individuals with lower incomes are substantially highlighted when it comes to the existence of a disease, among the remaining economic groups, this difference is not as remarkable. On the other hand, and regarding the evaluation of the perception of their states of health, there is a greater correlation with the individuals' incomes. Consequently, it is clear that the higher the senior population's financial capacity, the more significant the evaluation of a good state of health. Simultaneously, the more deprived seniors are those who generally evaluate their state of health as reasonable and poor.

Table 29. State of health, according to income structure, 2007 (%)

Structure of the Total Average Monthly Income (€)	Pathology Present			State of health Evaluation				Total
	Yes	No	Did not Answer	Good	Reasonable	Poor	Did not answer	
Up to 300	63.1	33.7	3.2	18.7	67.4	10.7	3.2	187
301-750	51.8	47.1	1.2	28.1	63.5	7.9	0.6	342
751-1,500	44.7	53.6	1.7	34.6	60.3	3.4	1.7	179
> to 1,501	53.2	46.8	0.0	38.3	55.3	6.4	0.0	47
NR	47.3	52.2	0.5	44.1	48.0	6.9	1.1	569
Total	50.5	48.3	1.2	34.9	56.6	7.2	1.3	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

The individual's economic capacity has considerable influence on his leisure time activities and thus it is understandable that traveling habits are more frequent the higher the income. Hence there is is justified that there is a differentiated reality among those who have average monthly incomes equal to or lower than 300€ (19.8% often travels) and those who have average monthly incomes equal to or higher than 1,501€ (85.1% often travels).

Similarly, those individuals who have greater financial capacity are the ones who are most dedicated to associativism (among those who have average monthly incomes equal to or lower than 300€, only 2.1% have a significant degree of associativism and 67.4% none at all; while among those that have total average monthly incomes equal to or higher than 1,501€, the associativism percentage is the highest: 17%).

Reflecting upon the degree of satisfaction of leisure time activities, there is a direct correlation between the increase in incomes and the increase of the individuals' satisfaction (14,9% of the individuals with incomes equal to or higher than 1,501€ per month and 5,9% with incomes lower than 300€).

Table 30. Leisure time, according to income structure, 2007 (%)

Structure of the Total Average Monthly Income (€)	Often travels	Degree of Associativism		Leisure Time Satisfaction				Total (N.)
	Yes	Significant	Null	Totally Satisfied	Satisfied	Unsatisfied	Totally Unsatisfied	
Up until 300	19.8	2.1	67.4	5.9	69.5	11.2	0	187
301-750	40.4	4.4	60.8	9.6	71.3	10.8	0.6	342
751-1,500	64.8	15.1	50.8	10.1	68.7	12.8	0.6	179
> to 1,501	85.1	17	57.4	14.9	74.5	4.3	2.1	47
NR	49.6	2.3	76.8	10.2	73.3	5.8	1.2	569
Total	46.3	5.1	67.1	9.6	71.7	8.8	0.8	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

As far as the usage of collective health infrastructures is concerned, there is a dichotomy in the type of medical care, based on income. Consequently, among the more deprived senior population there is a higher and more frequent use of primary health care, whilst the target population with a higher financial capacity tends to use the differentiated health care.

As for social infrastructures, although there are no dichotomies based on income, the day centre and the socialization centre are mostly used by individuals with lower financial capacities. Those who have better resources have a wider range of similar services.

Table 31. Health and social collective infrastructures usage according to income structure, 2007 (%)

Structure of the Total Average Monthly Income (€)	Often uses		Monthly usage frequency		Often uses		Total (N.)
	Health Care Centre	Hospital	Health Care Centre	Hospital	Day Care Centre	Socialization Centre	
Up to 300	84.0	57.8	22.5	3.7	4.8	5.3	187
301-750	87.4	63.7	16.1	1.2	1.5	1.5	342
751-1,500	84.9	66.5	16.8	2.2	1.1	3.4	179
> to 1,501	74.5	70.2	10.6	8.5	2.1	2.1	47
NR	79.6	44.6	13.4	1.8	2.8	1.2	569
Total	82.8	55.3	15.7	2.2	2.5	2.2	1,324

Source: CEDRU Surveys, 2007

Legend: NR - Did not answer; NSA - Not applicable

2.3.3. 3rd sub-group based on household composition

In terms of the household variable, there are also important differences in a set of spheres of the senior population's life, leading to specific needs.

The analysis of the housing context based on the household composition introduces a set of discrepancies: in the first place, seniors with dependent children are the only typology in which more than half of the population does not live in their own house. It is also worth mentioning that it is among seniors living with a dependent senior, followed by seniors living with descendants and seniors living alone that total rent situations are mostly predominant (44.4%, 36.8% and 36.5%, respectively).

With regard to the size of the lodging, the senior living with descendants typology, followed by senior living alone are the ones with more expression in terms of lodgings with 0 to 1 rooms.

As for the state of preservation of the lodging, seniors who live alone and those who live with their children are the household typologies that live in the worst housing conditions. When it comes to seniors living alone, there is a smaller amount of lodgings in a good preservation state (30.8%) and the second higher incidences of lodgings in need of minor repairs and in a degraded state, in need of major repair work (20.2% and 6.5%, respectively). The senior typology living with descendants also shows housing difficulties, which is proven by the fact that it is the second typology with fewer houses in a good preservation state (39.7%) and more degraded too, in need of major repair work (11.8%).

Table 32. Housing context, according to household composition, 2007 (%)

Household Composition	Lodging Occupation Regime		Rooms of the Lodging			Lodging's State of Preservation				Total (N.)
	Own house	Total rent	0-1	2-3	>4	Good	Reasonable	In need of Minor Repairs	Degraded (in need of major repairs)	
Couple living with descendants	69.2	28.4	1.2	37.3	60.9	57.4	31.4	6.5	3.6	169
Couple living with senior	66.7	33.3	0.0	33.3	66.7	50.0	33.3	16.7	0.0	6
Senior living with descendants	47.1	36.8	7.4	39.7	51.5	39.7	30.9	17.6	11.8	68
Senior living with senior	55.6	44.4	0.0	55.6	44.4	44.4	11.1	44.4	0.0	9
Senior living with spouse	72.2	25.4	0.3	64.9	32.8	42.1	41.0	11.6	2.9	629
Senior living alone	52.4	36.5	2.6	67.3	24.3	30.8	37.3	20.2	6.5	416
Other	44.4	44.4	11.1	50.0	38.9	33.3	11.1	33.3	11.1	18
NR	77.8	22.2	0.0	33.3	66.7	44.4	0.0	33.3	22.2	9
Total	63.8	30.3	1.7	60.2	35.2	40.3	37.2	14.7	4.8	1,324

Source: CEDRU Surveys, 2007

Legend: NR - Did not answer; NSA - Not applicable

Within the scope of the economic profile, it is important to point out that it is among the couple living with senior and senior living with spouse household typologies that the situations of active work occur

most frequently, after retirement (16.7% and 8.6%, respectively) and for this reason, they present extra sources of income besides their pensions.

The structure of the total average monthly income shows that the couples living with a dependant senior and those living alone subsist below the poverty threshold. On the other hand, households made up of a couple living with descendants hold the higher total average monthly incomes (10.1% is higher than 1,501€). Subsequently, both household typologies are those that present the lower total average monthly expenses (equal to or lower than 300€).

Table 33. Economic profile, according to household composition, 2007 (%)

Household Composition	Situation Regarding Work, in Case of Pensioners	Structure of the Total Average Monthly Income (€)				Structure of the Total Average Monthly Expenses (€)				Total (N.)
	Active	<300	301-750	751-1,500	> 1,501	<300	301-750	751-1,500	> 1,501	
Couple living with descendants	6.5	4.7	16.0	25.4	10.1	29.0	39.6	13.6	0.0	169
Couple living with senior	16.7	33.3	0.0	16.7	0.0	16.7	16.7	16.7	0.0	6
Senior living with descendants	5.9	16.2	33.8	10.3	1.5	30.9	32.4	5.9	0.0	68
Senior living with senior	0.0	11.1	22.2	11.1	0.0	55.6	11.1	0.0	0.0	9
Senior living with spouse	8.6	11.1	26.2	14.3	2.7	36.7	27.7	7.3	0.6	629
Senior living alone	3.6	20.9	27.9	7.9	2.2	47.1	15.6	1.7	0.0	416
Other	0.0	27.8	38.9	11.1	16.7	38.9	38.9	11.1	0.0	18
NR	0.0	33.3	22.2	22.2	0.0	33.3	22.2	22.2	0.0	9
Total	6.4	14.1	25.8	13.5	3.5	38.7	25.6	6.4	0.3	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

Likewise, the family dynamics are also substantially varied according to the domestic household typology. From this analysis it is possible to observe that the typologies of couple living with descendants and senior living with descendants hold a more regular contact frequency with their children, which is somewhat expected, since it is still a single household. The most problematic situations take place in the typologies couple living with senior and senior living alone, because the contact frequency with their direct descendants is quite rare and consequently, these are the households in which there is a lower inter-generational exchange - an important factor for the senior population's well-being and active ageing.

Table 34. Family dynamics, according to household composition, 2007 (%)

Household Composition	Contact Frequency with Children			Total (N.)
	Regular	Occasional	Rare	
Couple living with descendants	87.6	3.6	0.0	169
Couple living with senior	50.0	16.7	33.3	6
Senior living with descendants	83.8	10.3	2.9	68
Senior living with senior	33.3	33.3	11.1	9
Senior living with spouse	56.4	26.4	8.4	629
Senior living alone	41.8	27.6	9.9	416
Other	50.0	11.1	5.6	18
NR	55.6	22.2	11.1	9
Total	56.9	22.8	7.6	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

With regard to the support provided, seniors with descendants, senior living alone and seniors living with another senior are the most vulnerable household typologies, since they benefit from more support in the group of typologies analyzed. On the other hand, couples with seniors and also couples with

descendants and couples living with the spouse are the most favorable realities, because these are the groups with fewer needs and thus the most autonomous.

Table 35. Support provided, according to household composition, 2007 (%)

Household Composition	Support/Assistance Typology from Which They Benefit						Total (N.)
	Domestic Tasks	Personal Care	Financial Help	Mobility	Health Care	Leisure	
Couple living with descendants	14.2	5.9	5.3	6.5	10.1	7.1	169
Couple living with senior	16.7	0.0	16.7	0.0	0.0	0.0	6
Senior living with descendants	36.8	16.2	27.9	20.6	17.6	22.1	68
Senior living with senior	22.2	22.2	0.0	11.1	22.2	0.0	9
Senior living with spouse	14.6	5.6	4.5	5.2	11.4	6.2	629
Senior living alone	24.8	11.8	13.2	13.9	14.2	10.8	416
Other	33.3	16.7	0.0	16.7	22.2	22.2	18
NR	22.2	0.0	11.1	11.1	22.2	11.1	9
Total	19.3	8.3	8.6	9.1	12.7	8.8	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

As far as the state of health is concerned, and in a descending order, seniors living with a senior, seniors living with descendants and seniors living alone are those who present more vulnerable states of health since they also present high incidences of pathologies (77.8%, 63.2% and 57.5%, respectively). In parallel, it is also among the household typologies senior living with descendants and senior living alone that there are less assessments of a good state of health. In fact, the target population who admits to having a poor state of health comprises couples living with senior, senior living with descendants and seniors living alone (16.7%, 11.8% and 9.4%, respectively).

Table 36. State of health, according to household composition, 2007 (%)

Household Composition	Pathology Present			State of Health Evaluation				Total (N.)
	Yes	No	Did not answer	Good	Reasonable	Poor	Did not answer	
Couple living with descendants	37.9	60.4	1.8	49.1	45.6	4.7	0.6	169
Couple living with senior	50.0	50.0	0.0	33.3	50.0	16.7	0.0	6
Senior living with descendants	63.2	36.8	0.0	20.6	66.2	11.8	1.5	68
Senior living with senior	77.8	22.2	0.0	33.3	66.7	0.0	0.0	9
Senior living with spouse	46.7	52.1	1.1	39.0	54.1	5.7	1.3	629
Senior living alone	57.5	41.1	1.4	26.7	62.5	9.4	1.4	416
Other	72.2	27.8	0.0	16.7	72.2	5.6	5.6	18
NR	66.7	33.3	0.0	11.1	66.7	22.2	0.0	9
Total	50.5	48.3	1.2	34.9	56.6	7.2	1.3	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

With regard to the leisure time activity, the first aspect for analysis is the fact that the household composition typologies that travel less often are mainly the couple living with senior (only 16.7 travels often), followed by the senior living with senior (33.3%) and senior living alone (34.1%). On the other hand are the couple living with descendants and senior living with spouse, as this is the population that travels more often (60.9% and 51.5%, respectively).

The degree of associativism occurs exclusively among the couple living with descendants (8.3%), senior living with spouse (5.7%) and senior living alone (3.8%).

The household composition typologies most unsatisfied with their leisure time activities are: senior living with senior (11.1%), senior living with descendants (10.3%) and senior living alone (9.1%), whereas the

couple living with descendants and senior living with spouse are those more satisfied with their leisure activities.

Table 37. Leisure time, according to household composition, 2007 (%)

Household Composition	Travels often	Degree of Associativism		Leisure Time Satisfaction				Total (N.)
	Yes	Significant	Null	Totally Satisfied	Satisfied	Unsatisfied	Totally Unsatisfied	
Couple living with descendants	60.9	8.3	60.4	8.9	76.3	7.1	2.4	169
Couple living with senior	16.7	0.0	83.3	16.7	66.7	0.0	0.0	6
Senior living with descendants	45.6	0.0	66.2	5.9	70.6	10.3	2.9	68
Senior living with senior	33.3	0.0	66.7	22.2	66.7	11.1	0.0	9
Senior living with spouse	51.5	5.7	66.6	11.1	73.1	8.9	0.5	629
Senior living alone	34.1	3.8	70.4	7.0	69.0	9.1	0.5	416
Other	33.3	0.0	72.2	27.8	50.0	11.1	0.0	18
NR	33.3	11.1	66.7	11.1	66.7	0.0	0.0	9
Total	46.3	5.1	67.1	9.6	71.7	8.8	0.8	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

The use of collective health infrastructures indicates that, whether in terms of primary or differentiated health care, although in all household composition typologies it is highly used, it is in the couple living with senior typology that the proportion is higher (100%). This is justified by the fact that the dependent senior presents a greater need for health care. On the other hand is the couple living with descendants typology, which holds the record for the least use of this kind of health care (78.7%), which is a result of these households in general being composed of younger seniors and thus with less vulnerable states of health.

However, this usage pattern is not reproduced in the analysis of the usage frequencies. Looking at the analysis of the monthly frequency usage, seniors living alone (16.6%) and senior living with spouse (16.1%) are those who most often use primary health care, as opposed to couple living with senior (0%). On the other hand, and regarding differentiated health care, couple living with descendants (4.7%) is the typology with a higher monthly frequency of hospitals, due to the occurrence of emergencies, in detriment of disease prevention, health promotion, among other primary medical care.

The use of social infrastructures, sustained in the day centre and socialization centre social responses shows that among the target population the senior living alone typology is unique in terms of day centre, for it clearly holds a greater use (5.3%). This situation is associated to the fact they are alone and for this reason, more dependent on care. As far as socialization centers are concerned, its main users are generally seniors living alone (3.4%) and seniors living with spouse (2.1%), who are precisely those who live in a greater state of isolation and seek the social infrastructures that provide social gathering.

Table 38. Health and social collective infrastructures use, according to household composition, 2007 (%)

Household Composition	Often uses		Monthly Use Frequency		Often Uses		Total (N.)
	Health Care Centre	Hospital	Health Centre	Hospital	Day Care Centre	Socialization Centre	
Couple living with descendants	78.7	55.0	12.4	4.7	0.6	0.0	169
Couple living with senior	100.0	66.7	0.0	0.0	0.0	0.0	6
Senior living with descendants	86.8	55.9	14.7	0.0	0.0	1.5	68
Senior living with senior	88.9	55.6	11.1	0.0	0.0	0.0	9
Senior living with spouse	84.6	56.1	16.1	2.1	1.6	2.1	629
Senior living alone	80.3	53.4	16.6	1.7	5.3	3.4	416
Other	94.4	66.7	27.8	5.6	0.0	5.6	18
NR	77.8	55.6	11.1	0.0	0.0	0.0	9
Total	82.8	55.3	15.7	2.2	2.5	2.2	1324

Source: CEDRU Surveys, 2007

Legend: NR - Did not answer; NSA - Not applicable

2.3.4. 4th sub-group based on gender

Gender is an essential variable, insofar it is associated to several disparities, which are particularly crucial when it comes to the ageing population.

With regard to the lodging occupation regime, although there are many asymmetries between men and women, there is a greater number of women living in renting situations, as opposed to owning a house, which is a dominant reality among men.

Notwithstanding, with regard to the number of rooms per lodging, women are in a much more positive situation, since they hold a lower incidence of small lodgings (1.4% lives in lodgings with 0 to 1 rooms) and a greater incidence of larger lodgings (36.5% resides in lodgings with 4 or more rooms), when compared to men.

In terms of the lodgings' state of preservation, male individuals are in a more advantageous situation when compared to women, despite the non-existence of significant disparities. There is a slight supremacy from men when it comes to depicting a lodging in a good state of preservation (41.1% for men and 39.6% for women), because 13.5% believes their lodging requires minor repairs and 4.6% considers it is in a degraded state (in need of major repair work), while for the opposite gender these values are as high as 15.8% and 4.9%, respectively.

Table 39. Housing context, according to gender, 2007 (%)

Gender	Lodging Occupation Regime		Rooms of the Lodging			Lodging's State of Preservation				Total (N.)
	Own house	Total rent	0-1	2-3	>4	Good	Reasonable	In Need of Minor Repairs	Degraded (in need of major repairs)	
Female	63.5	31.2	1.4	59.8	36.5	39.6	37.4	15.8	4.9	657
Male	64.2	29.4	1.9	60.6	33.9	41.1	36.9	13.5	4.6	667
Total	63.8	30.3	1.7	60.2	35.2	40.3	37.2	14.7	4.8	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

The first great discrepancy between genders when it comes to economic profile is in retirement situations. Men are those that mostly tend to remain active (9% as opposed to 3.8% for women). Consequently, women show a greater dependency on pensions while men tend to diversify their income resources.

This conclusion explains the fact the female gender presents a higher level of economic vulnerability and poverty situations, which can be proved by the analysis of the total average monthly income structure. Furthermore, among the target population, women hold a higher occurrence of average monthly income equal to or lower than 300€ and, as such, of surviving below the poverty threshold. Men experience better economic situations (average monthly income equal to or higher than 1,501€ or varying between 751€ and 1,500€) - 4.3% and 16.5% respectively). Despite these slight dichotomies, it is important to mention the high proportion of male and female seniors that survive below the poverty threshold and with low average financial resources.

Similarly, the structure of the total average monthly income illustrates that mainly women reveal lower expenses (41.7% has expenses equal to or lower than 300€, while that amount only occurs in 35.8% of men), whereas on the contrary, the higher expenses occur among men, since they are the ones who can afford it the most.

Table 40. Economic profile, according to gender, 2007 (%)

Gender	Situation in Terms of Work, in the Case of Pensioners	Structure of the Total Average Monthly Expenses (€)				Situation in Terms of Work, in the Case of Pensioners				Total (N.)
	Active	< 300	301-750	751-1,500	> 1,501	< 300	301-750	751-1,500	> 1,501	
Female	3.8	16.0	26.3	10.5	2.7	41.7	27.4	5.3	0.2	657
Male	9.0	12.3	25.3	16.5	4.3	35.8	23.8	7.5	0.4	667
Total	6.4	14.1	25.8	13.5	3.5	38.7	25.6	6.4	0.3	1,324

Source: CEDRU Surveys, 2007

Legend: NR - Did not answer; NSA - Not applicable

The interpretation of the results regarding family dynamics reinforce women's vulnerability when compared to men, since women live mostly alone (37.7% of women live alone, while this reality only affects 25.2% of men). This is deeply connected with the higher life expectancy for women and it also demonstrates that the majority of this gender lives in isolation.

However, when it comes to contact with children, the situation is slightly reversed, given that women have a more regular contact than men (59.2% and 54.7%, respectively) and in fact, occasional and rare contacts are higher among men. Overall, there are no significant discrepancies.

Table 41. Family dynamics, according to gender, 2007 (%)

Gender	Household Typology			Contact Frequency with Children			Total (N.)
	Couple with Descendants	Senior Living with Spouse	Senior Alone	Regular	Occasional	Rare	
Female	12.2	38.8	37.7	59.2	21.6	7.0	657
Male	13.3	56.1	25.2	54.7	24.0	8.2	667
Total	12.8	47.5	31.4	56.9	22.8	7.6	1,324

Source: CEDRU surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

More than evidencing dichotomies in quantitative terms, the analysis of the assistance given to the senior population reveals that differentiated help is provided according to gender. Thus, the male gender reveals greater needs regarding personal help, namely, in domestic tasks, personal care and health care. On the contrary, women have a greater dependency in economic terms and in regard to mobility and leisure.

Table 42. Support provided, according to gender, 2007 (%)

Gender	Support/Assistance Typology from which They Benefit						Total (N.)
	Domestic Tasks	Personal Care	Financial Help	Mobility	Health Care	Leisure	
Female	16.4	7.0	9.0	11.1	12.0	10.0	657
Male	22.0	9.6	8.2	7.2	13.3	7.5	667
Total	19.3	8.3	8.6	9.1	12.7	8.8	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

Although demographic indicators of the average life expectancy and mortality rate suggest a better situation for women, it is among them that there is a higher existence of pathologies (55.9% in comparison to 45.3% for men). Naturally, this situation cannot be dissociated from the fact that women use primary health care more often, make more and more frequently diagnostic examinations, which allow them to prevent diseases more properly and for this reason, to have a clearer perception of their state of health. Closely associated to these factors, it is possible to recognize that men present a better evaluation of their health state (39.4%) when compared to women (30.3%). Additionally, women often evaluate their health states as reasonable or poor.

Table 43. State of health, according to gender, 2007 (%)

Gender	Pathology Present			State of Health Evaluation				Total (N.)
	Yes	No	Did not Answer	Good	Reasonable	Poor	Did not answer	
Female	55.9	43.4	0.8	30.3	61.3	7.6	0.8	657
Male	45.3	53.1	1.6	39.4	52.0	6.7	1.8	667
Total	50.5	48.3	1.2	34.9	56.6	7.2	1.3	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

The manner in which men and women occupy their leisure time is rather different. The male gender presents more dynamic and active occupations, often travel and have a more significant degree of associativism as well (48.8% and 8.4%, respectively, in contrast with 44% and 1.7% for women).

Consequently, it is understandable that men are the most satisfied gender when it comes to the occupation of their leisure time. On the other hand, women are generally more unsatisfied and totally unsatisfied with their leisure activities.

Table 44. Leisure time, according to gender, 2007 (%)

Gender	Travels often	Degree of Associativism		Leisure Time Satisfaction				Total (N.)
	Yes	Significant	Null	Totally Satisfied	Satisfied	Unsatisfied	Totally Unsatisfied	
Female	44.0	1.7	74.1	9.4	70.3	11.4	1.1	657
Male	48.6	8.4	60.3	9.7	73.0	6.1	0.6	667
Total	46.3	5.1	67.1	9.6	71.7	8.8	0.8	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

As previously mentioned, women use primary health care on a more regular basis than men (84.8% and 80.8%, respectively), while when it comes to hospital infrastructures, the situation is slight reversed (55.9% for men and 54.6% for women). This situation is associated to the distinct behavior from men and women as far as their health is concerned, because while women are more concerned with disease prevention (routine appointments and diagnostic examinations), men tend to use health infrastructures

mostly in emergencies. This reality is illustrated in the analysis of the monthly frequency of the health centre, which is higher among women, and hospitals, slightly higher among men.

With regard to the use of social infrastructures, as far as day centers are concerned, the frequency of use is quite similar among both genders (women 2.6% and men 2.4%). Within the scope of socialization centers, though, men clearly tend to use this social response more than women (2.5% and 1.8%, respectively).

Table 45. Health and social collective infrastructures use according to gender, 2007 (%)

Gender	Often Uses		Monthly Use Frequency		Often Uses		Total (N.)
	Health Centre	Hospital	Health Centre	Hospital	Day Care Centre	Socialization Centre	
Female	84.8	54.6	18.9	1.5	2.6	1.8	657
Male	80.8	55.9	12.6	2.8	2.4	2.5	667
Total	82.8	55.3	15.7	2.2	2.5	2.2	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

2.3.5. 5th sub-group based on the Urban Area Type

Besides the variables which are closely associated to the individuals' profile, according to where they live - if it is in APR or APU - there are important differences, which lead to a specific profile and needs in the entire senior population.

In the housing context, the occupation regime of own house lodging is most expressive in APR (79.5%), so that 13.6% of the population is in a situation of total rent. In APU, although most of the population resides in their own house (60.9%), 34.4% live in a total rent regime.

Regarding the size of the lodgings, it is in APR that the most antagonist realities are evidenced. If it is true that there is a larger number of individuals living in small lodgings in the rural context (2.3% lives in lodgings with 0 to 1 rooms, while in APU this reality only affects 1.6% of the senior population), it is also in the rural context that most individuals live in larger lodgings (40.9% lives in lodgings with 4 or more rooms, while in APU 34.8% of the target population owns such a lodging).

As far as the state of preservation of the lodging is concerned, it is generally in APU that the senior population has their lodgings in a better state, because 41.7% considers their house to be in a good state of preservation (whereas in APR this value is 32.6%). In addition, it is in APR that most individuals consider their homes in need of minor repairs (22.7% in comparison to APU's 13.3%), although the state of degradation of the lodgings shows a slight superiority in APU (4.9%) when compared to APR (3.8%).

Table 46. Housing context, according the Urban Areas Typology, 2007 (%)

Urban Areas Type	Lodging Occupation Regime		Rooms of the Lodging			Lodging's State of Preservation				Total (N.)
	Own house	Total rent	0-1	2-3	>-4	Good	Reasonable	In Need of Minor Repairs	Degraded (in need of major repairs)	
APR	79.5	13.6	2.3	56.1	40.9	32.6	38.6	22.7	3.8	132
APU	60.9	34.4	1.6	61.7	34.8	41.7	38.0	13.3	4.9	1096
Total	63.8	30.3	1.7	60.2	35.2	40.3	37.2	14.7	4.8	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

As far as the economic profile is concerned, it is important to point out that it is in APR that a larger proportion of the senior population remains active after retirement (6.1%), although not quite differing from what occurs in APU (5.7%).

Through this diversity of income sources, it is in APR that the average monthly income is increasingly higher (21.2% earns between 751€ and 1,500€ and 6.1% earns 1,501€ or more). However, it is also in APR that there is a larger incidence of seniors living with meager financial resources and inclusively surviving below the poverty threshold (23.5% lives with 300€ or less a month, while in APU only 13.2% lives in these circumstances). This situation allows APR seniors to have higher total average monthly expenses than APU's.

Table 47. Economic profile, according to the Urban Areas Type, 2007 (%)

Urban Areas Type	Situation Regarding Work, in Case of Pensioners	Structure of the Total Average Monthly Income (€)				Structure of the Total Average Monthly Expenses (€)				Total (N.)
	Active	<300	301-750	751-1,500	>1,501	<300	301-750	751-1,500	>1,501	
APR	6.1	23.5	24.2	21.2	6.1	23.5	24.2	21.2	6.1	132
APU	5.7	13.2	26.2	13.2	3.5	13.2	26.2	13.2	3.5	1096
Total	6.4	14.1	25.8	13.5	3.5	14.1	25.8	13.5	3.5	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

From the analysis of the household, there are two conclusions worth highlighting: the fact that in APR there is a larger proportion of the “couple living with descendants” typology (15.9% as opposed to 11.7%), while in APU there is a higher occurrence of seniors living alone and, thus, isolated.

The contact frequency between seniors and their children clearly illustrates that family dynamics play a more significant role in APR (59.8% as opposed to 57% in APU).

The interpretation of these results emphasizes that seniors in APU are in a greater situation of isolation, but simultaneously have greater interaction with their descendants.

Table 48. Family dynamics, according to the Urban Area Type, 2007 (%)

Urban Area Type	Family Household Typology			Contact Frequency with Children			Total (N.)
	Couple with Descendants	Senior Living with Spouse	Senior Living Alone	Regular	Occasional	Rare	
APR	15.9	43.2	27.3	59.8	24.2	10.6	132
APU	11.7	48.6	31.9	57.0	23.0	6.9	1096
Total	12.8	47.5	31.4	56.9	22.8	7.6	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

In APR the target population benefits from more assistance and support, regardless of the support/assistance typology, than in APU. This conclusion suggests that APR seniors need more assistance (because of their extra vulnerability), but also that they benefit from a greater range of care, by relatives, while in APU the support is not as significant. In addition, many seniors are not able to obtain support from the State or from Institutions for the reason that they cannot afford it or that they do not fulfill the necessary requirements to obtain these benefits.

Table 49. Support provided, according to the Urban Area Type, 2007 (%)

Urban Areas Type	Support/Assistance Typology from which They Benefit						Total (N.)
	Domestic Tasks	Personal Care	Financial Help	Mobility	Health Care	Leisure	
APR	27.3	15.2	15.2	18.9	21.2	16.7	132
APU	19.2	7.1	7.7	7.1	10.9	6.6	1096
Total	20.5	8.8	8.6	9.1	12.7	8.8	1.324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

The analysis of the state of health illustrates that in APU a larger proportion of seniors presents a pathology (52.6%, as opposed to 45.5% in APR), which cannot once more be dissociated from that fact that it is in APU that most individuals use primary health care, as will be further analyzed.

Notwithstanding, it is in APU that a greater number of individuals evaluate their health as good (34.2%, as opposed to 30.3% in APR). Furthermore, the poor state of health evaluations is most relevant in APR (9.8%, as opposed to 6.9% in APU).

Table 50. State of health, according to the Urban Area Type, 2007 (%)

Urban Areas Type	Pathology Present			State of Health Evaluation				Total (N.)
	Yes	No	Did not answer	Good	Reasonable	Poor	Did not Answer	
APR	45.5	53.8	0.8	30.3	58.3	9.8	1.5	132
APU	52.6	46.1	1.4	34.2	57.5	6.9	1.4	1096
Total	50.5	48.3	1.2	34.9	56.6	7.2	1.3	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

It is in APU that seniors show more active behavior in terms of occupation of their leisure time, since they have traveling habits (49.2% in comparison to 28.8% in APR), and it is also in APU that a greater degree of associativism is registered (5.7% in comparison to 1.5%), although null associativism assumes higher proportions in APU (71.6%).

However, the degree of satisfaction with leisure time is more positive in APR than in APU, because in APR 12.1% of individuals feels totally satisfied, whereas in APU, only 8.9% feels satisfied. Likewise, in APR, the proportion of individuals feeling unsatisfied is also lower (7.6%) than in APU (9.1%).

Table 51. Leisure time, according to the Urban Areas Type, 2007 (%)

Urban Areas Type	Travels often	Degree of Associativism		Leisure Time Satisfaction				Total (N.)
	Yes	Significant	Null	Totally Satisfied	Satisfied	Unsatisfied	Totally Unsatisfied	
APR	28.8	1.5	53.0	12.1	62.9	7.6	0.0	132
APU	49.2	5.7	71.6	8.9	74.2	9.1	0.9	1096
Total	46.3	5.1	67.1	9.6	71.7	8.8	0.8	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

The use of health infrastructures, regardless of being primary or differentiated, is higher in APU than in APR, which might be associated to a greater concentration of health infrastructures in APU. This might also indicate a greater proximity between these and APU's residential areas. However, when it comes to

the monthly usage frequency, it is slightly higher in APR in terms of primary health care and clearly high in terms of hospital attendance.

Finally, the use of social infrastructures shows that it is in APR that the social response day centre is often used by the senior population (4.5%, as opposed to 2.1% in APU), as well as the social response socialization centre, although there are no significant asymmetries between the urban and rural territories.

Table 52. Health and social collective infrastructures use, according to the Urban Areas Type, 2007 (%)

Urban Areas Type	Often uses		Monthly Use Frequency		Often Uses		Total (N.)
	Health Centre	Hospital	Health Centre	Hospital	Day Care Centre	Socialization Centre	
APR	73.5	42.4	17.4	6.8	4.5	2.3	132
APU	84.0	59.8	16.4	1.8	2.1	2.0	1096
Total	82.8	55.3	15.7	2.2	2.5	2.2	1,324

Source: CEDRU Surveys, 2007.

Legend: NR - Did not answer; NSA - Not applicable

2.3.6. Summary evaluation of the senior population segments

Based on the analysis previously carried out in an individual manner for each of the five sub-groups of the Portuguese senior population, an evaluation template was developed, which is presented below. This analytic template's goal is to summarize the situation of each segment of the senior population, in the context of each sub-group.

Table 53. Summary evaluation template of each segment of the senior population's situation in regard to multiple factors

Segments of the senior population		Housing Conditions	Economic Situation	Family Dynamics	Support Dependency	State of Health	Leisure Time	Health and Social Collective Infrastructure Use	Average Evaluation
Age Groups	55-64 years old	****	****	****	***	***	***	****	****
	65-74 years old	***	***	***	***	***	***	***	***
	75-84 years old	***	***	**	**	**	***	***	***
	> 85 years old	.	**	.	.	.	**	.	.
Structure of the Total Average Monthly Income	Up to 300	.	.	.	**	.	**	**	.
	301-750	***	***	**	***	***	***	***	***
	751-1,500	***	***	****	***	****	****	***	***
	> 1,501	****	****	****	****	****	****	***	****
Household Composition	Couple living with descendants	**	****	****	***	****	****	****	****
	Couple living with senior	***	.	.	****	**	***	***	**
	Senior living with descendants	.	***	****	.	.	***	****	**
	Senior living with a senior	****	***	.	**	****	**	****	***
	Senior living with spouse	***	****	**	**	***	****	.	***
	Senior living alone	.	.	.	**	.	**	.	.
Gender	Female	**	.	**	***	**	**	***	**
	Male	***	***	***	***	***	***	**	***
Urban Areas Type	APR	***	***	***	***	***	***	**	***
	APU	***	**	**	.	***	**	***	**

LEGEND:

GOOD	****	REASONABLE	***	POOR	**	REALLY POOR	.
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From this methodology, it is thus possible to identify **five segments of the senior population that are characterized by a greater vulnerability**, for they present greater needs and consequently need stronger support. The segments are as follows:

- ▶ **The older seniors:** The senior population (aged 85+ years old) is a particularly vulnerable segment, because the worst housing conditions, economic conditions and fragile family dynamics are associated to them, at a national level. Furthermore, this segment of the population needs extra help and support due to the fact that their health is weaker, they have less leisure activities and more often return to social and health infrastructures. Thus, as age increases, the states of health get weaker and individuals lose their autonomy, being more and more dependant and vulnerable, incapable of responding to a series of everyday life circumstances;
- ▶ **The poorer:** The population with total average monthly incomes equal to or lower than 300€ are a particularly vulnerable segment, based on income, because they live below the poverty threshold and thus face a set of limitations and needs associated to their low incomes. As a result, when compared to the other segments based on the structure of the total average monthly income, this segment is living in the poorest housing conditions; have less structured family relations; depend on support and assistance; have poor health (when they are not the ones who mostly use health infrastructures); have the worst leisure time occupation scenarios and are the most dependant on social infrastructures;
- ▶ **The ones who live alone:** Based on the household composition typology of the senior population at a national level, it can be observed that those who live all by themselves are a rather vulnerable segment. Seniors living alone are the ones who depict a greater degree of weak housing conditions, worst economic conditions, fragile family relations, greater dependency on support, a poorer state of health, lack of leisure time activities and a greater use of social and health infrastructures;
- ▶ **The women:** Based on gender, there are profound discrepancies among the senior population in Portugal, which somehow are associated to the vulnerable role that women still play in society these days. In fact, if there is a certain equity when it comes to the dependency of men and women in terms of support and assistance, in all of the remaining analysis domains, women present greater difficulties and vulnerabilities, such as: more fragile housing contexts, family dynamics, states of health and leisure time activities. However, it is at the economic level that heterogeneity among men and women tends to be stronger, women being the most vulnerable segment. On the contrary, as far as the use of social and health infrastructures is concerned, men are more vulnerable and dependent than women;
- ▶ **Those who reside in an urban context:** Urban-rural dichotomies, which have been under evaluation in numerous studies in the last decades, also play a relevant part in terms of studying the senior population. There are no remarkable contrasts between APR and APU when it comes to using collective, health and social infrastructures and to state of health, but as far as all the other domains are concerned, the differences are rather significant. Seniors living in an urban context (APU) are the ones who live in a poorer economic condition and have weaker family relationships. Subject to a less frequent contact with their direct descendants, the seniors who live alone, although they are the ones with a wider set of leisure activities, are the most unsatisfied with it. However, it is in the daily life assistance and support benefiting level that most dichotomies are highlighted. Although it is in APR that more seniors benefit from support, this analysis reveals the lack of assistance in the urban context and these seniors do not present discrepancies as far as the state of health is concerned and live in poorer economic conditions.

2.3.7. Two specific segments: immigrants and the elderly poor

Immigrants

The confirmation of Portugal as a host country for immigrants within the context of international migrations is a relatively recent phenomenon. The presence of foreigners in the Portuguese society dates back to as recently as 1960s.

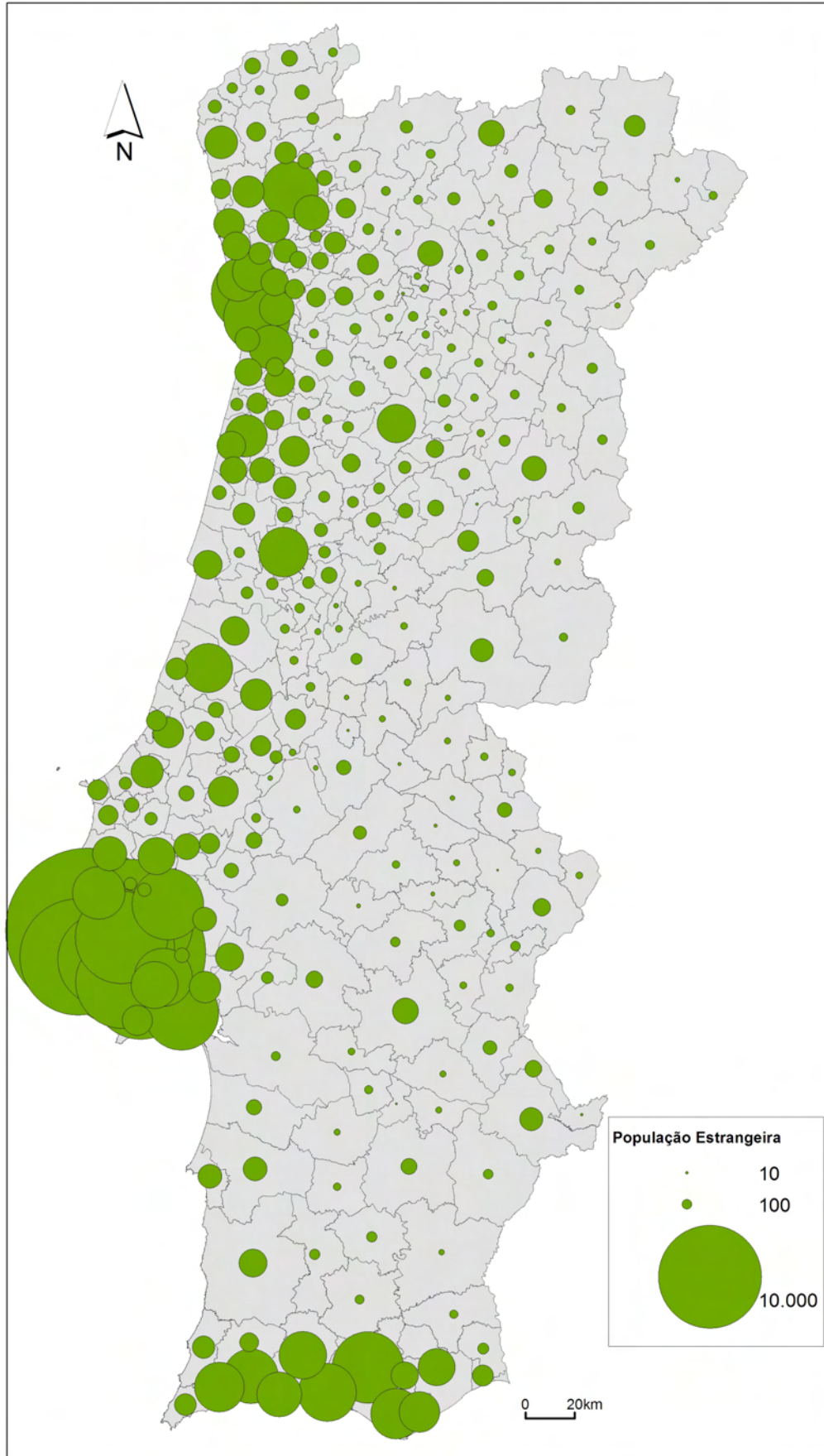
It was the fall of the political regime in Portugal (April 1974) that led Portugal into becoming a host country to immigrants. The independence of the African colonies gave rise to a change in nationality of the citizens of these countries and, consequently, those living in Portugal, as well as the large numbers that arrived immediately after the revolution, became foreign citizens (Esteves, 2004).

In 2001, 65.3% of the foreign population living in the Metropolitan Area of Lisbon (MAL) came from the *Países Africanos de Língua Oficial Portuguesa* (PALOP) - (Portuguese-Speaking African Countries). The choice of Portugal as a country of destination resulted from factors, such as linguistic proximity, historical ties, easier entry and the recent economic prosperity.

However, the start of the nineties saw a new advent in immigration to Portugal, which translated into a significant increase in the number of immigrants due to Portugal's accession to the European Community (EC) and to the Portuguese economy's growing dynamic. As a result, the proportion of the foreign resident population rose from 1.1% in 1991 to 2.2% in 2001. This increase was even more pronounced in the MAL, where the concentration of immigrants grew from 45,667 in 1991 to 125,927 in 2001, which corresponds to a 175% increase. This period also saw a diversification of the geographical origins of the immigrants: Brazil, Eastern Europe and Asian countries (the latter two groups of immigrants being still small minorities).

In general, the spatial residential pattern of the foreign population tends to reproduce the hierarchies of the Portuguese urban system (*Figure 27*). In 2001, 57% of the total number of foreign citizens residing in Portugal was concentrated along the Atlantic Axis, with particular prevalence in the MAL.

Figure 27. Foreign population residing in Mainland Portugal, in 2001 (No.)



Source: Andrade, I. 2006.

The brief history of Portugal as an immigration country and the characteristics of the immigration process (involving mainly young people of a working age) and a strong spatial concentration in the MAL, show that the foreign senior population in Portugal is still not very expressive.

It is however important to present some of the main problems and needs revealed by this segment, namely by those aged 55 and over. This analysis will be based on secondary information sources, namely on the intense production of scientific research studies and reports that have been undertaken in the last years. An in-depth study of their needs is vital for the development of better policies for the integration of immigrants, a crucial factor in increasingly multi-ethnic societies and cosmopolitan cities. Although Portugal was given second place in the Migrant Integration Policy Index (MIPEX) (the most thorough comparative study of measures for the integration of immigrants, from a group of 27 European countries and Canada, based on the analysis of 140 indicators grouped into six political fields) a set of practices leading to social exclusion tend to persist at a national level (*Figure 28* and *29*).

Figure 28. Portugal's overall situation, according to the MIPEX - Migrant Integration Policy Index, 2006-2007 (%)

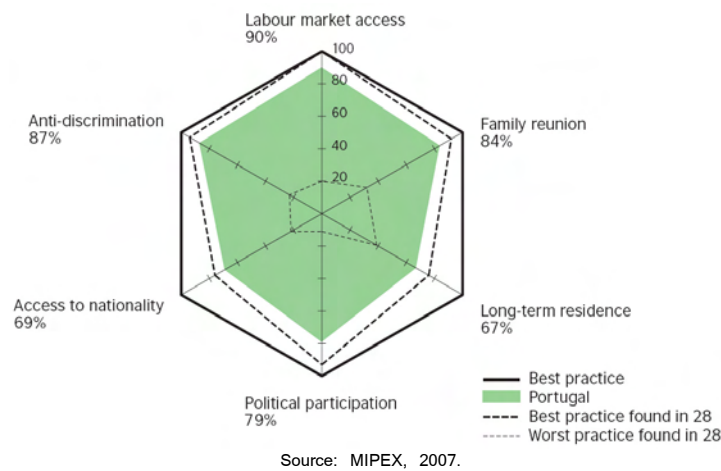
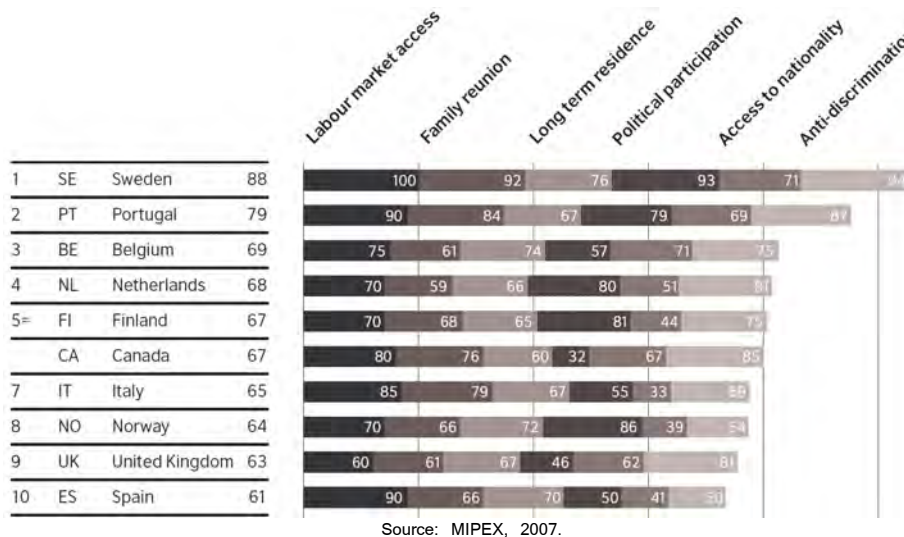


Figure 29. Top 10 ranking, according to the MIPEX - Migrant Integration Policy Index, 2006-2007 (%)



In their daily lives, the immigrant senior population residing in Portugal is faced with several needs. While many of these are transversal to those identified within the scope of the Portuguese senior population, others are specific to this segment and result from the actual conditions of the immigrants.

Out of these, stand out four critical areas- health, labour market, housing and justice and citizenship - and are therefore considered priority intervention areas for the promotion of greater social inclusion and the active ageing of immigrant seniors.

Health

A great deal of international research has called attention to the fact that the right to health continues to be one of the main barriers to the social integration of immigrants in the host societies. As explained in a recent report by the International Organization for Migration (IOM), although health policies - in their component of promoting the health of immigrants - vary from country to country, there is a tendency for the health of immigrants to be viewed as a cost rather than a benefit (IOM, 2005; Andrade, 2006).

In Portugal, although the right to the access to and use of health care by immigrants has been enacted, in practice there are many barriers hindering its materialization. On the demand side, the following constraints are highlighted: reduced preventive habits; economic difficulties; precarious labour conditions; geographic and linguistic mobility difficulties; difficulty in being informed on their rights and duties and on the working model of the National Health Service (NHS). These constraints become all the worse in the case of undocumented immigrants, as not only is their economic and social vulnerability greater, but also their fear of being reported to the police by the health professionals for not having documents increases. On the supply side, the following stand out: i) the persistence of preconceived opinions and discriminatory patterns in relation to immigrants; ii) the lack of knowledge of the legislation in force by health and administrative professionals, as well as the countless difficulties in complying with the existing legislation; iii) the excessive bureaucratization of the NHS; iv) the inexistence of translators and socio-cultural mediators to facilitate the communication process; and v) the poor awareness of the cultural diversity that continues to mark the population in general and the health professionals in particular (Andrade, 2006; OI, 2007).

In light of this overall framework, it is essential to develop strategies aimed at promoting the access to and use of healthcare by immigrants. These strategies should take into consideration a wide range of measures and actions, yet priority should be given to: i) training, education and communication actions designed to combat the lack of knowledge of immigrants as regards their rights and duties, and also in relation to the overall functioning of the NHS; ii) promoting the intercultural training of health and administrative professionals of the NHS; iii) undertaking a vast number of detailed scientific research actions on the access to and use of health care by immigrants; and iv) developing a national health policy that takes into account the social, cultural and religious background of each community of immigrants and ethnic minorities living in Portugal.

Labour Market

The integration of immigrants in the labour market is oriented by precarious, badly paid, physically demanding and socially devalued jobs. As revealed by a recent document of the *Observatório do Emprego e Formação Profissional* (OEFPP) - (Employment and Vocational Training Observatory), the immigrant population in Portugal tends to have low qualification and vocational training levels, as well as a weak command of the Portuguese language, two of the main factors which explain their concentration in few economic activity sectors: 26% in civil construction, 15% in the restaurant sector and 35% in cleaning/household services. Still according to this document, on average, approximately 20% of immigrants fall below the wage average of the Portuguese population and show limited wage mobility (OEFPP, 2008).

Although the labour integration of immigrants is characterized by a number of situations, since there has been an increase of qualified immigrants, such as situations of immigrant entrepreneurship, precarious jobs prevail.

Although there is no academic research on this segment of the immigrant population, seniors are a particularly vulnerable group insofar as they reveal higher rates of illiteracy and info-exclusion, low or no levels of instruction and vocational training.

Taking into consideration the Immigrant Integration Plan, it is vital to: i) organize specific aware-raising campaigns on safety at work for senior immigrant workers, in economic activity sectors that display higher accident rates, and on the rights and duties of immigrant workers; ii) create measures aimed at facilitating the social, professional and labour integration of immigrants through the development of basic skills in the Portuguese language and training actions.

Housing

In 1974, a large number of immigrants and returnees from the former colonies arrived in the MAL in a short period of time. Although the *Instituto de Apoio a Retorno de Nacionais* (IARN) - (Institute Set up to Support those Returning from the Former Portuguese Colonies) redistributed the returnees throughout Portugal, most of them became concentrated in the MAL. As most of this population had a low socio-economic level, their access to the housing market was strongly constrained. Consequently, there was a strong concentration of this population in slum and clandestine quarters on the immediate outskirts of Lisbon, which over the years became larger and larger. The residential areas of the immigrant population were primarily territorially marginalized, not integrated in the remaining consolidated urban fabric, and deprived of collective and basic infrastructures.

The awareness of the proliferation of highly degraded neighborhoods in the MAL gave rise to the development of several public operations in terms of housing policies over the following years, the most important being the *Programa Especial de Realojamento* (PER) - (Special Rehousing Programme) in 1993. Nevertheless, the neighborhoods set up under the PER to rehouse these populations served to emphasize the residential and ethnic segregation of the immigrant population, among other weaknesses.

Currently, in terms of housing, many immigrants have still not been rehoused and, given their financial incapacity to access the housing market in order to buy or rent property, they continue to live in unacceptable housing conditions (Esteves, 2004).

In the particular case of the senior population, there are two types of specific problems related to their present housing situation. The living conditions of those who live in slums are worsened by the poor housing conditions, which is a particularly pertinent issue in the case of seniors, since their state of health tends to deteriorate, making them more vulnerable as age advances. Those who live in apartments, notwithstanding the effort involved in the rehousing process, end up being confronted with many different problems that diminish their quality of life, namely the fact that they live on high floors sometimes with no elevator, which limits their mobility, or the fact that they do not live with their children, leading to their isolation.

In this context, there are two interventions that are considered as priorities: the conclusion in the short run of the other PER neighborhoods and the development of social support with a view to providing mobility support, preventing isolation and other needs of those who tend to live alone.

Justice and Citizenship

Immigrants are particularly prone to suffer violations of their human rights as a result of a set of vulnerabilities, such as low levels of instruction, economic capacity, and at times the fact that they are undocumented.

The awareness of this reality led the United Nations, in conjunction with the IOM and ten NGO, to hold the United Nations Convention on the Rights of Migrant Workers in 2003 so as to protect the rights of migrant workers. Although laid down in the Portuguese Constitution, in general the principle of equality of citizens in the eyes of the law, irrespective of several factors, namely race and the principle of equal rights between Portuguese citizens and foreign citizens, most immigrants continue to reveal a significant lack of knowledge of their rights and duties. It is in this sense that several entities of civil society have undertaken a number of measures to resolve this situation. Worthy of note are the efforts undertaken by the *Alto Comissariado para a Imigração e Diálogo Intercultural* (ACIDI) - (High Commission for Immigration and Intercultural Dialogue) in drawing up and disseminating guides on the rights and duties of immigrants in the various sectors of society (access to health care, labour market, housing, education, vocational training, legal protection, among others) and the seminars and other actions of debate and reflection on citizenship and immigrants' rights.

This issue is of crucial importance in fighting the trafficking and exploiting of different segments of this population. However, in the specific case of the senior immigrants' segment, the question of citizenship, justice and rights is particularly important, given the high illiteracy rate due to the fact that this population in general has a lower level of instruction and is less informed, among which participative cultural habits are still in an embryonic stage.

Against this backdrop, the Immigrant Integration Plan presents a wide set of interventions needed to suppress these needs and difficulties with which the immigrants are confronted in their day-to-day lives in Portugal. The most important is the need to make feasible the full access to justice, to provide whenever necessary translation and interpretation services so that language is no longer a barrier to the total access to their rights, and to reinforce the role of the Immigrant Legal Assistance Bureaus, the SOS Immigrant and the role of the consulates from the countries of origin.

The elderly poor

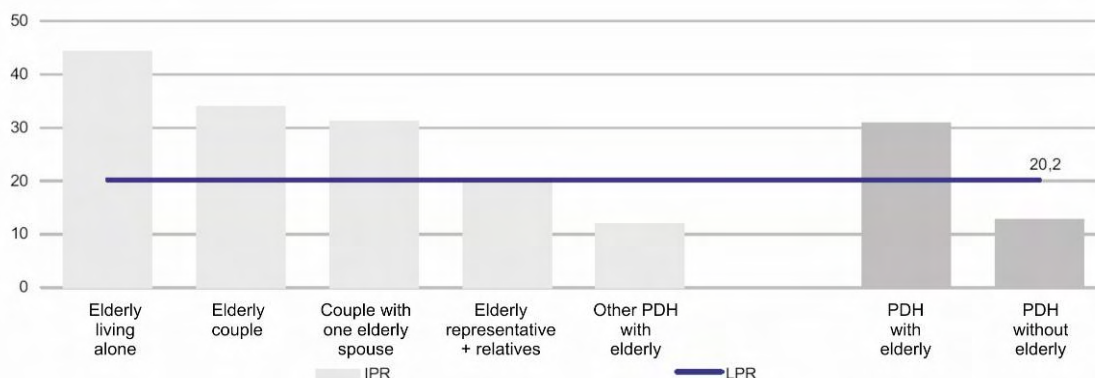
Poverty, understood as a phenomenon that results from the shortage of resources to satisfy basic needs, is in Portugal closely associated to the country's development and to the rapid modernization process of the last decades (PNAI, 2006).

The risk of poverty and its persistent nature varies according to several variables, such as gender, age group, nationality, levels of education and professional activity, inter alia. However, there are groups that display a set of conjunctural constraints, making them much more vulnerable to situations of poverty. Among these, the more pronounced ones are: children, the elderly, women, immigrants and ethnic minorities, disabled people, the victims of domestic violence, human trafficking victims, drug-dependent people, population infected by diseases such as HIV/Aids, former convicts, homeless people, numerous families and elderly single-person families.

Recent studies have emphasized the incidence of poverty in the different households with elderly people. Based on the data from the household budgets 2000, a study from INE evidenced that the index of poverty according to income in the several types of household was higher among the elderly (INE, 2004). According to that same study, 31.1% of the households with elderly were poor, whereas in those without elderly only 12.8% were in a situation of poverty. Within the scope of households with elderly people, those comprising one senior living alone reach the highest poverty rate according to income

(44%), followed by elderly couples and couples in which one of the members is a senior (34% and 31%).

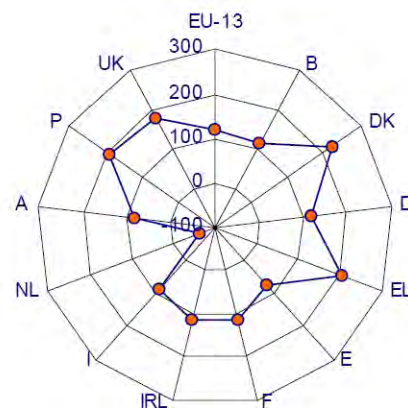
Figure 30. Indexes of poverty according to income and typology of private domestic household, Portugal, 2000 (%)



Source: Gonçalves, C.; Silva, C. (2004) - *Revista de Estudos Demográficos*, nº35, artigo 6º, INE.

In the international context, the poverty situation among the elderly population is, when compared to other UE-15 countries, rather disadvantageous for Portugal. According to the conclusions of the *Departamento de Prospectiva e Planeamento* (DPP) - (Prospective and Planning Department) do Ministry of Planning study, the proportion of elderly people in the lower income brackets was, in 1995, not very superior to the rest of the country's population, but was in a worst situation concerning the EU (DPP, 2000).

Figure 31. Proportion of pensioners in the lower income bracket (remaining population of the country = 100)



Source: EUROSTAT, in DPP, 2000.

According to the *Plano Nacional de Acção para a Inclusão* (PNAI) 2006-2008 - (National Action Plan for Inclusion 2006-2008), the elderly population is the population group most subject to poverty (at the greatest risk of poverty). Similarly to the international scenario, in Portugal the elderly population is also the segment with the lowest earnings. Government statistics based on recent studies indicate that 30% of the elderly in Portugal live in poverty: approximately 300,000 survive on less than 300€ a month, the amount corresponding to the internationally-defined poverty threshold. Many levels of economic adversity may be identified among this population.

It is, however, those who live exclusively off their pensions - old-age pensions or survivor's pensions, who earn less than 300€ - and those who do not have access to any other financial support, that are

considered to be in the most chronic situations, as they constitute pockets of poverty unable to benefit from an appropriate livelihood.

On a national level, the phenomenon of poverty among the elderly has become a cause of concern insofar as it involves many dimensions, resulting from structural factors and is therefore of difficult resolution:

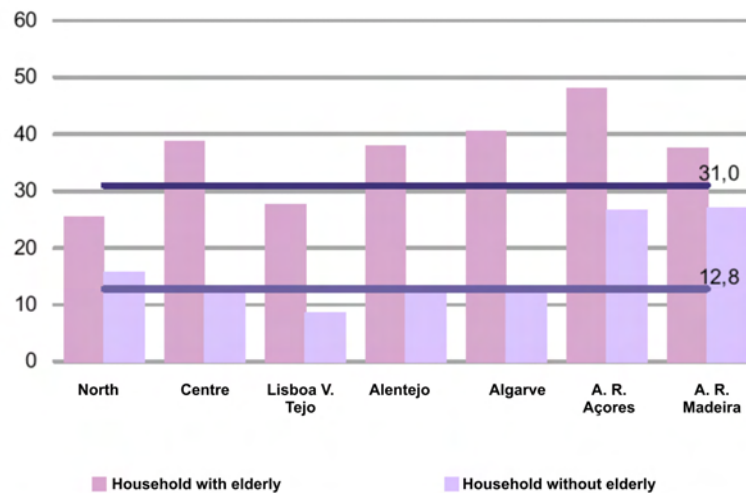
- ▶ A social protection system that is still lagging behind those of many Member States;
- ▶ The predominance of low levels of instruction and a high illiteracy rate among the elderly;
- ▶ Double isolation (social/family and physical) due to the fact that many old people live alone and far away from their children and relatives.

A recent study by the *Ministério do Trabalho e da Solidariedade Social* (MTSS) - (Ministry of Labour and Social Solidarity) has evidenced that elderly people are the population's sub-group living at a higher risk of poverty. This study, based on a one-dimensional analysis of poverty, using monetary resources for its measurement (monetary poverty), has considered that 29.7% of the elderly (approximately 445,917 people aged 65 or over) in 2001 were at risk of poverty. Similarly, the study states that the social security system has played an important role in the improvement of the population's quality of life, such as pensions in the elderly population's case *Departamento de Estudos Estatística Planeamento* (DGEEP) - Directorate-General for Studies, Statistics and Planning, 2006).

According to Eurostat, the problems associated to poverty among the elderly in Portugal have been improving little by little over the last years, the at-risk-of-poverty rate having dropped from 38% in 1995 to 28% in 2005. The at-risk-of-poverty rate of families of 1 adult over the age of 65 has also dropped, falling from 57% in 1995 to 42% in 2005.

Although the poverty of the elderly is scattered throughout the country, it is more prevalent in some areas.

A territorial analysis of the poverty indexes according to income by NUTS II, according to what was previously mentioned in INE's study, shows a differentiated incidence of this phenomenon, albeit there is a predominance of poverty in households with seniors in all regions. The Autonomous Regions of Madeira and Azores are the most critical and, regardless of being households with or without elderly people, their indexes of poverty according to income tend to be higher. Regarding households without seniors, it is in the Lisbon NUT II, that the registered poverty rates are lower, while when it comes to households with seniors, it is in the North NUT II that the reality is more favorable. Overall, as far as households with elderly people are concerned, NUTS II North and Lisboa and Vale do Tejo are in the top positions, while the remaining NUTS II present similar realities.

Figure 32. Indexes of poverty according to income, Portugal and NUTS II, 2000 (%)

Source: INE, in Gonçalves, C. & Silva, C., 2004.

The poorest and oldest rural territories - where peasants and former rural salaried workers with low pensions live - maintain a “continuity between poverty and the underdeveloped surroundings” (PNAI 2006-2008). In urban areas, namely the main cities and agglomerations - and particularly in the MAL - the situations tend to be more ambiguous. On the one hand, poverty is more visible - slum neighborhoods, of illegal origin, social neighborhoods or old neighborhoods stand in stark contrast to the urban surroundings, forming areas of social exclusion and spatial segregation. On the other hand, scattered throughout the urban areas are old people living in poverty and social exclusion, abandoned by their families and by society, with no references at an institutional level. These are serious situations that do not benefit from the effects of spatial concentration.

3. Analysis of needs, problems and difficulties of seniors in Portugal

3.1. Health

In the present study, health is seen as a primordial analysis factor, as it is a fundamental human right, an essential condition to active ageing. The increase in age also promotes a progressive change in the biological and psychological structure of individuals, which leads to new and more complex needs at the health care level. Despite the significant progress registered in the health sciences department in the last decades - which have contributed to the increase of the average life expectancy - ageing continues to give rise to frailty and dependence situations that can be prevented.

The health definition hereby adopted follows the designation provided by the World Health Organization (WHO), as a complete physical, mental and social health status. It is necessary to analyze health in two dimensions, with two specific goals:

- ▶ To diagnose and evaluate the physical, mental and social health status of the senior population;
- ▶ To analyze their accessibility to public health infrastructures.

The analysis of these two research lines is essential for a deeper knowledge of health and health care needs of the study's target group, given that its complementarity with other variables is crucial to a holistic vision of the needs of seniors in Portugal.

Health Status

In Portugal, almost half of the senior population presents a pathology that requires regular medical care. A read-out of the TAU from INE shows, however, that it is in the APU that a larger number of individuals reports suffering from a pathology (53%), although in the APR 45% have also answered positively when asked whether they suffered from any pathology.

The existence of a pathology also varies according to gender and age variables. In fact, there is a higher evidence of pathology among women (56%) than among men (45%). There is also a positive correlation with age, i.e. the existence of pathologies is higher among the oldest age groups (63.6%).

Table 54. Existence of illness, according to gender and age, 2007 (%)

Existence of pathology	Gender		Age Groups				Total
	M	F	55-64	65-74	75-84	85+	
Yes	45.3	55.9	45.9	47.4	58.9	63.6	50.5
No	53.1	43.4	53.5	51.2	39.9	32.7	48.3
Did not answer	1.6	0.8	0.7	1.4	1.2	3.6	1.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

Several studies have shown health gender inequalities in the senior population, not only in Europe but also in the USA and Brazil, showing that all over the world, women live longer than men, although this does not mean that they have better health conditions (Parahyba, 2006).

Breakdown according to nationality shows that regardless of being Portuguese or foreign citizens, there is always some pathology that needs health care. Nonetheless, the prevalence of a disease among foreign citizens (56%) is higher than among natives (50%). Recent research has shown that this is related to the immigration process (individuals that come from less developed countries which are limited in terms of health care; several difficulties of the migratory process related to nutrition, physical exhaustion and psychological stress). Likewise, the immigrant status in the host society (bad work and lodging conditions, bad life conditions in general and often difficulties they have to face to reach medical care), which promotes a deterioration of the immigrants' health. However, in their majority, immigrants that do not have official papers are a particularly vulnerable group and have an even more difficult access to health care as the status (legal or illegal) provides different treatment (Andrade, 2006).

Along with the existence or not of a disease, it is important to evaluate the population's general health status, a study that is being carried out in Portugal since 1989. This evaluation is based essentially on the health evaluation inferred by the individuals themselves. Consequently, these instruments can only measure deviations related to individual health status (Santana, 1995).

The analysis of the individual health status by the senior population in Portugal is mainly of fair health (57%); 35% say that they are in good health and only 7% give a negative evaluation. Although there are no significant gender differences, among men the evaluation is more positive: 39.4% state that they are in good health, while only 30.3% of women have the same kind of opinion. On the other hand, as regards fairer assumptions, women register a higher percentage. In fact, several studies have confirmed that gender differences - which have an influence on the perception of the health status - are important when searching for health care (WHO, 2001), as can be seen further in this analysis when studying the access and use of health cares according to gender.

An analysis by age groups shows that people have a weaker perception of their health status as they grow older: the highest percentage of negative evaluations occurs among individuals who are 85 years or older (16.4%). This appears to be a direct consequence of the functional decline individuals suffer along with ageing.

Table 55. Evaluation of the health status, according to gender, age group and Urban Area Type, 2007 (%)

Evaluation of the Health Status	Gender		Age Groups				Urban Area Type			Total
	M	F	55-64	65-74	75-84	85+	APU	AMU	APR	
Good	39.4	30.3	40.3	36.6	26.9	25.5	34.2	49.0	30.3	34.9
Fair	52.0	61.3	52.8	58.0	59.8	54.5	57.5	44.8	58.3	56.6
Poor	6.7	7.6	6.2	4.2	11.5	16.4	6.9	6.3	9.8	7.2
Did not answer	1.8	0.8	0.7	1.2	1.8	3.6	1.4	0.0	1.5	1.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

In APU and in APR, the majority of the senior population has a fair perception of their health status (57,5 and 58,3%, correspondingly). Nevertheless, it is important to take into account that it is in the rural areas that the negative perception of health status is higher (10%). Among the multiple factors that contribute to this reality, it is important to highlight the reduced access to medical care in a rural context, since these infrastructures are mainly built in urban areas, as these are the places where we find a greater population rate, therefore, providing economies of scale.

The perception of health status according to nationality once more reveals a consensus between Portuguese and foreigners, as in both cases the majority declares to have a fair health status (57% and 61%, respectively). Still, the percentage of foreigners who consider being in good health is higher than those of Portuguese nationality (39% and 35%, respectively), and no foreigner considers being in poor health.

The social and economical inequalities also have a great impact on the perception of the health status. Since the 60's, several researches in different countries have proved that social, economic and spatial inequalities influence the access and use of medical care and, subsequently, the effective and perceived health status.

The evaluation of the health status among the senior population varies directly with education and income levels. Indeed, it is among the senior population with lower education levels that the negative evaluation of health status is the highest (68.2% of the illiterate population and 60.7% of the population who have only attended primary school consider themselves to have a poor health status). On the other extreme, among senior individuals who have a university degree, the majority considers to have a good health status (55.8%). As for the second variable, although in all of the income levels the evaluation of a health status falls on fair, it is among the population with lower economic resources that the perception of a poor health status acquires greater relevance. Notwithstanding, it is among those with greater economic resources that the highest evaluations of good health status are registered.

In fact, people with higher education levels are better informed about healthy behavior, life styles and attitudes towards the promotion of health and the prevention of diseases, than those with lower education levels. Consequently, it is the population with better economic resources who have better access to specialized medical care and private health services. On the other hand, it is the senior population who comes from social and economic ill-favoured groups that tends to be more dependent on general practitioners and emergency services, often delaying the visit to a doctor and therefore diminishing the capacity to improve their health status (Fonseca *et al.*, 2007). For this reason, the level of education and economic capacity variables become of the utmost importance, since they support the cyclical relation among poverty, social exclusion and health versus sickness.

Table 56. Evaluation of the health status, according to the education levels of the senior population, 2007 (%)

Evaluation of the Health Status	Levels of education					
	Illiterate	Primary School (1 st to 4 th year)	2 nd Level Basic Education	3 rd Level Basic Education	Secondary Education	University
Good	14.1	30.4	50.3	48.7	45.7	55.8
Fair	17.6	7.5	4.5	2.6	1.4	3.8
Poor	68.2	60.7	43.9	44.7	52.9	40.4
Did not answer	0.0	1.5	1.3	3.9	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

Table 57. Evaluation of the health status, according to the total monthly income, 2007 (%)

Total Monthly Income (€)	Evaluation of the Health Status				
	Good	Fair	Poor	Did not Answer	Total
< than 300	18.7	67.4	10.7	3.2	100.0
301-750	28.1	63.5	7.9	0.6	100.0
751-1,500	34.6	60.3	3.4	1.7	100.0
> than 1,501	38.3	55.3	6.4	0.0	100.0
Did not answer/Not applicable	34.9	56.6	7.2	1.3	100.0

Source: CEDRU Survey, 2007.

Access to primary health care

Primary health care is the first stage of health care provision. With the essential aim of prevention, diagnosis and treatment or rehabilitation, the knowledge of its pattern of use is of the utmost importance for the evaluation of a certain population's health, since the higher its use, the better the results will be in terms of general health condition.

The study reveals that the majority of the population aged 55 years or over uses the health centre (83%). An analysis according to the TAU shows that in all categories the majority of the senior population uses the type of health care provided by the health centers. It is in the APR that the rate of those who do not use these centers is higher (18.2%).

With regard to gender, there are considerable using rates, given that it is higher than 80%. However, women present a slightly prevailing use. On the one hand, this conclusion reflects that women are more concerned with health promotion and disease prevention. On the other hand, it is also a consequence of the fact that women are the main users of some of the health care rendered by the primary health care services, namely family planning, maternal and paediatric health appointments.

As age increases, there is also a gradual increase in the use of primary health care, with the exception of the two older groups, as they are much more dependent, therefore requiring more specialized services, and they have a much greater difficulty to move.

Table 58. Use of primary health care, according to gender, age groups and Urban Area Type, 2007 (%)

Usually Uses	Gender		Age Groups				Urban Area Type			Total
	M	F	55-64	65-74	75-84	85+	APU	AMU	APR	
Yes	80.0	84.8	78.3	85.2	86.7	72.7	84.0	81.3	73.5	82.8
No	13.2	11.6	15.7	11.0	8.5	21.8	11.9	10.4	18.2	12.4
Did not answer	6.0	3.7	6.0	3.8	4.8	5.5	4.1	8.3	8.3	4.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

The use of primary health care services by the senior population also presents an inverse relation according to their income. In fact, it is among individuals with a lower monthly income that the

percentage of use of these services is higher (in individuals with an income lower than 300€ and between 301€ and 750€, the usage percentage is 84% and 87.4%, respectively, while individuals with a total monthly income higher than 1,501€, the rate is the lowest, 74.5%).

Table 59. Use of primary health care, according to total monthly income (€) in Portugal, 2007 (%)

Total Monthly Income (€)	Usage of Primary Health Care			Total
	Yes	No	Did not answer	
< than 300	84.0	11.8	4.3	100.0
301 - 750	87.4	9.1	3.5	100.0
751 - 1,500	84.9	9.5	5.6	100.0
> than 1,501	74.5	19.1	6.4	100.0
Did not answer/Not applicable	79.6	14.9	5.4	100.0

Source: CEDRU Survey, 2007.

It is important to point out that from the total of individuals who use this type of medical care, although the majority has an identified pathology (53.2%), a relatively considerable percentage shows signs of a disease that requires health care (45.5%). In spite of the fact that these results derive from a growing awareness of the importance of health promotion, at the same time it also reflects an inadequate use of these collective infrastructures, as a way to escape loneliness, a problem this population quite often faces.

Overall, the frequency of use of these types of health care is limited, since the majority of the senior population seldom uses this type of services (25%), or they use them only several times a year (24%). However, it is worth pointing out that 16% does use this kind of primary health care once a month.

The demand for primary health care differs significantly according to age. In fact, it is among the eldest individuals that a higher rate of regular use occurs: among individuals aged between 55-64 years, the most relevant frequency of use of these services is seldom (29.5%); between 65-74 years old the rate of usage increases to several times a year (26.2%); in the 75-84 years old age group it becomes clear that most of the individuals use these services several times a year (31.7%); finally, among the eldest individuals, the most common frequency of usage of these services is monthly (27.3%). The increased use of primary health care services when getting older is a consequence of the loss of capacities along this process.

Table 60. Frequency of usage of primary health care, according to age groups, 2007 (%)

Frequency of Use	Age Groups				Total
	55-64	65-74	75-84	85+	
Several times a week	0.5	0.4	0.3	0.0	0.4
Weekly	1.2	1.4	1.5	3.6	1.4
Several times a month	1.6	4.0	3.9	1.8	3.1
Monthly	12.9	15.4	18.1	27.3	15.7
Several times a year	17.1	26.2	31.7	12.7	23.9
Yearly	6.0	3.0	4.5	3.6	4.4
Seldom	29.5	26.0	18.1	10.9	24.5
Did not answer	23.3	18.8	17.5	32.7	20.6
Not applicable	8.1	4.8	4.2	7.3	5.9
Total	100.0	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

The reason for the use of these health care services is mainly for routine appointments (34.7%), without any significant inequality between genders. However, an analysis of the TAU shows that in APU, most of the population uses the health care services for routine appointments (39.1%), while in AMU and

APR, illness and emergency situations are the most common (37.5% and 22.7%, respectively). There is a spatial disparity based on the TAU as regards health promotion and illness prevention for the senior population and it is in the urban areas where they are more aware of these issues.

As for the level of satisfaction with primary health care, most seniors are satisfied (62.8%). This global picture ends up being an analysis broken-down by TAU (APU 65% and 56% in the APR). The level of satisfaction is also constant when one analyses the perceptions according to gender (women 64% and men 61%).

Table 61. Reason for using primary health care, according to Urban Area Type, 2007 (%)

Reason for Using Primary Health Care	Urban Area Type			Total
	APU	AMU	APR	
Disease / emergency	11.6	37.5	22.7	14.6
Routine appointments	39.1	4.2	19.7	34.7
Routine appointments and disease / emergency	1.6	18.8	4.5	3.1
Routine appointments / to obtain medical prescription	12.7	6.3	12.9	12.2
Routine appoints / complementary diagnosis	1.7	1.0	1.5	1.7
To obtain a medical prescription	11.6	7.3	9.1	11.0
Complementary diagnosis	2.7	0.0	0.8	2.3
Others	0.5	0.0	0.8	0.5
Did not answer	11.8	24.0	24.2	13.9
Not applicable	6.8	1.0	3.8	6.0
Total	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

It is important to emphasize that the evaluation of the level of satisfaction based on nationality shows that, although the majority of Portuguese and foreign citizens are satisfied, the level of satisfaction is higher among the latter (78%) than among the former (63%). The main factor that explains this reality is that the majority of immigrants living in Portugal come from less developed countries, where health care services present significant weaknesses. Therefore, as several recent researches have revealed, this explains that statistically there are no significant situations of trans-nationalism to obtain health care among the immigrant communities in Portugal, something that is quite common among communities and ethnic minorities in other European countries (Andrade, 2006; Freitas, 2006).

In spite of this tendency towards a global positive evaluation, the senior population identifies a group of constraints within the primary health care services, among which can be highlighted: the amount of time people have to wait for the doctor's appointment and health service, which has been pointed out by more than half of the senior population (52.3%), and the deficient geographical accessibility (23.5%), which includes constraints such as great the distance between the elder's home and the public health care services; deficient road access or an ineffective public transport network.

Accessibility to differentiated health care services

The differentiated or hospital health care services - designed mostly for healing and treatment of disease - should present a different average use pattern, which should not be the same as the one presented by primary health care services.

Most of the senior population living in Portugal uses the differentiated medical care (55.3%). This average global pattern is a reality for both genders, although men tend to use these services more than women (55.9%). Bearing in mind that in terms of primary health care services an opposite situation has been registered - behavior regarding health promotion and disease prevention are more relevant among women - men tend to turn to medical care mainly in situations of disease and when in need of some kind of treatment.

An analysis of the access and use of differentiated medical care according to the TAU reveals some geographic dissimilarities: in APU, 59.8% uses this kind of medical services, while in the APR it represents a mere 42.4%. These differences derive from the fact that most hospital infrastructures are concentrated in urban areas, which promotes significant inequalities between urban and rural areas.

Table 62. Use of the differentiated medical care services, according to gender, age group and Urban Area Type, 2007 (%)

Usually Uses	Gender		Age Groups				Urban Area Type			Total
	M	F	55-64	65-74	75-84	85+	APU	AMU	APR	
Yes	55.9	54.6	54.8	55.8	54.1	61.8	59.8	21.9	42.4	55.3
No	20.5	25.6	26.0	22.4	21.1	16.4	20.8	35.4	32.6	23.0
Did not answer	23.5	19.8	19.1	21.8	24.8	21.8	19.4	42.7	25.0	21.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

As the household's total monthly income rises, so does the access and use of differentiated medical care services, despite the fact that more than half of the population resorts to it.

Among the factors that explain this reality are the costs of health care services in hospitals, which are comparatively higher than those of the primary health care services. The existence of a higher offer of technical care in the hospital units, explains the fact that individuals with lower economic resources choose this option instead of looking for an answer in the primary health care services.

Table 63. Usage of differentiated medical care, according to the total monthly income (€), 2007 (%)

Total Monthly Income	Differentiated Medical Care Use			
	Yes	No	Did not answer	Total
< than 300	57.8	23.5	18.7	100.0
301 - 750	63.7	16.1	20.2	100.0
751 - 1,500	66.5	17.9	15.6	100.0
> than 1,501	70.2	12.8	17.0	100.0
Did not answer/Not applicable	44.6	29.5	25.8	100.0

Source: CEDRU Survey, 2007.

The frequency of usage of these health care services is mainly rare among the senior population (30.7%). A separate analysis by age groups shows, once more, that the older groups are more frequently associated with this service.

Table 64. Frequency of use of the differentiated medical care services, according to age group, 2007 (%)

Frequency of Use	Age Groups				Total
	55-64	65-74	75-84	85+	
Weekly	0.2	1.0	0.6	1.8	0.7
Monthly	3.0	1.2	2.1	5.5	2.2
Several times a year	10.6	9.2	12.7	9.1	10.5
Yearly	5.5	3.2	3.6	5.5	4.2
Rarely	27.2	36.2	26.3	32.7	30.7
Did not answer	37.1	36.2	45.6	38.2	38.9
Didn't apply	16.4	13.0	9.1	7.3	12.9
Total	100.0	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

In terms of differentiated health care, the emergency services are significantly predominant (24.5%), followed by external appointments (12.1%). The level of satisfaction in relation to this type of health care is considerably lower than the one observed in terms of primary health care (only 42% of the

population is satisfied). Nevertheless, a detailed analysis according to the TAU shows that, although in none of them the satisfaction rate reaches half of the population, in the APU it is considerably higher (46%), when compared to the one in the APR (30%). This difference in the levels of satisfaction is once more evidence, among other factors, of the urban-rural dichotomy that characterizes the spatial pattern of this kind of infrastructures.

As we have observed in terms of primary health care services, the accessibility to the differentiated health care services is limited by constraints related to the geographical accessibility (43.4%) and the waiting time (41.1%).

3.2. Social Service

Collective infrastructures of a social nature have a double function in today's society: urban planning, due to their important centrality, capable of promoting an urban structuring of the territory; promoting the population's quality of life, because they are strategic responses of support to families, sustained by a new philosophy of social policies (Simões, 2006).

The awareness of this reality has motivated a growing investment in social infrastructures in recent years, promoted by public and private entities and for different target-groups. Recent investments at a national scale in social policies reflect a higher concern and awareness of the importance of the expansion of the network and social services for the elderly, as a way to fight poverty and social/spatial exclusion, which affect many elderly people and their families.

However, the investments in this area still show a great number of insufficiencies, because the population ageing is a relatively recent issue in Portugal, as well as the dominant cultural patterns that still benefit the family as a care provider to the elderly.

Accessibility overview

An overall evaluation of the use of the social responses by the senior population reveals that these are still seldom used. However, based on the results of national surveys, four social responses were identified as being more relevant, due to slightly higher usage rates: day centers (2.5%), domiciliary care (2.3%), social centers (2.2%) and retirement homes (1.7%). Overall, this overview matches the results of the last *Carta Social* (Social Charter), since these are the most common social responses at national level. In the year 2005, there were 2,252 domiciliary care services for the elderly, 1,880 day centers, 1,508 retirement homes and 508 social centers. The remaining available social responses are of less significance (39 senior residences, 17 temporary senior shelters for emergencies and 10 night centers) (DPPE, 2007). A more detailed analysis of the available services for elders will be presented in Module 2.

However, the data obtained through the survey, as well as the references of the 2005 Social Charter by the MTSS should be looked at bearing in mind the following:

- ▶ The usage rate of the social response retirement home is under-evaluated, since the survey was mainly conducted to senior passers-by. The other social responses are also under-evaluated, regarding the study's target audience - population aged 55 years and over - which still have autonomy and independence and therefore make less use of the social responses;
- ▶ As far as the 2005 Social Charter is concerned, these are also under-evaluated as they do not include an important segment of non-registered infrastructures, due to multiple reasons, one of them being the illegality of their operation.

Table 65. Elderly social responses usage, 2007 (%)

Type of Social Response	Usage			Total
	Yes	No	No reply	
Day centre	2.5	79.1	18.4	100.0
Domiciliary care	2.3	95.7	2.0	100.0
Social centre	2.2	80.0	17.8	100.0
Retirement home	1.7	79.5	18.7	100.0
Vacation centre	0.8	81.0	18.2	100.0
Emergency Temporary Shelter (CAT)	0.7	97.3	2.0	100.0
Residencies	0.2	66.1	33.7	100.0
Night centre	0.0	81.3	18.7	100.0

Source: CEDRU survey, 2007.

Domiciliary Care

Domiciliary Care is the second social response most used by the senior population. Although there are no outstanding disparities between genders, there is a higher use by male individuals (53.3%) comparatively to the female gender (46.7%). This social response consists of providing personalized care, at home. Culturally, men are more dependent on these kinds of tasks.

The usage according to age groups shows that the individuals who belong to the intermediate age groups (65-74 and 75-84 years) are the ones who use this type of service more frequently (40% and 36.7%, respectively). The variation of this service use, based on age, is closely related to the increase of dependency and loss of autonomy associated with ageing. Seniors aged 55-64 years have lesser needs and are more self-sufficient. However, it is among the eldest (85 or over) that there is less use: due to their advanced age, dependency levels force them in many cases to be institutionalized or to move in with relatives. Services provided by domiciliary care are suppressed by the care provided by families or institutions.

A breakdown by TAU highlights that in urban areas the usage is higher (66.7%) - associated to the higher fragmentation of the family structure and the isolation of the elderly in the urban context, contrasting with the rural environment reality.

Table 66. Domiciliary care use, by gender, age group and Urban Area Type, 2007 (%)

Do you use ?	Gender		Age group				Urban Area Type		
	M	F	55-64	65-74	75-84	85+	APU	AMU	APR
Yes	53.3	46.7	16.7	40.0	36.7	6.7	66.7	13.3	20.0

Source: CEDRU Survey, 2007.

An analysis of the use of this social response, according to marital status, shows that married individuals use these services more frequently (46.7% of total users), closely followed by widowed individuals (40%). The most frequent use of this service is associated to the type of smaller households - 40% of the seniors live only with their spouses and 37% live alone - which is expected, as larger families benefit from the support of descendents and/or members of the same household.

Among the senior population living in Portugal, there is an inverse correlation between the usage proportion of this social response and the household income level. Although the non-usage of this social response is the most common situation among individuals from different economic classes, there is a higher usage rate among individuals with less financial capacity. This service is mostly requested by individuals with low incomes, which is related to the type of care and services provided, whereas individuals with higher economic capacity are able to use different types of service.

Table 67. Social response domiciliary care use, by total monthly income, 2007 (%)

Total Monthly Income Structure (€)	Domiciliary Support Use			
	Yes	No	No answer	Total
< a 300	3.7	90.9	5.3	100.0
301-750	2.9	95.0	2.0	100.0
751-1,500	2.2	97.8	0.0	100.0
> a 1,501	2.1	97.9	0.0	100.0
No answer/Not applicable	1.4	96.8	1.8	100.0

Source: CEDRU Survey, 2007.

There is a clear oscillation in the use of domiciliary care depending on the education level variable. It is among illiterate individuals or those with low education levels that the higher usage rates of this social response are registered, while there are no records of the top education levels using this social response. This statement can be explained by the fact that higher education levels are usually associated to higher incomes and therefore to populations with an economic capacity that enables them to access other types of social responses and services.

Table 68. Domiciliary care use, by education level, 2007 (%)

Education Level	Domiciliary Care Use			
	Yes	No	No answer	Total
Illiterate	2.4	97.6	0.0	100.0
Reads and writes	0.0	100.0	0.0	100.0
Primary school (1st to 4th year)	2.7	95.2	2.1	100.0
2nd level basic education	1.9	98.1	0.0	100.0
3rd level basic education	0.0	98.7	1.3	100.0
Secondary education	0.0	100.0	0.0	100.0
University education	0.0	100.0	0.0	100.0
No answer	4.0	85.9	10.1	100.0
Total	2.3	95.7	2.0	100.0

Source: CEDRU Survey, 2007.

The motives underlying the use of this type of social response, though wide-ranging, are essentially the result of the individuals' lack of capacity in carrying out their domestic tasks (23.3%) and the loss of autonomy (16.7%). However, motivations of a different kind are also among the reasons for their need: continued medical care (10%); need for personal care (6.7%); impossibility to be alone (3.3%).

The choice of the domiciliary care service is usually based on the proximity to the user's residence (13.3%), even though other factors can contribute to the selection of the service, such as: people known by the user or their relatives, having benefited from the service, the provision of night care and medical care.

Related with the very nature of this service, half of the senior population uses it on a daily basis (50%).

In terms of the level of satisfaction with the social response provided, a high percentage of users make a positive assessment of the domiciliary care (87%). Half consider the fee charged to the family as reasonable (17% considers it expensive; 7% considers it cheap and 3% very expensive).

The service payment is mostly ensured by the user itself (53%) and in 17% of the cases by direct family. Shared responsibilities between user and family have a residual importance (7%).

Social centre

The social centre, the third most used social response by the senior population, has slightly different usage levels according to gender: Among the individuals that declare to use this social responses, 58.6% are male and 41.4% female. Among other factors, the higher demand for social-recreational and cultural activities by male individuals can be explained by the fact that these are usually free from domestic tasks.

A breakdown by age groups reveals that it is higher (34.5%) in individuals aged 65-74. This happens because younger seniors (55-64 years) are mostly active and therefore do not need, or have the availability, to enjoy these types of social responses (despite a reasonable usage rate - 31% - which is linked to retirements before 65 years old). Among the older seniors, the usage of the social centers decreases in direct correlation to the growing loss of autonomy and mobility.

The use of social centers by TAU emphasizes a strong urban-rural dichotomy, since users of this social response are mostly found in APU (75.9%), whereas the usage in APR is considerably lower (10.3%). This discrepancy results not only from the higher concentration of social infrastructures in urban areas, associated to higher population densities. In rural areas the senior population usually maintains agricultural and cattle raising practices as a form of contributing to the family's economy and subsistence, as well as a free-time occupation to cover the typical scarcity of social infrastructures and services in these territories.

Table 69. Social centre use, by gender, age group and Urban Area Type, 2007 (%)

Do you use ?	Gender		Age group				Urban Area Type		
	M	F	55-64	65-74	75-84	85+	APU	AMU	APR
Yes	58.6	41.4	31.0	34.5	24.1	10.3	75.9	13.8	10.3

Source: CEDRU Survey, 2007.

Most users of this social response are married (51.7%), although widowed and single individuals also represent some relevance (37.9% and 10.3%, respectively), thus validating the importance of these infrastructures as meeting points for those living alone.

The use of this social response by type of household highlights that users of social centers are almost exclusively seniors living alone (48.3%) and seniors living only with their spouse (44.8%).

Similarly to what happens in the domiciliary care, the use of social centers diminishes as the income is higher. It is among individuals with lower incomes that the most significant usage rates occur, with a gradual increase of non-usage, as the income increases.

The motivation behind the use of social centers is essentially the demand for a space where social interaction and occupation of free time can be promoted (55%). This issue takes on a particular relevance because it indicates the void in time occupation that occurs when individuals leave an economic active life behind. In Portugal, there is still lack of awareness as to the potential role of the elderly in the development of several economic and socially relevant activities, such as volunteering, a rather common activity in Central European countries.

Table 70. Social centre use, by structure of total monthly income, 2007 (%)

Structure of Total Monthly Income (€)	Usage of Social Centre			
	Yes	No	No answer	Total
< a 300	5.3	89.3	5.3	100.0
301-750	1.5	96.5	2.0	100.0
751-1,500	3.4	96.6	0.0	100.0
> a 1,501	2.1	97.9	0.0	100.0
No answer/Not applicable	1.2	97.0	1.8	100.0

Source: CEDRU Survey, 2007.

The main selection factor for the choice of the social centre is its proximity to the users' residence (35%), which stresses the importance of integrating these infrastructures in the daily geographic territory of the senior population. This concern has not always been present in urban planning at a local level.

The frequency of usage of the social centers is mostly daily (27.6%), although the weekly frequency is also significant (17.2%), which demonstrates how central this type of infrastructures becomes in the population's day-to-day life.

Among the users of this social response, there is a positive evaluation of the services they benefit from (44.8%), followed by a reasonable evaluation (31%). No negative evaluation has been identified at a national level. Amongst other aspects, this positive assessment is caused by the fact that most users consider it low-priced.

The financial burden with the social centre is mostly of the users' responsibility (35%), although in 14% of the situations such responsibility belongs to the State; 10% to the family and 3.4%, shared between users and their families.

Day centre

Day centre is the most used social response by the senior population, due to the fact that it provides the most basic care and services and therefore it allows individuals to remain in their social-family environment.

Contrary to what was observed in the other social responses, day centre is mostly demanded by female individuals (51.5%) (differences registered from male individuals are minor (48.5%)).

Evaluating the age groups separately, we find a higher use of the day centers by individuals aged 75-84 years (42.4%). This can be explained bearing in mind the fact that younger seniors usually have higher autonomy levels and thus can carry out their most elementary daily activities. On the other hand, older individuals (85+ years old) are associated to higher dependency levels - hence, this response is insufficient, leading them to seek for more integrated services - and physical limitations that eventually restraint the use of the social response.

Day centers also present an urban-rural dichotomy: a usage rate close to 70% is associated to the APU; in the APR, the usage rate is only 18.2%. Although the explanation for this reality lies in several factors, once again the most observed are the location patterns of these collective infrastructures, mostly concentrated in highly populated areas. There are also more structured relations of family solidarity in the rural context, where direct and indirect descendants continue to be the main care providers to the elderly, limiting the need for formal care providers, even for social and cultural reasons.

Table 71. Day centre use, by gender, age groups and Urban Area Type, 2007 (%)

Do you use ?	Gender		Age groups				Urban Area Type		
	M	F	55-64	65-74	75-84	85+	APU	AMU	APR
Yes	48.5	51.5	27.3	18.2	42.4	12.1	69.7	12.1	18.2

Source: CEDRU Survey, 2007.

Most users of this social response are widowed individuals (45.5%), but the proportion of married users is also significant (33.3%). In terms of household typology, senior citizens living alone (66.7%), followed by seniors living with their spouses (30.3%) are those who use day centers the most.

Overall, it is those most in need that use this type of social response, since the higher usage rate occurs among individuals with a total monthly average income below 300€. However, it is important to mention that in the senior population with higher financial capacity (total monthly average income higher than 1,501€) the usage rate is higher than in the intermediate groups.

A breakdown by income and TAU reveals a remarkable dichotomy between urban and rural areas. While at APU individuals of all economic levels use day centers, in the APR, income causes the use of day centers to vary significantly, the highest usage rate being among seniors with less economic resources, decreasing significantly amongst individuals of the following economic level (3.1% rate) and null in the two higher economic groups.

Table 72. Day centre use, by structure of total monthly income, 2007 (%)

Structure of Total Monthly Income (€)	Day Centre Use				Use (yes) by Urban Area Type	
	Yes	No	No answer	Total Global	APU	APR
< to 300	4.8	71.1	24.1	100.0	2.8	9.7
301-750	1.5	65.8	32.7	100.0	1.4	3.1
751-1,500	1.1	81.6	17.3	100.0	1.4	0.0
> a 1,501	2.7	75.7	21.6	100.0	2.6	0.0
No answer/Not applicable	2.8	88.9	8.3	100.0	2.5	6.1

Source: CEDRU Survey, 2007.

The identification of the motives that lead users to use this social response shows a demand essentially based on basic needs, such as leisure activities (36.4%) and meals (18.2%).

The social response selection criteria are once again related to its proximity to the users' residence (21.2%). However, financial factors are also mentioned (low price, corresponds to 9.1%), as well as the lack of other options (6.1%). The frequency of usage is mostly daily (54.5%).

The global evaluation seniors make of this social response is mostly favorable (45.5% of users), although the reasonable evaluation is equally significant (30.3%). Furthermore, it is important to mention that no individual has made a negative assessment.

In the evaluation regarding family contribution to the social response, a diversity of opinions is found. Most users consider that the referred contribution to be low-priced (30.3%), followed by expensive and reasonable, with equal percentages (21.2%). Despite having little statistical significance, it is important to notice that 3% of the population considers it very expensive. The charges of this social response are mostly paid by the users themselves (48.5%), with families supporting that cost in 15.2% of the situations (in 6.1% of the situations it is the individual that pays and in 3% the charges are covered by the State).

Retirement homes

The retirement homes social response is mostly used by male individuals (60.9%); among female individuals this usage rate is clearly lower (39.1%). This reality translates the lack of autonomy that characterizes male individuals in carrying out domestic tasks, namely cooking, domestic hygiene and comfort, but also in health care.

The proportion of users of this social response clearly increases with ageing: there are no retirement home users aged 55-64 years or over. In the group of individuals aged 85 years or over, the proportion is lower than in the two previous age groups. This can be explained by the survey model: carried out essentially to passers-by, it limits the proportion of older individuals surveyed (because of their lesser autonomy and mobility, they are frequently confined to the infrastructures), leading to an under-representation in the sample obtained.

The use of this social response, when compared to the previous ones, reveals a higher antagonism between urban and rural contexts, as 52.2% of its users live in APU and no usage was registered in APR. This reality reveals not only the spatial concentration of these types of social infrastructures in urban areas, due to financial viability factors inherent to the investment, but also the differences in the family structures and dynamics, with a higher effective capacity of inter-help in rural contexts.

Table 73. Retirement homes usage, by gender, age group and Urban Area Type, 2007 (%)

Do you use ?	Gender		Age groups				Urban Area Type		
	M	F	55 - 64	65 - 74	75 - 84	85 or more	APU	AMU	APR
Yes	60.9	39.1	0.0	30.4	52.2	17.4	52.2	47.8	0.0

Source: CEDRU Survey, 2007.

Users of this social response are mostly widowed individuals (73.9%) and, associated to this condition, seniors living on their own (78.3%). Other typologies have been identified, although with a residual expression (8.7% live with their spouse; 8.7% have a household merely made up of descendents).

The relation between the use of retirement homes and income level reveals a decline in use, as the population's economic resources increase. Among the possible explanations is the fact that individuals with higher financial capacity in general seek social responses of higher quality (contrary to the previously analyzed social responses), because this one implies leaving one's home. This is a good example of the considerable expansion of assisted residencies, managed by private entities, registered in the past years.

Table 74. Retirement home use, by structure of total monthly income, 2007 (%)

Structure of Total Monthly Income (€)	Usage of Retirement Home			
	Yes	No	No answer	Total
< to 300	2.9	92.2	4.9	100.0
301-750	2.7	95.4	1.9	100.0
751-1,500	0.1	99.9	0.0	100.0
> to 1,501	0.0	100.0	0.0	100.0
No answer/Not applicable	1.1	97.2	1.8	100.0

Source: CEDRU Survey, 2007.

The motives leading to institutionalization in retirement homes are essentially four: need for regular care (21.7%); illness (8.7%); inability to execute domestic tasks (8.7%); to avoid solitude (4.3%).

In relation to the motives behind the selection of the home equipment, although the majority of users has not answered, two criteria were identified: proximity to residence (13%) and proximity to family

(4.3%), showing the users' and their respective descendents' concern in maintaining the seniors integrated in their daily territories.

The global evaluation of the retirement home social response is mostly positive (73.9%). On the other hand, as far as the family contribution is concerned, some differences occur in relation to the other social responses previously analyzed, as 47.8% of the population served considers it to be reasonable and 30.4% expensive, which is understandable given the fact that it is not a partial but all-inclusive service, in order to respond to this population's needs.

The payment of the family's contribution of this social response is mostly made by the beneficiaries themselves (69.5%), 21.7% having mentioned a shared contribution between the beneficiary and his family.

3.3. Socialization networks

From an individual perspective, the demographic ageing process is not only influenced by significant physiological and psychological shifts, but also by important social transformations, including the transition from an economically active life to a retirement situation. These circumstances lead to a gradually limited social life, thereafter focused on contacts with family, friends and neighbors. Bearing in mind this social framework, the interpersonal relationships are crucial for the individual's balance and well-being throughout the ageing process. Interpersonal relationships should compensate the bio-psychosocial reconfiguration and take on different forms throughout the various stages of development and life cycle of this population.

Unsurprisingly, family is seen as a core element in this process, because, as it has been confirmed in recent research, despite the existence of formal caregivers who are increasingly more qualified and specialized in providing services to the senior population, the family structure is irreplaceable. The family fulfils the need of each individual for intimacy bonds, affection, complicity and mutual understanding. Although the traditional family structure has undergone some transformations, it is still the main guarantee for solidarity and promotion of the individuals' quality of life during the ageing process.

Social relationships also contribute to a balanced and active ageing process. The capacity to interact outside the core family is fundamental in the course of the ageing process itself, which is natural and progressive.

In the course of the last few years, several researches have sought to identify the social support function in the ageing process. Despite the diversity of functions introduced, those presented by Barron, considering that they are regarded as the most suitable explanation for the main reasons that lead individuals to obtain and maintain social support networks. Primarily, the emotional support function is examined, which is associated to the individual's need to have someone available to talk and listen to, which is translated into crucial emotional well-being for each individual's balance. Therefore, their participation in socio-cultural activities is promoted and the individual becomes socially active as well. By including demonstrations of affection, tenderness, love and respect, this function promotes well-being that is vital for the individuals' balance. This fact compels them to participate in social and cultural activities, thus keeping themselves socially active; secondly, the material and instrumental support function which consists of activities promoted by others, allowing seniors to solve practical problems and/or make daily tasks easier; finally, the information support function, through which people receive relevant information or guidance that helps them to understand the world, society and the ongoing changes, thus allowing them to adjust (Barron, 1996).

It is necessary to point out that, when compared to family structures, the social support networks establish free-will relationships. Furthermore, it is common for friends and neighbors to belong to the same generation, which is a relevant aspect for the promotion of well-being.

Household Structure

In Portugal, the prevailing typology in terms of household is: senior living with spouse (4.75%), followed by senior living alone (31.4%) and finally, senior living with spouse and descendents (12.8%).

The typology of the household comprising a senior and his/her spouse is not linked to the level of urbanity - since it is the main typology in all TAU - but one can say that it is more relevant in the APU (48.6%). In the other household typologies, there are no considerable differences among TAU. However, it is in the APU that there is a larger number of seniors living alone. In the APR, the relevant household typologies are: senior living with another senior; senior living with descendents and senior living with spouse and descendents. Thus, it becomes clear that in rural contexts there is a tendency to constitute larger households, where relationships between generations prevail and where there is a greater dynamic as regards family relationships.

Table 75. Senior citizen's household typology, according to Urban Area Type, 2007 (%)

Household Typology	Urban Area Type			Total
	APU	AMU	APR	
Senior living alone	31.9	31.3	27.3	31.4
Senior living with spouse	48.6	40.6	43.2	47.5
Senior living with another senior	0.5	1.0	1.5	0.7
Senior couple living with another senior	0.5	0.0	0.8	0.5
Senior living with descendents	5.0	3.1	7.6	5.1
Senior couple with descendents	11.7	20.8	15.9	12.8
Other	1.1	2.1	3.0	1.4
Did not answer	0.6	1.0	0.8	0.7
Total	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

The household typology based on the gender variable generates important conclusions, which reflect fundamental features of the family structure in the Portuguese society. The household typologies with the senior living alone are mostly composed of women (59.6%), which is a result of their higher average life expectancy in comparison to men. It is also important to point out that in the household typologies that include a dependent elderly person, women also play the most relevant role. This can be related to their longevity and also to their important role in the care giving process. Finally, it is also relevant to emphasize that the majority of seniors living with descendents are women, which is due to the fact that they are less autonomous in terms of mobility, vulnerability and in the provision of support to their children and grandchildren.

The analysis of the household typology based on the age variable confirms that the percentage of seniors living alone increases with ageing and therefore the highest number of single-member families occurs among the older seniors (58.2%). Among the individuals aged 65-74 years, the main type is composed of seniors living only with their spouse (*empty nesters*). This is related to the fact that during this period most descendents already have an autonomous household and therefore do not live with their parents. In the 75-84 and 85+ age groups, the type composed by seniors living with their spouse loses its relevance due to the increase in mortality, which in its turn leads to a progressive increase of the single-member families.

Table 76. Seniors' household typology, according to gender, 2007 (%)

Household typology	Gender		Total
	Female	Male	
Senior living alone	59.6	40.4	100.0
Senior living with spouse	40.5	59.5	100.0
Senior living with another senior	88.9	11.1	100.0
Senior couple living with another senior	66.7	33.3	100.0
Senior living with descendents	73.5	26.5	100.0
Senior couple with descendents	47.3	52.7	100.0
Other	33.3	66.7	100.0
Did not answer	66.7	33.3	100.0

Source: CEDRU Survey, 2007.

Table 77. Seniors household typology, according to age group, 2007 (%)

Household Typology	Age Groups				Total
	55-64	65-74	75-84	85+	
Senior living alone	20.7	26.4	48.6	58.2	31.4
Senior living with spouse	40.8	59.8	41.4	27.3	47.5
Senior living with another senior	0.0	1.4	0.6	0.0	0.7
Senior couple living with another senior	0.2	0.8	0.3	0.0	0.5
Senior living with descendents	6.5	3.2	5.7	7.3	5.1
Senior couple with descendents	28.6	7.0	2.1	3.6	12.8
Did not answer	0.7	0.6	0.6	1.8	0.7
Other	2.5	0.8	0.6	1.8	1.4
Total	100.0	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

The analysis of the household type based on nationality highlights a significant difference among the native population: the main typology is of a senior living with their spouse (47.8%), whereas among the foreign population the main typology is of a senior living with their spouse and descendents (33.3%). In fact, among the foreign population living in Portugal (namely in terms of the African Communities), the age profile and the demographic behavior are very different from the Portuguese society. Recent studies carried out by the *Observatório da Imigração* (OI) - (Immigration Observatory) concluded that in 2001 the live births by a foreign father and/or mother - in the total of live births - largely outweighs the foreign population living in Portugal. It also concluded that, in the last few years, the importance of live births by at least one foreign parent has grown (Rosa, Seabra and Santos, 2003). Thus, it becomes evident that the Portuguese demography is influenced by the presence of foreign citizens, due to their cultural and social behaviors, which include higher birth rates and, consequently, larger families.

In terms of the structure of the average monthly income of each household, the typologies of senior living with couple and senior living alone are the ones with the highest economic difficulties. This is due to the fact that in these typologies it is possible to find the largest number of families with an average monthly income below 300€. On the other hand, the household typology of senior couple with descendents has the highest financial capacity, with a significant proportion (10.1%). Finally, the household typologies of senior with spouse, senior living with a senior citizen and senior living with descendents register average financial situations.

Table 78. Seniors' household typology, according to the structure of the average monthly income, 2007 (%)

Structure of the Average Monthly Income (€)	Household Typology								
	Senior Living Alone	Senior Living with Spouse	Senior Living with Another Senior	Senior Couple Living with Another Senior	Senior Living with Descendants	Senior Couple with	Did Not Answer	Other	Total
< to 300	20.9	11.1	11.1	33.3	16.2	4.7	33.3	27.8	14.1
301-750	27.9	26.2	22.2	0.0	33.8	16.0	22.2	38.9	25.8
751-1,500	7.9	14.3	11.1	16.7	10.3	25.4	22.2	11.1	13.5
> to 1,501	2.2	2.7	0.0	0.0	1.5	10.1	0.0	16.7	3.5
Did not answer/Not applicable	41.1	45.6	55.6	50.0	38.2	43.8	22.2	5.6	43.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

Typology of Established Relationships

In the analysis of the family relationships of the senior population in Portugal, is it important to evaluate the frequency of their contact with their descendants. In what the contacts with 1st degree direct descendants (children) are concerned, most of them do so on a regular basis (56.9%), followed by occasional contacts (22.8%). Only 7.6% admits to rarely having contact with their children and 3% does not have any contact whatsoever.

As for their contact with grandchildren, the situation is identical, though less frequent: dominant contacts are regular (37.8%).

In an analysis according to TAU, the regular contact between seniors and their children is higher in APR. Contacts with grandchildren are more regular in APU than in APR, which, among other factors, can be explained: on the one hand, by the migrations of younger people from rural to urban areas, for economic reasons, or for study purposes, thus contributing to the weakening of their contacts with their grandparents who remain in rural areas; on the other hand, because it is in the urban contexts that female labour participation reaches higher levels, leaving seniors with more responsibility in taking care of their grandchildren.

Consequently, although the Portuguese society has undergone several transformations over the last years with a direct impact on the family structures and relationships, there is preservation of the inter-generational contacts and of the family relationships, although still with some territorial specificities.

The analysis of the provision of support and aid to the senior is in line with the previous conclusion, through which family remains as the main care provider, while friends and neighbors play a minor role.

Table 79. Frequency of the seniors' contact with children and grandchildren, according to gender, 2007 (%)

Frequency of the Contact	Contact with Children			Contact with Grandchildren		
	Female	Male	Total	Female	Male	Total
Regular	51.6	48.4	100.0	50.7	49.3	100.0
Occasional	47.0	53.0	100.0	48.1	51.9	100.0
Rare	45.5	54.5	100.0	47.8	52.2	100.0
No contact	52.5	47.5	100.0	49.3	50.7	100.0
Not applicable	44.3	55.7	100.0	49.5	50.5	100.0
Did not answer	57.1	42.9	100.0	57.1	42.9	100.0
Total	49.6	50.4	100.0	49.6	50.4	100.0

Source: CEDRU Survey, 2007.

Contacts with descendants (children and grandchildren) according to gender indicate the existence of different relationships based on this variable, albeit not very relevant. At a national level, women have a

more regular contact with children and grandchildren (51.6% and 50.7%, respectively). This family relational framework highlights the importance of women in the education and life of their descendants, reflecting cultural patterns according to which education and taking care of children is a task for women.

Migration Course

Among the population that migrated at a national scale, the majority maintains connections with their homeland (58.2%). These connections are of a varied nature, although family ties are the most common (55.2%); friendship ties and the fact that they own a house come in second place.

As to a probable return, only 13.3% think of it as a possibility. The motivations for a hypothetical return are mostly emotional ties (51%) and the search for greater tranquility and quality of life (17.7%). Among those who do not consider returning, three factors stand out: the fact that they enjoy where they presently live (16.3%); having a structured life (family and assets) where they presently live (11.4%); absence of material or immaterial ties to their homeland (11.1%).

Within the scope of international migration, most of the seniors living in Portugal who were born in a foreign country migrated mostly in the period following the decolonization: 35.4% arrived in Portugal between 1975 e 1979 and 29.2% during the 80's.

However, the main motive for immigrating to Portugal was to search for better life conditions in general (44%), followed by family reasons (21%), which include decision-making by their ascendants in which they had no influence, family re-gathering and others.

The preservation of family ties with the country of birth is much more significant (85.4%) than in internal migrations. The connection of citizens with their country of birth is basically emotional, bearing in mind that the most mentioned factors are family ties (85.4%), friendship ties (21%); financial conditions and the fact that they own a house (10.4%).

Among this population there is a greater intensity of family interaction, i.e., 83% of the foreign citizens have regular contact with their children and there is no record of the absence of contact. This conclusion gains even more weight when compared to the underlying reality of the national citizens, among which the contact with their children, albeit high, is considerably lower (56.6%), and furthermore approximately 3% has no contact at all.

Given that these are international migratory movements and the fact that the reason for immigrating to Portugal is mainly for better quality of life, 33.3% do not visit their home countries, 45.8% rarely visit it and only 4.2% do so occasionally. This situation does not seem to present a significant relation with the type of entrance and permanence in the national territory: 87.5% have a permanent residence permit and 4.2% a temporary residence permit.

Most senior individuals from foreign countries have a good knowledge of the Portuguese language (75%) because they have been living in Portugal for so long, some of them for decades, and do not present irregularity/lack of documentation. Their social interaction therefore has no considerable restraints.

Even though their integration process in the Portuguese society cannot be confined to social interaction, 63% do not intend to go back to their home country and the main reason is that they enjoy living in Portugal. However, a wider list of reasons encourages this decision: lack of material and immaterial connections with their home country and family, financial and political motivations.

Family and Social Relationship Impacts

The quality of family relationships is a decisive factor in the quality of life and health of the individuals and, subsequently, in the promotion of active and balanced ageing. The surveyed population with a good state of health perception has regular contact with their children (60%). It is also among seniors who establish regular contacts with their children that the satisfaction in terms of occupation of free time is greater. It is also important to note that there is also a positive connection among seniors that have regular contact with their children and those who do not intend to be institutionalized.

3.4. Housing

In addition to a framework of greater economic deprivation of the senior population is their physical and psychological incapacity that, in conjunction, limit several actions, such as those aimed at the preservation, rehabilitation and restoration of the houses/flats in which they live. These constraints lead to the degradation of the housing stock, compromise their quality of life, their well-being and safety, and lead to an increase in risk situations and/or accidents.

The lack of an effective housing adaptability to the real needs of this population, articulated with the difficulties, needs and underlying states of debilitated health related to their age, gives rise to situations of extreme difficulty in terms of mobility, causing them to spend long periods of time at home. This situation fosters the social isolation of seniors in their own homes, preventing them from having access to basic needs, such as access to health care, doing their own shopping or participating in simple social interchange and leisure activities.

Aware of these social problems, in the last few years the central and local administration has created means to support the elderly in terms of housing, many of which are still being launched.

Overview of the housing stock

Housing Occupation Regime

Most of the senior population lives in their own home (63.8%), although the situations of those who rent are also significant, namely total rent (30.3%). Worth noting is the instability and insecurity that affects approximately 3% of the reporting population, who depend on other people in order to have somewhere to live (1.8% in a situation of provision free of charge and 1.1% in a situation of provision free of charge by relatives).

The housing occupation regime broken down by TAU shows that in all types of urban areas the predominance is for own home, although this is more relevant in APR (79,5%). In contrast, it is in APU that renting prevails, whereas in rural contexts this situation is not very common. The urban contexts are those that offer a greater variety of housing occupation regimes, renting being an important housing response, especially for situations of temporary stay or economic incapacity to own a home.

The housing occupation regime differs according to gender, although in terms of occupation of one's own home and of total renting, the situation of men and women is very similar. Partial renting is common mostly amongst men (56.3%, in comparison to 43.8% of women), which relates to situations of people living in boarding houses or the sharing of housing with work colleagues or fellow-citizens. In contrast, the provision of housing free of charge, by relatives or not, prevails among women as they tend to have lower economic resources and to benefit from greater family protection and support, which is associated to the social representations to which they are more vulnerable.

Table 80. Housing occupation regime, according to Urban Area Type, 2007 (%)

Housing Occupation Regime	Urban Area Type			Total
	APU	AMU	APR	
Partial rent	1.5	0.0	0.0	1.2
Total rent	34.4	6.3	13.6	30.3
Own home	60.9	76.0	79.5	63.8
Provided free of charge	1.4	3.1	4.5	1.8
Provided free of charge by relatives	1.0	0.0	2.3	1.1
Institutionalized	0.5	14.6	0.0	1.5
Did not reply	0.3	0.0	0.0	0.2
Not applicable	0.1	0.0	0.0	0.1
Total	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

Table 81. Housing occupation regime, according to gender, 2007 (%)

Housing Occupation Regime	Gender		
	Female	Male	Total
Partial rent	43.8	56.3	100.0
Total rent	51.1	48.9	100.0
Own home	49.3	50.7	100.0
Provided free of charge	54.2	45.8	100.0
Provided free of charge by relatives	57.1	42.9	100.0
Institutionalized	25.0	75.0	100.0
Did not reply	66.7	33.3	100.0
Not applicable	0.0	100.0	100.0
Total	49.6	50.4	100.0

Source: CEDRU Survey, 2007.

Economic capacity differs according to gender, with consequences in several areas, particularly in housing, making it an important variable. The analysis shows that the average monthly income of women tends to be lower: it is mainly women who receive an income equal to or less than 300€ (56.1%). As the income bracket gets higher, the predominance of men also increases. The difference between genders reaches its maximum in the 1,501€> income bracket: 61.7% of the seniors who receive this amount on a monthly basis are men.

Table 82. Structure of the total monthly income, according to gender, 2007 (%)

Structure of the Total Monthly Income (€)	Gender		
	Female	Male	Total
< 300	56.1	43.9	100.0
301-750	50.6	49.4	100.0
751-1,500	38.5	61.5	100.0
> 1,501	38.3	61.7	100.0
Did not reply/Not applicable	51.3	48.7	100.0
Total	49.6	50.4	100.0

Source: CEDRU Survey, 2007.

The differences in the housing occupation regime based on the age variable are not very significant. Nonetheless, although the own home occupation regime is prevalent in all age groups, as age increases, the proportion of individuals living in their own home tends to decrease. In the 55-64 age bracket, 67.7% live in their own home; in seniors aged 75-84 years old and 85 or above, this type of housing occupation is around 58%. It should be pointed out that the situations that indicate greater housing vulnerability occur among the oldest senior population; it is in the 75-84 and 85-and-over age brackets when the partial rent and provision free of charge have greater significance. Finally, it should be noted

that the situations of institutionalization reveal a direct correspondence to the increase in age, which results from the increase in dependency due to the loss of functionalities.

Table 83. Housing occupation regime, according to age group, 2007 (%)

Housing Occupation Regime	Age Groups					
	55-64	65-74	75-84	85+	Did not reply	Total
Partial rent	1.4	1.0	1.2	1.8	0.0	1.2
Total rent	28.6	30.2	32.3	30.9	50.0	30.3
Own home	67.7	65.0	58.0	58.2	50.0	63.8
Provided free of charge	1.8	1.6	1.8	3.6	0.0	1.8
Provided free of charge by relatives	0.2	0.8	2.1	3.6	0.0	1.1
Institutionalized	0.0	1.2	3.9	1.8	0.0	1.5
Did not reply	0.0	0.2	0.6	0.0	0.0	0.2
Not applicable	0.2	0.0	0.0	0.0	0.0	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

The analysis of the housing occupation regime according to nationality reveals a striking difference between Portuguese and foreign citizens. While the Portuguese senior population lives mainly in their own home (64%), among foreign citizens the total rent regime prevails (72%). Among the factors that explain this dichotomy, it is important to stress that: foreign citizens tend to have socially more undervalued and badly paid jobs, and therefore less capacity to buy their own home (50% of foreign senior citizens have an average monthly income equal to or less than 500€, while only 29.3% of national seniors find themselves in this situation). The factors associated to legal status are emphasized, since the processes underlying the acquisition of a home call for a set of parameters at this level which these citizens are unable to meet.

Type of housing

The senior population lives mainly in flats (58.9%), although the number living in houses is quite significant (32.8%). When the type of housing is compared to the level of urbanity, a dichotomy is identified between the APU and the APR; while in the former the population lives mainly in flats (68.3%), in the APR houses clearly predominate (93.9%). Furthermore, it should be mentioned one of APU idiosyncrasies is that they combine very different types of housing, some of which are only present in this territorial framework (non-classic housing, rehousing flat or social flat). A greater housing precariousness and contrasts with the more homogeneous standard of the housing stock in the APR is thus evident.

As far as the type of housing is concerned, it should be further highlighted that there is a predominance of foreign citizens living in social flats (72%), against only 3.8% of Portuguese citizens.

Table 84. Type of housing, according to Urban Area Type, 2007 (%)

Type of Housing	Urban Area Type			Total
	APU	AMU	APR	
Non-classic housing	0.3	0.0	0.0	0.2
Flat	68.3	28.1	3.0	58.9
Rehousing flat	0.4	0.0	0.0	0.3
Social flat	5.7	0.0	0.0	4.8
House	23.4	55.2	93.9	32.8
Part of the house	0.7	1.0	0.8	0.8
Did not reply	0.5	1.0	2.3	0.8
Not applicable	0.5	14.6	0.0	1.5
Total	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

State of Preservation

The evaluation of the state of preservation of the housing in which the senior population lives indicates that, in general, houses/flats are in a good (40.3%) or reasonable state (37.2%). Nevertheless, it is important not to overlook the fact that 17.4% of the senior population lives in houses/flats that are in some need of rehabilitation or reconstruction and that 4.8% live in degraded buildings.

A cross-tabulation with age reveals that although in the four age groups considered most of the population lives in houses/flats in a good or reasonable state of preservation; in the two older age groups the need for rehabilitation works is greater due to its degraded state. The houses in need of great construction work are directly correlated with the increase in age. This situation is associated, among other factors, to the lower physical and psychological vitality of the individuals to perform restoration and preservation works of the houses/flats of which they are tenants. Furthermore, as previously mentioned, the more advanced the age, the greater the number of individuals who live in a rented house/flat and therefore the more dependent they are on the owner's initiative.

Table 85. State of preservation of housing, according to age group, 2007 (%)

State of Preservation of Housing	Age Groups				Total
	55-64	65-74	75-84	85+	
Good	53.7	36.0	29.9	38.2	40.3
Reasonable	30.4	41.6	39.9	32.7	37.2
In need of minor repairs	10.6	15.2	18.7	16.4	17.4
Degraded (in need of major rehabilitation works)	3.7	4.2	6.0	10.9	4.8
Did not reply	1.6	3.0	5.4	1.8	1.7
Total	100.0	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

It must be further highlighted that the houses/flats in need of minor or even major rehabilitation works are more relevant among the senior population with the lowest income, and consequently, those who have less financial capacity to undertake these works. This leads to a gradual deterioration of the housing conditions and the quality of life. It is thus evident that in residential areas primarily inhabited by deprived seniors, the housing stock is in an advanced state of degradation and there are more accidents at home and greater impediments to mobility.

Table 86. State of preservation of housing, according to the total monthly income structure, 2007 (%)

Total Monthly Income Structure (€)	State of Preservation of Housing				Total
	Good	Reasonable	In Need of Minor Repairs	Degraded	
Up to 150	1.3	0.2	2.1	3.2	1.1
151-300	7.9	13.8	21.6	19.0	13.1
301-500	12.5	16.1	19.1	20.6	15.5
501-750	9.2	12.0	11.3	4.8	10.3
751-1,000	12.7	6.1	4.6	3.2	8.3
1001-1,500	6.9	5.7	1.0	1.6	5.2
1,501-2,500	3.6	1.0	0.5	0.0	1.9
2,501-5,000	1.9	0.4	0.0	0.0	0.9
> 5,001	1.7	0.0	0.5	0.0	0.8
Did not reply/Not applicable	42.3	44.7	39.2	47.6	43.0
Total	100.0	100.0	100.0	100.0	100.0

Source: CEDRU survey, 2007.

Household Equipment

With regard to essential infrastructures, there are still situations of seniors living in houses/flats with no kitchen, water supply system, sewage system and/or sanitary installations, which constitute an indicator of the poverty and social exclusion of the elderly in the Portuguese society. The biggest lack of essential infrastructures is found in APR. This situation is a good indicator to assess the living conditions of the senior population. As for households, there are also shortages, as not all old people have equipment to help them with the housework, thereby providing a better quality of life (e.g. washing machine, cooker or refrigerator). It is curious, however, that all of the surveyed individuals have a telephone and the proportion of those who have a television is the same as those who have complete sanitary installations (96%).

Table 87. Housing infrastructures, 2007 (%)

Essential Infrastructures	%	Household appliances	%	Audio/video and communications	%
Kitchen	97	Stove	97	Telephone	100
Water supply system	97	Washing machine	92	Mobile phone	65
Sewerage system	95	Refrigerator	97	Television	96
Complete sanitary installations	96			Computer with Internet connection	16

Source: CEDRU Survey, 2007.

3.5. Leisure activities

Transition from active life to retirement is an important change in the life of individuals. In Portugal, some social representations are still very skeptical or pessimistic regarding this change due to the fact that an individuals' value is still centered on their professional and productive activity (ISS, 2007). There is still a certain level of unawareness of the fact that this is a very important period in life. The elderly person may not only remain productive, but also play an even greater and active role in the family and in society in general, due to a greater availability of free time, thus contributing to their own personal and professional fulfillment.

The lack of awareness and consideration for this stage in life translates into a rather reduced offer of social infrastructures designed as venues for fraternization, socializing and leisure-recreational activities, and also into an incipient offer of Programmes by the Central Administration targeted at particular needs. However, in the last few years, there has been a considerable increase in the number of Local Administration projects designed for this purpose, as a result of the increase in the average life expectancy and of the greater awareness of the experts on this subject.

It is therefore important to understand the way in which the senior population occupies its free time, as this will have repercussions on their personal satisfaction/achievement, on their overall well-being and on the promotion of active ageing.

The importance of an effective and diversified occupation of free time is decisive for the well-being of the senior population: 70.1% of those who consider themselves to be in a good state of health are also satisfied with their leisure activities. The awareness of this reality explains the growing investment, both public and private, in activities and services designed to provide the senior population with a variety of activities to fulfill in their free time.

Satisfaction with Leisure Activities

Most of the senior population living in Portugal is satisfied (71.7%) with the way they occupy their free time. The degree of satisfaction according to gender reveals that both men and women are overall satisfied. The degree of satisfaction according to the TAU shows significant variations, however. The

most positive evaluation is in the APR (the proportion of individuals who are totally satisfied is higher than that in the APU: 12.1% and 8.9%, respectively). Additionally, it is important to mention that it is exclusively in rural areas that there were no cases of total dissatisfaction.

Table 88. Seniors' satisfaction in terms of leisure activities, according to Urban Area Type, 2007 (%)

Level of Satisfaction	Urban Area Type			Total
	APU	AMU	APR	
Totally satisfied	8.9	14.6	12.1	9.6
Satisfied	74.2	55.2	62.9	71.7
Unsatisfied	9.1	6.3	7.6	8.8
Totally unsatisfied	0.9	1.0	0.0	0.8
Did not reply	6.9	22.9	17.4	9.1
Total	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

The analysis of the senior's satisfaction regarding leisure activities is very similar in the various levels of education. Nonetheless, among the more educated population, the proportion of people that are totally satisfied takes on greater relevance. In contrast, it is the population with the lowest levels of education that the levels of dissatisfaction or total dissatisfaction become more significant.

Table 89. Seniors' satisfaction in relation to their leisure activities, according to education level, 2007 (%)

Level of Education	Degree of Satisfaction					Total
	Totally Satisfied	Satisfied	Unsatisfied	Totally Unsatisfied	Did not reply	
Illiterate	3.5	75.3	14.1	3.5	3.5	100.0
Reads and writes	0.0	100.0	0.0	0.0	0.0	100.0
Primary school (1st to 4th year)	6.8	76.0	8.5	0.7	8.0	100.0
2nd level basic education	14.8	68.4	6.5	1.9	8.4	100.0
3rd level basic education	6.6	75.0	6.6	0.0	11.8	100.0
Middle-level course	17.1	71.4	5.7	0.0	5.7	100.0
Secondary education	14.3	71.4	8.6	0.0	5.7	100.0
University education	36.5	51.9	7.7	0.0	3.8	100.0
Did not reply	10.1	48.5	13.1	0.0	28.3	100.0
Total	9.6	71.7	8.8	0.8	9.1	100.0

Source: CEDRU Surveys, 2007.

In close connection to the levels of education, there are also differences in the evaluation of leisure activities, according to the income level. Although in all income groups satisfaction is the prevailing answer, slight differences can be seen: among the population with greater economic privation (incomes less than 300€), the proportion of individuals who are totally satisfied is very low (5.9%), particularly when compared to the proportion of those who are unsatisfied (11.2%). On the other hand, the proportion of individuals who are totally satisfied with their leisure activities among the senior population with greater economic capacity is higher than in the other income levels. The greater the economic capacity of individuals, the greater their overall satisfaction with leisure activities, insofar as they have access to more and better services, equipment and activities.

Table 90. Seniors' satisfaction in relation to their leisure activities, according to income, 2007 (%)

Structure of the Total Monthly Income (€)	Level of Satisfaction					Total
	Totally Satisfied	Satisfied	Unsatisfied	Totally Unsatisfied	Did not reply	
< 300	5.9	69.5	11.2	0.0	13.4	100.0
301-750	9.6	71.3	10.8	0.6	7.6	100.0
751-1,500	10.1	68.7	12.8	0.6	7.8	100.0
> 1,501	18.9	67.6	5.4	2.7	5.4	100.0
Did not reply/Not applicable	10.2	73.3	5.8	1.2	9.5	100.0
Total	9.6	71.7	8.8	0.8	9.1	100.0

Source: CEDRU Survey, 2007.

Leisure Activities

The most frequent leisure activities of seniors are: watching television (90.6%), walking (76.4%), socializing with family and friends (74.2%) and reading (63.7%); a significant part of the seniors (44.2%) also includes housework as part of their leisure activities; less frequent activities are spending time in libraries (9.9%), performing volunteer actions (8.4%) and studying (8.0%).

In regard to frequency, watching television is clearly the daily activity that prevails (53.6% of seniors), followed by daily socializing with family and friends (30.2% of the reporting population).

An analysis of leisure activities performed on a daily basis shows gender differences. Studying and watching television reveal a very similar profile between men and women, which is closely associated to the fact that the former is not very commonly performed among seniors, while the latter is the most common activity among this age group. However, there are activities predominantly carried out by women, as is the case of housework and caring for family members. This is a reflection of the social and cultural patterns of the Portuguese society, where these activities are seen as the women's responsibility, particularly among the oldest population. Other leisure activities predominate among men, namely learning activities (using the computer and the internet and reading on a daily basis) and socializing (daily socializing with family and friends, performing hobbies, games and sport). The heterogeneity in the activities carried out daily are due to the fact that senior women have a significant part of their time occupied with housework and family members, leaving them with little time to carry out activities outside the home environment that promote their socialization. Furthermore, women show less motivation and willingness to carry out these activities, as a result of cultural and social factors.

There are important territorial differences in some of the main leisure activities carried out by the senior population as a whole. Watching television, the most relevant leisure activity, is carried out on a daily basis mainly in APR (77.3%), as opposed to in APU (47%), which reveals the differences in the access/offer of leisure activities in both areas. Reading, on the other hand, is a daily activity that is carried out with greater frequency in APU than in APR. The rural population is associated to overall lower levels of education, which explains the lack of interest in reading and less access to information.

Table 91. Daily leisure activities of seniors, according to gender, 2007 (%)

Daily Leisure Activities	Gender	
	Female	Male
Study	50.0	50.0
Housework	88.3	11.7
Caring for family members	66.1	33.9
Watching television	52.0	48.0
Reading	45.7	54.3
Computer with internet connection	31.1	68.9
Socializing with family and friends	45.4	54.6
Walking	47.9	52.1
Sport	42.9	57.1
Hobbies, games	20.7	79.3

Source: CEDRU Survey, 2007.

Traveling

According to Ferreira (2004), the strengthening and expansion of the tourism phenomenon is one of the heavy trends which permanently mark the history of the 20th century, mainly from the 1950^{ies} on, at social and economic levels. It is in this context of rapid growth of international tourism flows that a recent evolution has been seen in the senior tourism market. On a European and international level, this evolution has been marked by great buoyancy. In such a way that between 1990 and 2000 its volume more than doubled: from a stable and consensual value of approximately 41 million international trips with a European destination in 1990 to an estimate of 74 to 85 million trips in 2000. It should be further highlighted that, in addition to its growing weight in absolute terms, the senior tourist market has recorded an above-average performance in international tourism overall, both nationally and internationally, being one of the segments that has undergone the most significant expansion.

An analysis of the tourism flows of seniors living in Portugal shows that this activity has not yet reached half of this population segment, given that only 46.3% travel often. Male individuals are very enthusiastic about traveling: the percentages of 52.9% for men and 47.1% for women are significant.

Traveling habits have a proportionally inverse relationship to age, as this activity decreases significantly as age increases: taking only the senior population that travels into consideration, 41.3% are aged between 55-64 years old, 36.4% between 65-74 years old, 20.7% between 75-84 years old; and only 1.3% of the population that travels is aged 85 or above. Factors such as loss of autonomy and functionalities as age increases lead to a lesser predisposition or even incapacity to travel.

There is also a strong correlation between traveling and level of education, as among the illiterate senior population or those who only have the 1st cycle of basic education, the majority does not travel. This is not so in the case of the other levels of education: there is a progressive increase in traveling among individuals with secondary and higher levels of education.

Marital status also affects the seniors' willingness to travel. In fact, of the married seniors, the majority (51.6%) travels on a regular basis, while among single individuals and widows/widowers, the majority does not travel (55.6% and 67.4%, respectively).

The senior tourism market varies according to the TAU: it is a common practice in APU (almost half of the senior population living here travels regularly), less frequent in AMU (a little over 1/3 of the seniors living here travel on a regular basis), and even less significant in rural areas, where only around 1 in every 4 seniors travel for tourism purposes.

Table 92. Traveling habits among the senior population, according to Urban Area Type, 2007 (%)

Regular Traveling	Urban Area Type		
	APU	AMU	APR
Yes	49.2	37.5	28.8
No	50.4	61.5	70.5
Did not reply	0.5	1.0	0.8
Total	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

In terms of travel destinations, traveling within Portugal clearly prevails (75%) and is more frequent than traveling abroad (8%). Approximately 17% of seniors claim to travel both within Portugal and abroad.

Associativism

In Portugal, there is no generalized culture of associativism among the senior population: approximately 2/3 of seniors have no associative involvement and only 18% reveal an occasional degree of associativism (member or associate of a single institution).

It should be noted that the significant and occasional degrees of associativism are always higher among men than women.

As far as age groups are concerned, it is among the youngest seniors (55-64 years old) that the associative involvement is greater (related to the decrease in the overall capacities associated to the advancing age). The oldest seniors (85 and above) are not the segment that reveals a lower degree of associativism as they do maintain some connections, albeit occasional, to some entity/institution.

Table 93. Seniors' associativism according to gender and age group, 2007 (%)

Degree of Associativism	Gender		Age Groups			
	M	F	55-64	65-74	75-84	85+
Significant	8.4	1.7	6.7	4.2	4.5	3.6
Occasional	21.3	14.8	16.8	20.0	15.7	25.5
None	60.3	74.1	67.3	66.0	69.5	61.8
Did not reply	10.0	9.4	9.2	9.8	10.3	9.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

A more detailed analysis by TAU shows that regardless of the type of urban area where seniors live, the degree of associativism that predominates is none in all of them. However, there is a certain singularity in APU due to the clear superiority in terms of extreme situations, i.e. these are the territories where there is a greater proportion of no associativism (71.6%) and simultaneously more significant associativism (5.7%).

Table 94. Seniors' associativism according to Urban Area Type, 2007 (%)

Degree of Associativism	Urban Area Type			
	APU	AMU	APR	Total
Significant	5.7	2.1	1.5	5.1
Occasional	19.7	8.3	11.4	18.1
None	71.6	35.4	53.0	67.1
Did not reply	2.9	54.2	34.1	9.7
Total	100.0	100.0	100.0	100.0

Source: CEDRU Survey, 2007.

Religion

The practice of religion is also an aspect to be considered when discussing leisure activities. The survey analysis shows that the senior population rarely goes to church (51.2%), although more than 1/3 goes on a weekly basis. It is mostly women who go to church (55.7%), although the difference between men and women is not very significant (44.3% of men).

Table 95. Church-going, according to gender, 2007 (%)

Church-going	Gender		
	Female	Male	Total
Go	55.7	44.3	100.0
Do not go	30.4	69.6	100.0
Did not reply	44.4	55.6	100.0
Total	49.6	50.4	100.0

Source: CEDRU Surveys, 2007.

A breakdown according to urban-rural type reveals that there are more church-goers in the rural areas: while in APR 37% of the seniors go to church every week, in APU this proportion is considerably lower (26.2%). This reality shows that in rural areas religion continues to play a greater role in senior's daily lives. On the other hand, the fact that the populations in urban contexts benefit from a greater offer of leisure infrastructures and services, causes church-going to become less important when compared to other activities.

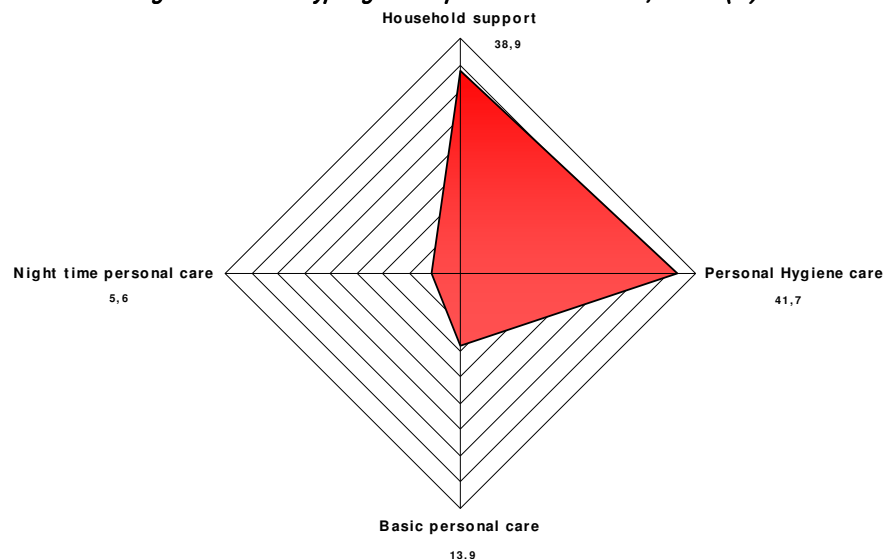
3.6. Global perception of the main needs

In order to characterize the senior population residing in Portugal, the identification and analysis of their main needs is essential. For that reason, a methodology was adopted in order to achieve their own perception of needs, an evaluation that reflects this population's main limitations and difficulties. This analysis was made according to major domains, considered crucial in an active ageing process.

Personal Care

The main requirements of the senior population regarding personal care are related to hygiene (41.7%), which is mostly associated to lack of autonomy for health reasons or insecurity in the ability to perform basic tasks, like taking a bath or getting dressed. The need for domiciliary support is also relevant, including both the individuals' needs (38.9%) and the provision of basic care (13.9%). With less relevance, the need for night period care was also referred (5.6%).

Figure 33. Main typologies of personal care needs, 2007 (%)

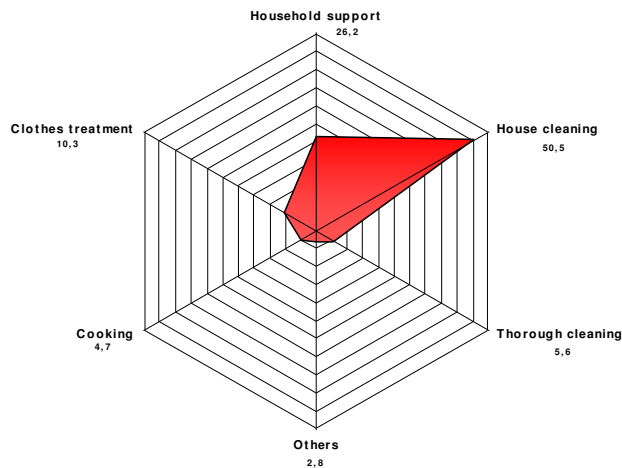


Source: CEDRU Survey, 2007.

Domestic Tasks

Seniors present a multiplicity of domestic needs. However, house cleaning is by far the most referred, gathering half the quotes (50.5%). The need for household support (26.2%) reflects needs associated with domestic tasks in general. Laundry work is the third greater need regarding domestic tasks.

Figure 34. Main typologies of domestic tasks needs, 2007 (%)

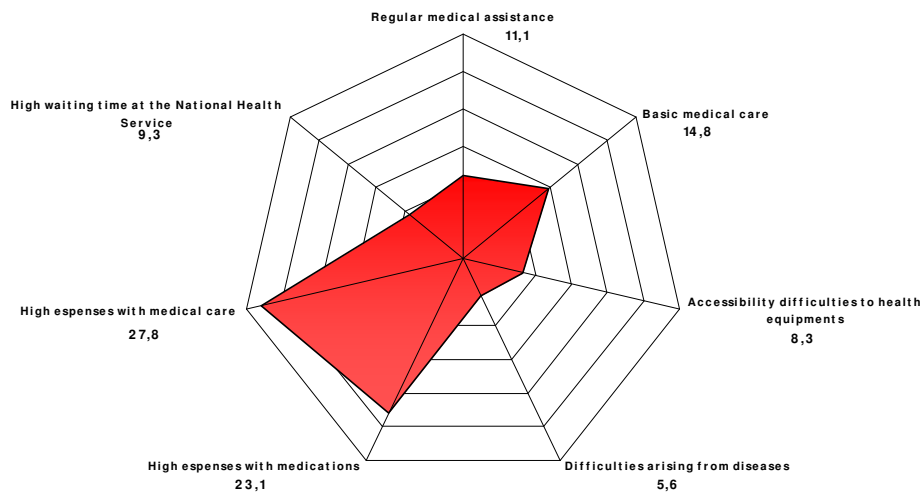


Source: CEDRU Survey, 2007.

Health care

Within the health care area, it was possible to identify a wide range of issues. Financial charges are the most mentioned, namely, the expenses with medical care (28%) - which includes costs with consultations, both in the NHS and/or in the private sector, use of complementary means of diagnosis, among others - followed by medication expenses (23%). Even though financial constraints are referred as one of the main limitations to the access to health care, another important issue is the need for the services themselves. Around 15% of the surveyed seniors need basic medical care, meaning that they are deprived of elementary medical assistance.

Figure 35. Main typologies of health care needs, 2007 (%)

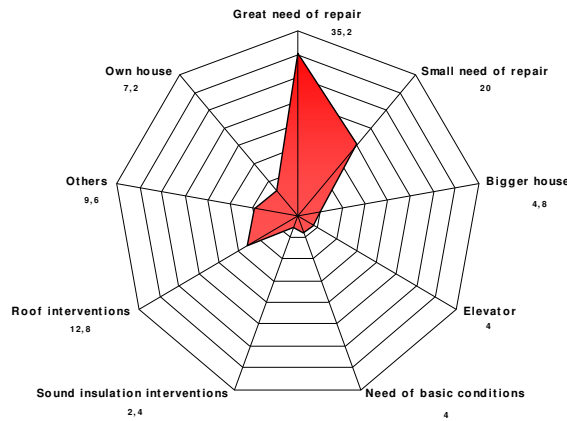


Source: CEDRU Survey, 2007.

Housing

In the housing context, the population aged 55 or over reveals two major needs: major house repairs (35.2%), smaller house interventions (20%). Several other needs associated with housing were presented, although with less statistical significance: roof repairs (12.8%); buying their own house (7.2%); buying a larger house (4.8%); having an elevator (4%); basic housing conditions (4%) and acoustic isolation intervention (2.4%).

Figure 36. Main typologies of housing needs, 2007 (%)

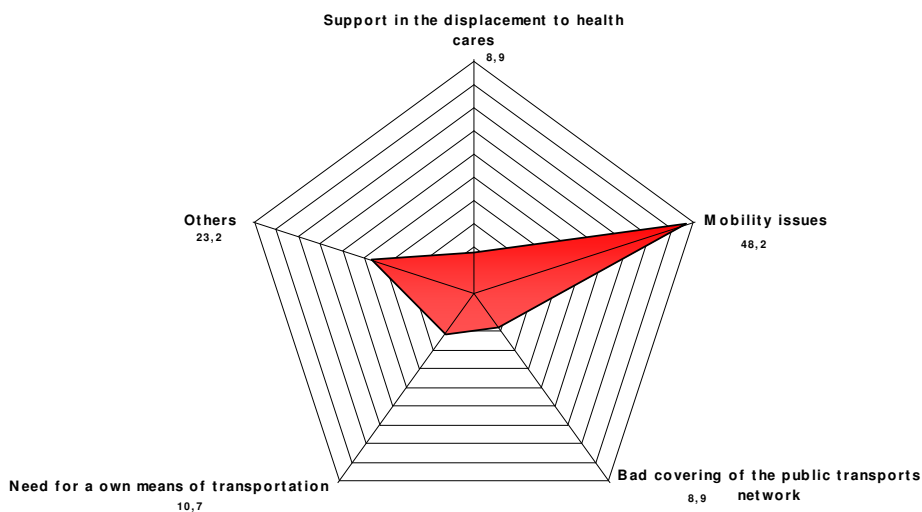


Source: CEDRU Survey, 2007.

Mobility

The individuals' mobility decreases with ageing, due to physical, but also psychological and social problems. This is a limitation to their everyday life and increases their dependency. At this level, the most significant needs are related with overall mobility issues (48.2%). The need for private transportation means (10.7%) reflects not only the expectation of greater autonomy, but also the need for a means of transportation adapted to the limitations of this population.

Figure 37. Main typologies of mobility needs, 2007 (%)

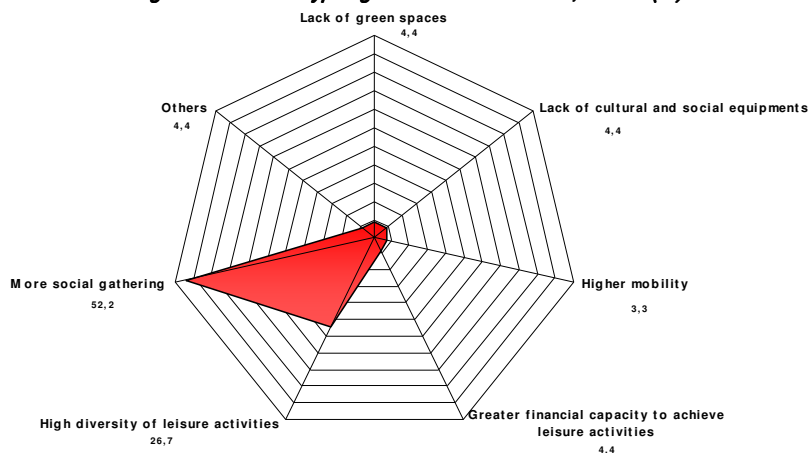


Source: CEDRU Survey, 2007.

Leisure

Leisure is also an essential component in this analysis, in the sense that we are dealing with a target population with spare time. Eager to fill it, it represents a key determinant for this population's quality of life. Most of the individuals mentioned the need for more socialization (52.2%) and recreational activities (26.7%), thus revealing the reduced offer of social responses (of both a material and immaterial nature) where it is possible to establish interpersonal relationships, preventing isolation and low self-esteem.

Figure 38. Main typologies of leisure needs, 2007 (%)

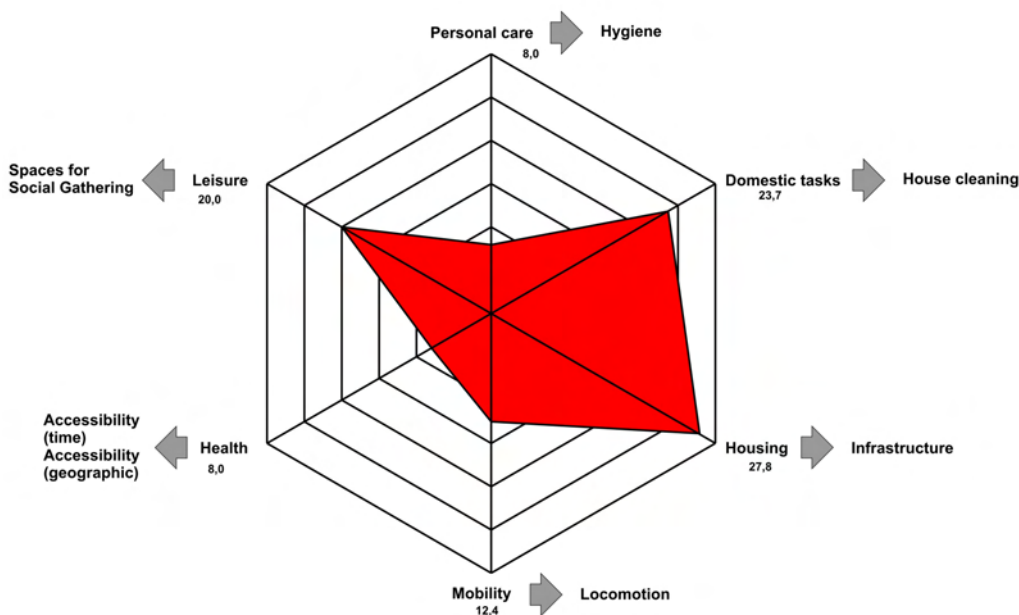


Source: CEDRU Survey, 2007.

Global Panorama

An overall analysis of the main areas of needs that affect the senior population on a daily basis reveals that it is in the housing context that seniors present greater needs. Support in domestic tasks (8,1%) and greater participation in leisure activities are also relevant. Notwithstanding the needs regarding personal care - health and mobility - these are considerably less important.

Figure 39. Main Typologies of needs for the elderly population in Portugal, 2007 (%)



Source: CEDRU Survey, 2007.

4. Summary

- ▶ The demographic ageing process phenomena is recent - second half of the 20th century - and it is extensible to almost all regions of the world. It is characterized by its increasing feminization; progressive solitude and isolation and “super-ageing”, associated to the significant increase of the older groups;
- ▶ The demographic projections estimate that in 2050 there will be about 2,000 million individuals over 60 years old, representing more than 20% of the world population;
- ▶ In Portugal, the demographic ageing process has gradually increased in the course of the last four decades, and it is estimated that in 2050 the elderly population might represent 1/3 of the national population’s effective;
- ▶ The main needs affecting the Portuguese senior population are mainly focused in the housing context, namely in what concerns repair and preservation work;
- ▶ Among the national senior population, it is thus possible to identify five segments of the senior population that are particularly vulnerable: the older seniors (with 85+ years old), the “poorer” (with average monthly incomes to or lower than 300€, living thus below the poverty threshold), “the ones who live alone” (composition typology of the “senior living alone”), the “women” and, finally, “those who reside in APU”.

MODULE 2

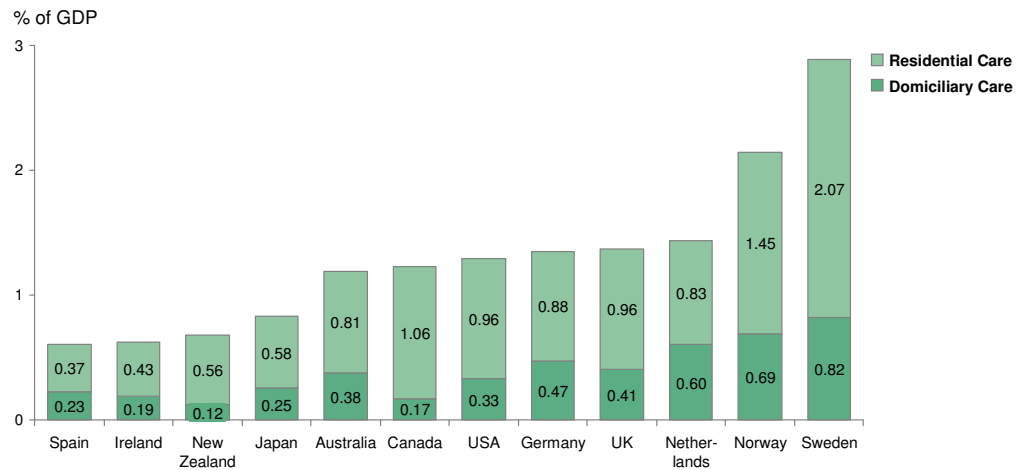
SUPPLY SIDE ANALYSIS

1. The role of the different “players” in service provision to the senior portuguese population: systemic approach

1.1. Elderly care industry: size, characteristics and growth perspectives

The elderly care industry has already reached high importance. In 2000, public and private expenditures on long-term elderly care represented relevant shares of Gross Domestic Product (GDP), ranging between ~0.6% in Spain and ~2.9% in Sweden. In most countries, residential care accounts for more than 50% of the value of the industry.

Figure 40. Public and private expenditure on long-term elderly care, 2000 (% GDP)



Source: OCDE Health project long-term care for older people, 2005.

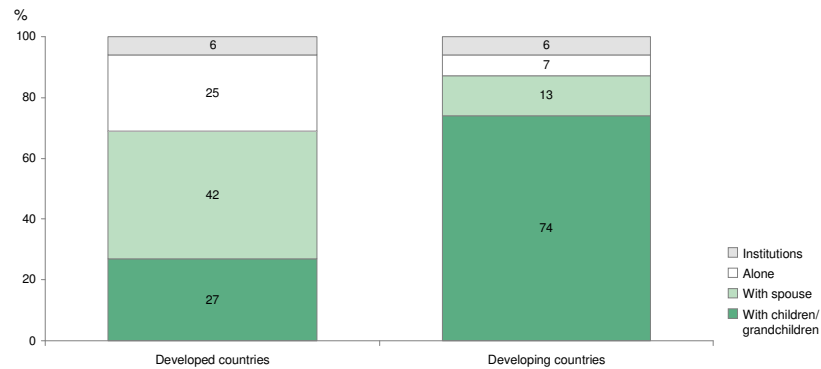
Elderly-focused industries are expected to grow significantly in the next years, fuelled by the ageing of the population. As an illustration, residential care in the USA is expected to rise at a rate of 11% per year from 2006 to 2014, while domiciliary care services are estimated to increase by 15% per year in the same period. These figures are far above the recent evolution, which was only 5% yearly for the first type of care and 7% per year for the second (from 1993 to 2006).

Besides population ageing, two factors are expected to drive the growth of the elderly care industry in the upcoming years:

- ▶ The lower involvement of families in the provision of elderly care;
- ▶ The greater openness of younger generations to paid elderly care services and institutionalization.

As nations develop, living arrangements tend to change and families tend to participate less in elderly care provision. The comparison of living arrangements in developed and developing countries reveals that while in developing countries a low share of the elderly live alone or in institutions (~13%), in developed countries this percentage is much higher (~31%). These differences probably derive from the higher share of working women and nuclear families (with 1 or 2 children) and the lower time availability of people.

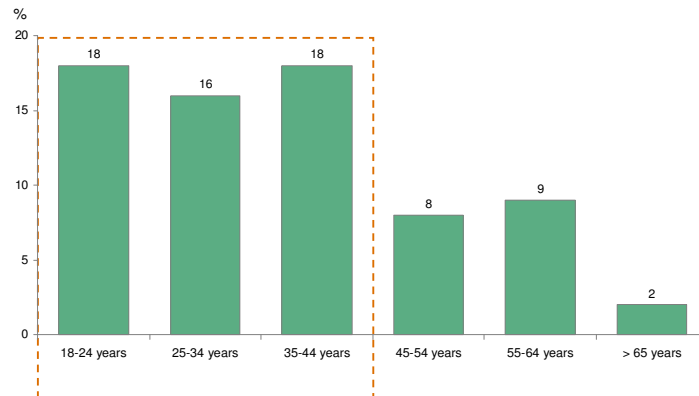
Figure 41. Comparison of living arrangements of people aged 65 years old and over in developing and developed countries (%)



Source: Living Arrangements of Older Persons Around the World, United Nations 2005; An Ageing World, 2001.

In parallel, younger generations, who lead more independent lives and have been witnessing the improvement in the variety and quality of elderly care services are much more open to both institutionalization and domiciliary care. As an illustration, in a recent research study conducted in Spain, ~18% of people between 35 and 44 answered “residential care” to the question “Where do you want to live as an elderly?”. In contrast, only 2% of people above 65 gave this same answer.

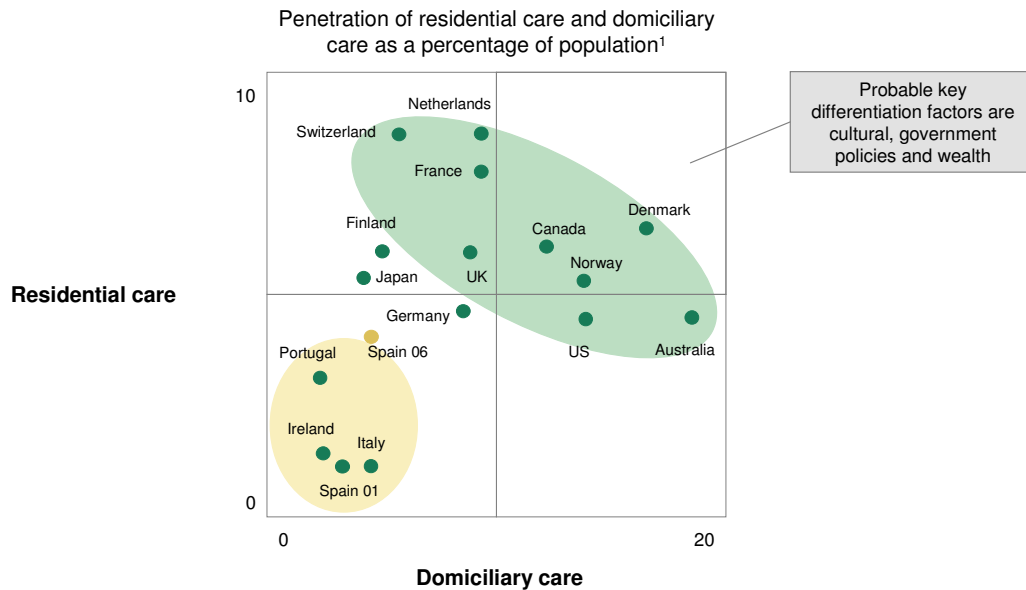
Figure 42. Answer residential care to question “where do you want to live as an elderly?” (%)



Source: Fundación La Caixa.

Currently, and based on the information of the last Census (2001), the penetration of elderly care services varies across EU countries, forming two distinctive groups:

- ▶ Northern and Central European countries typically have higher penetration rates (up to 10% in residential care and up to 20% in domiciliary care), although with different care services mixes;
- ▶ Southern European countries have lower penetration rates (<5% each type of care).

Figure 43. Degree of penetration of elderly care services across selected countries

Note (1): Penetration based on 2001 census data.

Source: *Fundación La Caixa*.

It can be observed that poorer and more traditional countries have lower penetration rates of elderly care services. Thus, economic and cultural aspects seem to influence the development of the elderly care industry. In addition, public policy also seems to be a driving force for the growth of elderly care services, as shown by the high penetration rates of services in “welfare countries”.

Supply overview of elderly care in Portugal

Following a trend visible in developed countries (especially European ones), in the last decades the Portuguese society has undergone important demographic changes, the most important probably being the rise in the average life expectancy. Despite reflecting a positive evolution in health care and in the living conditions of most of the population, this phenomenon triggers new necessities. The most paradigmatic of all examples is the creation of new equipment and services meant to support the elderly population. These needs have not always been fulfilled by governmental investments, which originate a progressive and concerning hiatus between the current (and potential) demand and the level of response in terms of offer.

The importance and impact of this “elderly” age group on society has grown significantly. In this reference frame, the emergence of new ways of intervening - mostly in terms of social services, but also in terms of health and education, so as to safeguard the quality of life of these citizens (physically, psychologically and socially) - has gained a pertinent position. Thus, the diversification of equipment and social responses for the elderly has become more significant: at a first instance, through the active role of public entities and later (as a result of the State’s inability to provide a quick and effective response to the growing demand) through private entities, non-profitable or not.

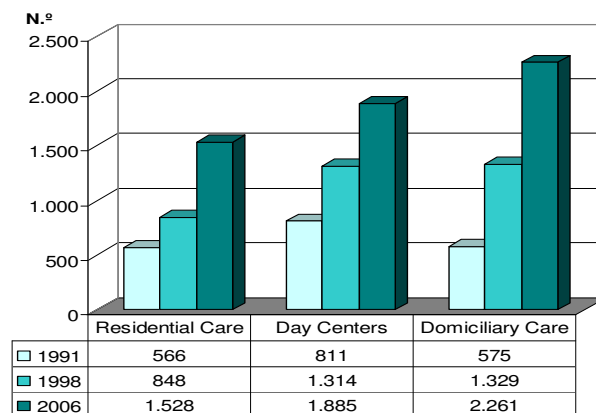
Nevertheless, due to the demographic ageing, only in the past few years there seems to have emerged a new and strong commitment towards solving questions related to the elderly population. Throughout our national history there have been several examples and initiatives that illustrate the role of different institutions which support aged citizens (although the distinction between social services for the general population and specifically for the elderly is not always perceptible or individually assumed).

It was only in the 20th century that an effective and consistent policy of support to the elderly was adopted, through considerable investments. This was a result of the emergence of new rights and social concerns (there are new entities, new infrastructures and new social services for the elderly). Through a new policy for the senior citizens, which was a part of the 1976 Constitution, a new stage began, with a different approach to matters related to the elderly. The more visible change between this period and the time when Portugal became an EC member, consisted of the transformation of asylums into old age homes and of the emergence of services and institutions for senior citizens.

On the other hand, the policy of assistance to the elderly in their homes was also introduced in Portugal in this period, namely through the creation of day centers, domiciliary services and socialization centers. The first social responses for this age group aimed mostly at institutionalization, whereas from this period onwards, the main focus was to keep users in their homes, in their regular daily environment. When Portugal became a member of the European Economic Community (EEC) in 1986, the investments in equipment and a new solution grew solidly.

In fact, in the last three decades, the investment in equipment and human resources training allowed a significant growth in terms of coverage related to social equipment. This is a result not only of an increasing awareness of social rights, but also of the knowledge obtained within the EU and of the growing importance of the State as a stimulus for new policies and concerted actions (programmes, integrated responses, specific initiatives for local development). These policies and actions were more visible in the social service and health areas, but they were also applied in the education and leisure domains. Moreover, it is the State's responsibility to verify, finance and develop social services and equipment.

Figure 44. Evolution of the number of social equipment, in the Mainland, 1991-2006 (N.)



Source: DGAS in INE, 1999; *Carta Social*, 2006.

Despite the key role of Portuguese “welfare families”, the supply of elderly care services has been growing in recent years. Moreover, a wide range of elderly care services (comprising residential care, domiciliary care, day centers and socialization centers) is already available.

Cross-cutting services: social responses provided by the State and the Third Sector

Social responses are the initiatives and social action services developed within or from a social infrastructure, organized in terms of the various target publics, with the aim of meeting certain needs of users.

There are many social responses for the elderly population and from 1998 to 2005, 1,780 more were created throughout the country. This represents a growth rate of 41.8%, thus reflecting a growing concern and awareness by the public opinion of the needs and importance in ensuring the well-being and quality of life of

the senior population in Portugal (DEEP, 2005).

There are currently nine social responses at a national level for the senior population, and each has a specific territorial division that is ensured by entities with very different legal natures.

Domiciliary Support Service

This social response consists of providing individuals and families with individualized and personalized care in the home when, due to illness, disability or other impediment they are temporarily or permanently unable to satisfy basic needs and/or daily life activities.

The objectives of this social response are:

- i) To contribute towards an improvement in the quality of life of individuals and families;
- ii) To ensure the provision of physical care and psychosocial support to individuals and families so as to contribute to their equilibrium and well-being;
- iii) To support individuals and families in satisfying basic needs and daily life activities;
- iv) To create conditions that make it possible to preserve and encourage inter-family relations;
- v) To collaborate and/or ensure the provision of health care;
- vi) To contribute towards delaying or avoiding institutionalization;
- vii) To prevent situations of dependency by promoting autonomy.

On a national level, this is the social response with the greatest offer (2,252 social responses), where the territorial division of the domiciliary support service for elderly people is very diverse. The NUTS II Centre is the region where this type of response is most concentrated, bringing together 41.1% of the total offer in Mainland Portugal. At the other extreme is the NUTS II Algarve, with only 2.8% of the response offer. In this interval, the NUTS II North takes second place, with 31.9% of the offer and Lisbon and Alentejo present very similar realities (11.9% and 12.4%, respectively).

Foster Care

This social response is exclusively targeted at people over the age of 65 and consists of temporarily or permanently integrating elderly people and/or those in a deprived situation in suitable families when, due to the absence or lack of family conditions and/or the inexistence or insufficiency of social responses, they are unable to remain in their own homes.

The goals of this social response are:

- i) To take in elderly people (three people at most) who are in a situation of dependency or who have lost their autonomy, live alone and without any socio-family support and/or in a situation of uncertainty;
- ii) To ensure elderly citizens of a socio-family and emotional environment that is capable of satisfying their needs and respects their identity, personality and privacy;
- iii) To avoid or delay institutionalization.

Residential Homes

The residential homes social response is ensured in infrastructures where elderly people are provided with social support activities via collective accommodation, of temporary or permanent use, food, health care, hygiene, comfort, encouraging social intercourse and animation and occupying the free time of the users.

The goals of this social response are:

- i) To take in elderly people, or others, whose social, family, economic and/or health situation does not

enable them to live in their own homes;

- ii) To ensure the provision of suitable care to meet their needs, with the aim of preserving their autonomy and independence;
- iii) To provide temporary lodging, as a form of family support;
- iv) To create conditions that make it possible to preserve and encourage inter-family relationships;
- v) To refer and accompany elderly people to situations that are more suited to their situation.

This social response is targeted at people over the age of 65, or younger, should the need arise.

In 2005, there was a total of 1,508 residential homes in Mainland Portugal. However, the territorial division of this social response is very asymmetrical as it is strongly concentrated in the NUTS II Centre (34.3%) and North (30.1%) and very scarce in the NUTS II Algarve (3.7%). The remaining NUTS II lie in the middle (Lisbon 18.1% and Alentejo 13.8%).

Assisted Housing

This social response is developed in infrastructures, comprising a set of apartments with common services for old people with total or partial autonomy.

As the implementation of this social response in Portugal is relatively recent, the total offer is still limited (39 houses). In comparison to the tendency of the other social responses for elderly people, its distribution over the NUTS II is distinct and differentiated. The greatest offer of this social response is in the NUTS II Lisbon (43.6%), followed by the NUTS II North (23.1%), NUTS II Alentejo (15.4%), Centre (12.8%) and, finally, the Algarve where the offer is much lower (5.1%).

Day Centre

This social response consists of the provision a group of services that contribute towards keeping the elderly in their socio-family environment. The target public are all those who are in need of the services provided, although there is a predominance of individuals over the age of 65.

The objectives of this social response are:

- i) To ensure the provision of suitable care to meet users' needs;
- ii) To contribute towards stabilizing or delaying the negative consequences of ageing;
- iii) To provide psycho-social support;
- iv) To contribute towards delaying or avoiding institutionalization;
- v) To prevent situations of dependency by promoting autonomy;
- vi) To favour the permanence of elderly people in their normal dwelling place.

This is the second most numerous response in Mainland Portugal, where there were a total of 1,880 day-care centers in 2005. Its territorial division shows the dominance of the NUTS II Centre and North, as these two regions account for more than half of the total offer (41% and 27.3%, respectively), followed by Lisbon and Alentejo, with relatively similar realities, albeit the proportion of the offer is considerably lower (14.1% and 14.6%, respectively). Once again, the NUTS II Algarve has the lowest offer (3%).

Socialization Centre

This social response is developed in infrastructures and supports socio-recreational and cultural activities, organized and driven by the active participation of the elderly. Its target population are the residents in the respective community of the social response, although it is primarily directed at people over the age of 65.

The objectives of this social response are:

- i) To prevent loneliness and isolation;
- ii) To encourage participation and improve social inclusion;
- iii) To foster interpersonal and intergenerational relations;
- iv) To contribute towards delaying or avoiding institutionalization.

In 2005, there were only 508 neighborhood centers in Mainland Portugal. The territorial division was however more homogeneous among the different NUTS II, in comparison to the other social responses. The greatest concentration of this social response is in the NUTS II North (32.7%), followed by the Lisbon (25.8%), Centre (25.4%), Alentejo (14.6%) Regions, with the NUTS II Algarve once again having the scarcest offer (1.6%).

Night Centre

This social response is developed in infrastructures and its aim is to host people, particularly elderly autonomous people, who cannot stay home alone during the night as they live in situations of loneliness, isolation or insecurity. The beneficiaries of this social response are autonomous people over the age of 65, although it can also be extended to other people.

The goals of this social response are:

- i) To host elderly, autonomous people during the night;
- ii) To ensure their well-being and safety;
- iii) To favour the permanence of these people in their normal dwelling place;
- iv) To avoid or delay institutionalization.

This social response is the one that presents the lowest total offer, with only 10 centers throughout Mainland Portugal in 2005. Most of the offer of this social response is in the NUTS II Centre (70%), followed by the NUTS II Alentejo (20%) and finally the NUTS II North (10%). There was no offer in the Lisbon and Algarve Region.

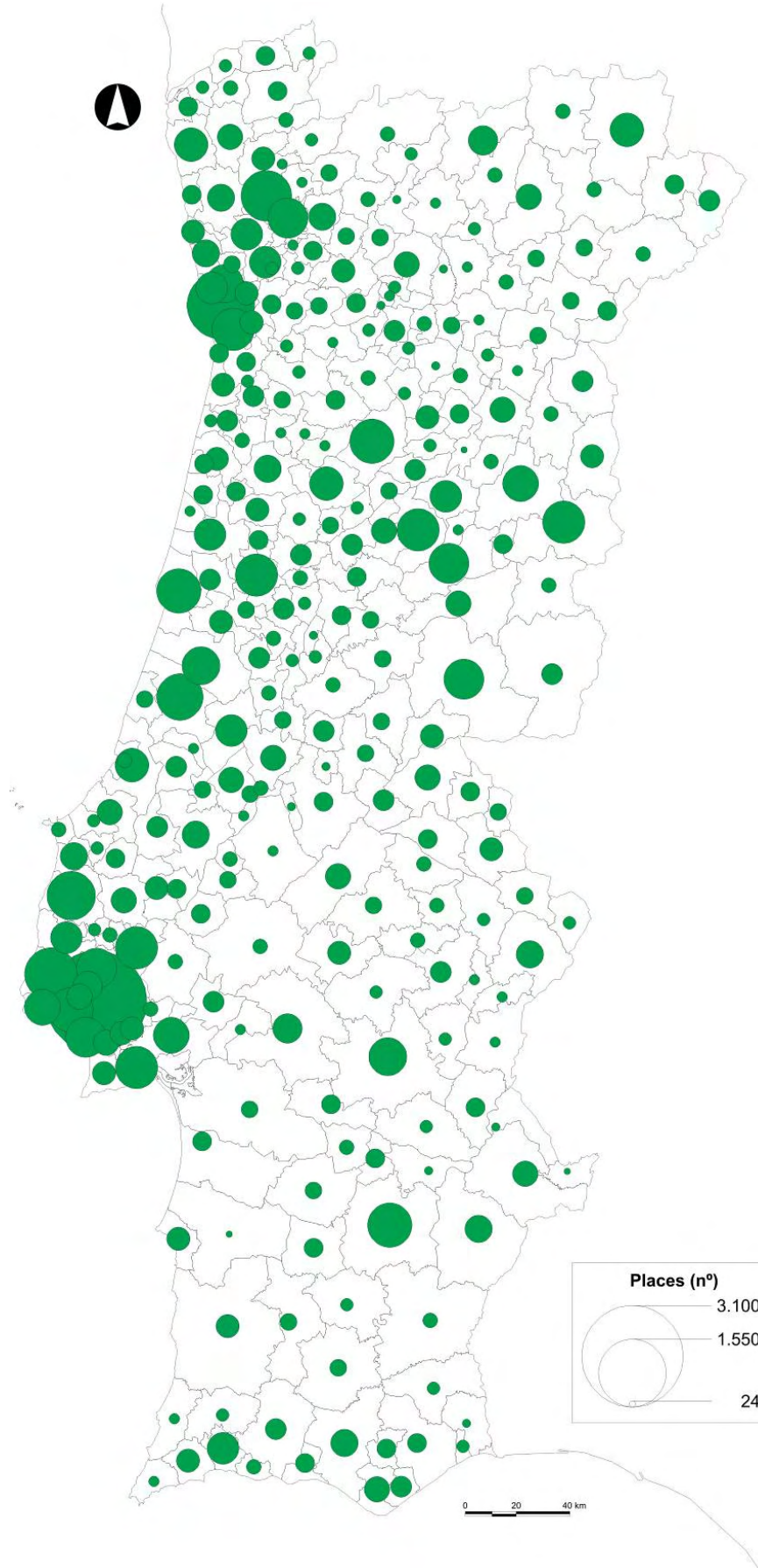
Vacation Centers

This social response is developed in infrastructures and is designed to meet the needs for leisure and a break from routine, vital for the physical, psychological and social balance of its users. The beneficiaries are elderly people, as well as the family in general.

The objectives of this social response are:

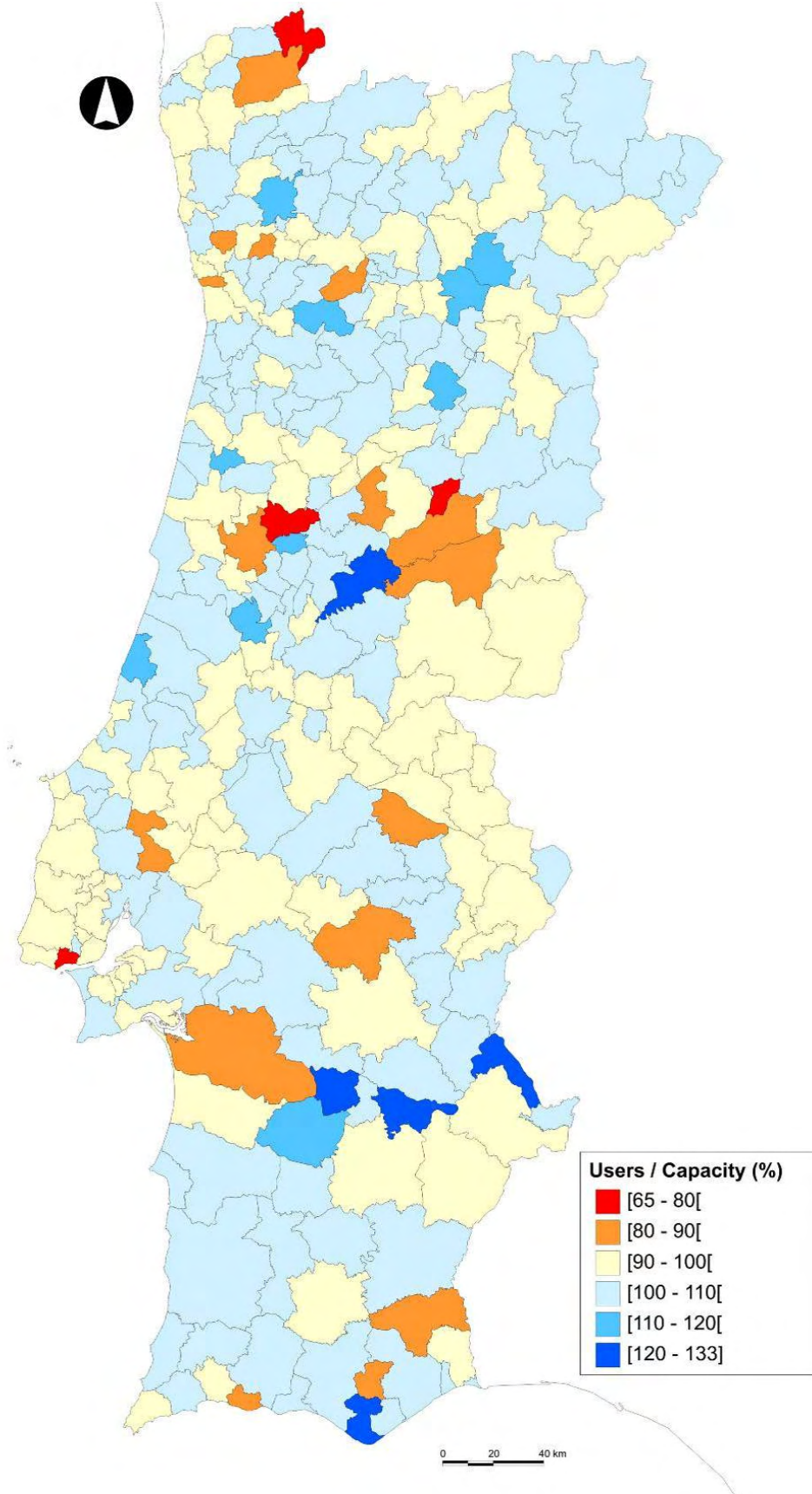
- i) Stays outside the normal residential environment;
- ii) Contacts with different communities and places;
- iii) Group experiences as a form of social integration;
- iv) To encourage the development of a spirit of inter-assistance;
- v) To foster creative ability and initiative spirit.

Figure 45. Places in residential care, 2005 (N.)



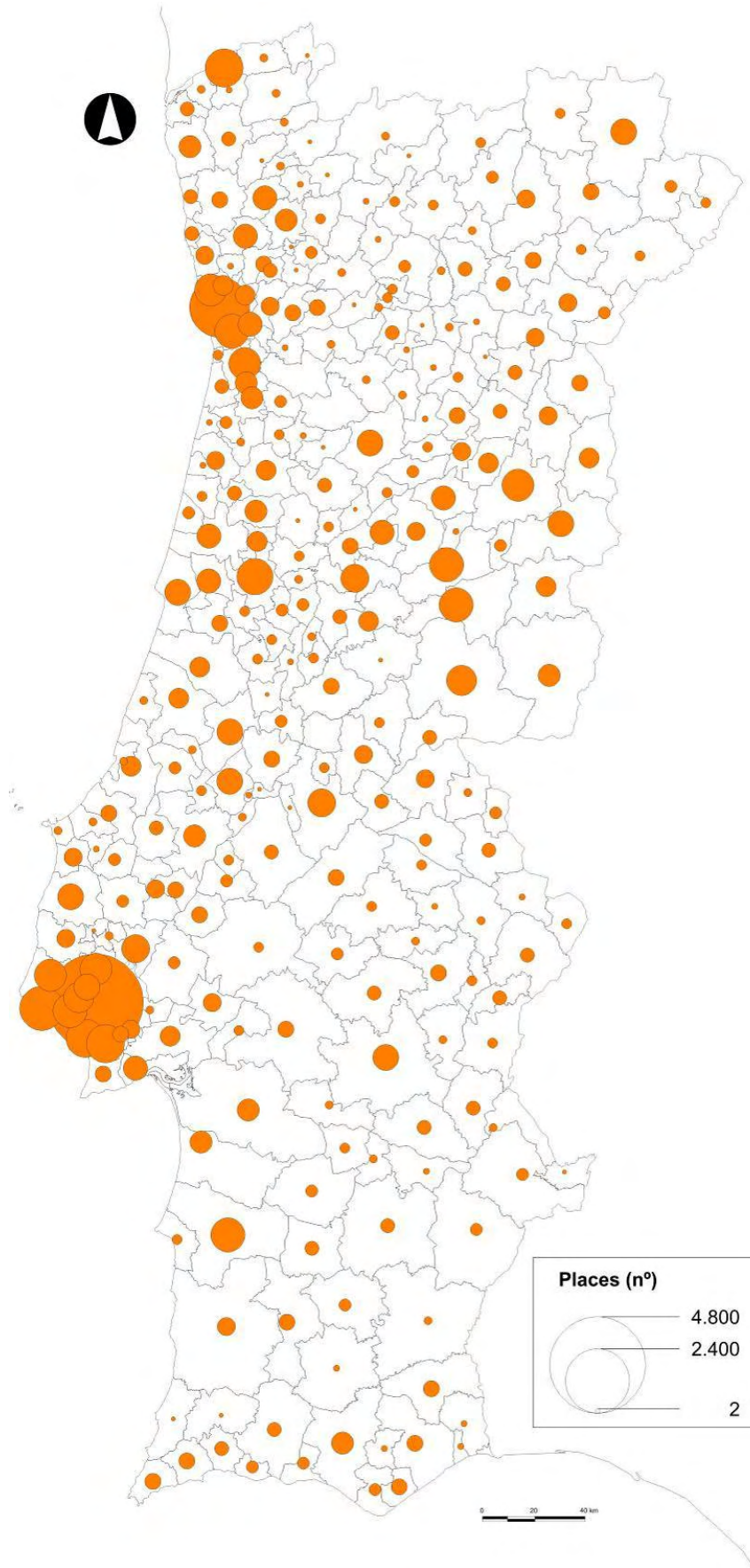
Source: *Carta Social*, 2007, MTSS.

Figure 46. Occupation rate in residential care, 2005 (%)



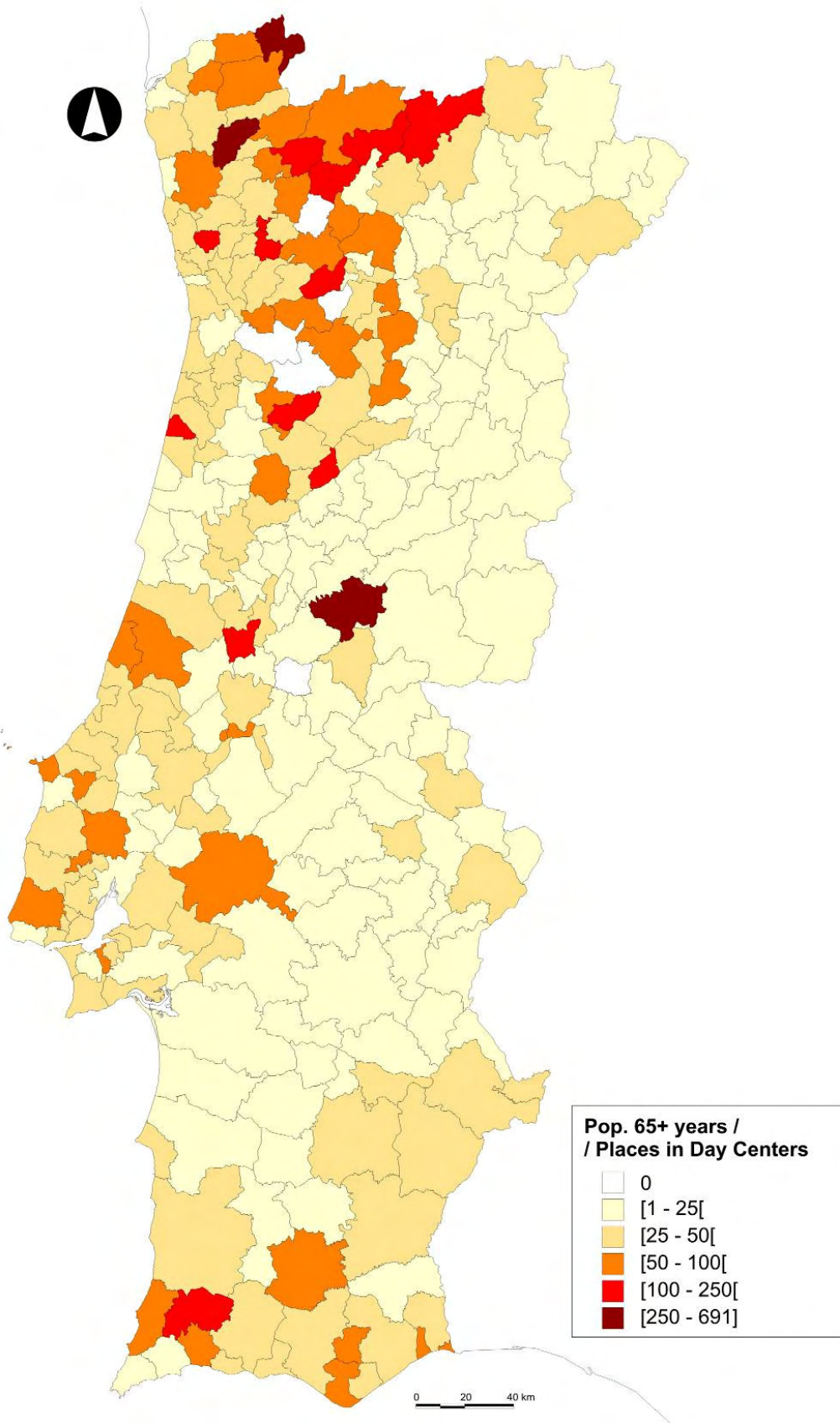
Source: *Carta Social*, 2007, MTSS.

Figure 47. Places in day centers, 2005 (N.)



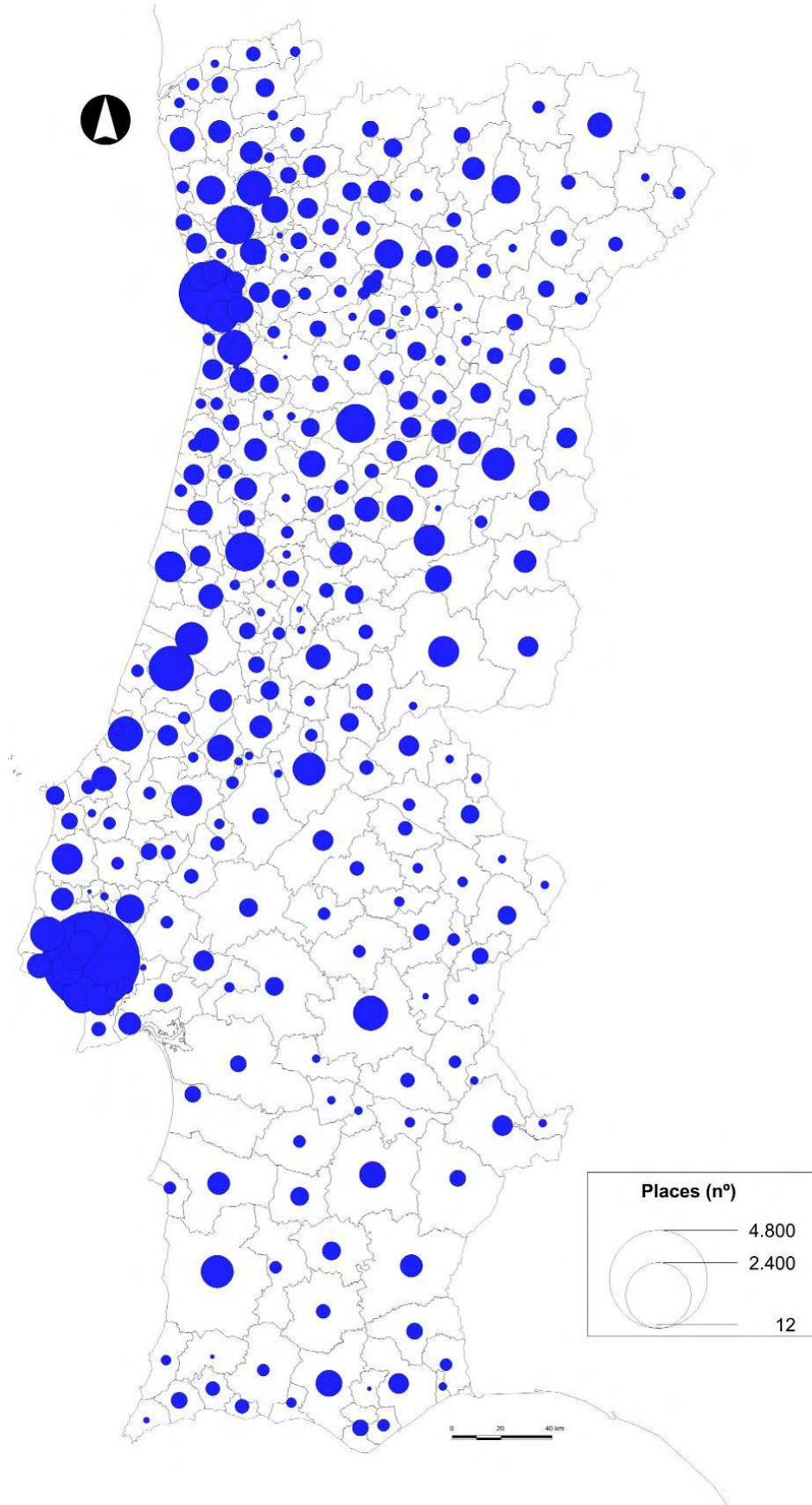
Source: *Carta Social*, 2007, MTSS.

Figure 48. Ratio population 65 years and over / Capacity (number of places) in day centers, 2005



Source: *Carta Social*, 2007, MTSS.

Figure 49. Domiciliary care provision capacity, 2005 (Number of places)



Source: *Carta Social*, 2007, MTSS.

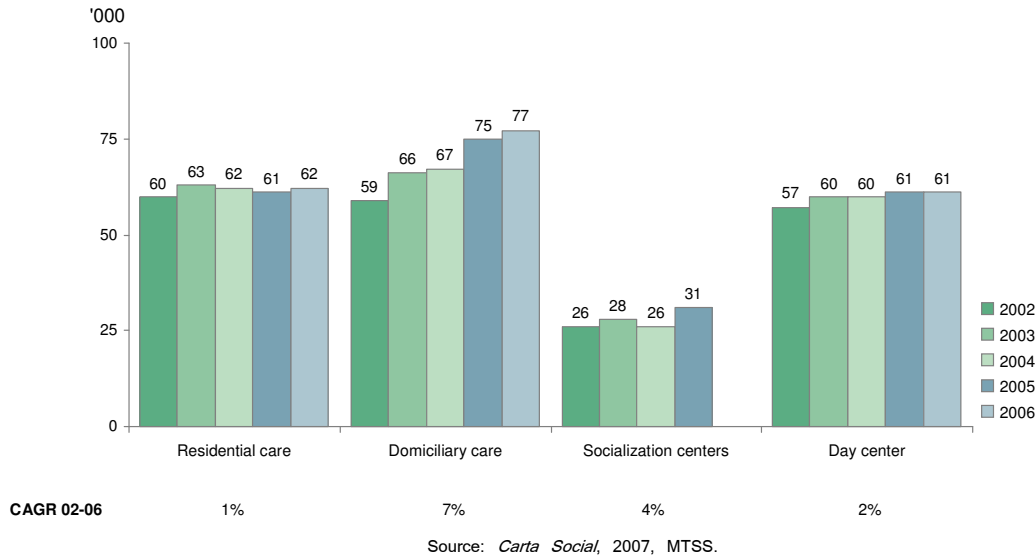
Figure 50. Total number of services for the elderly, 2005 (N.)



Source: *Carta Social*, 2007, MTSS.

Probably due to the Government's goal to promote the independence of senior citizens and delay as much as possible their institutionalization, domiciliary services and socialization centers have experienced the strongest growth rates (~7% and 4% per year, respectively). For the same reason, day centers and residential care services have been growing at a much slower rate (~1% and 2% respectively).

Figure 51. Evolution of key elderly care services capacity in Portugal, 2002-2006



Despite such growth, available elderly care services remain insufficient. Domiciliary care only reaches ~4.5% of the population aged 65 or over, residential and day centers only reach 4% of the elderly population and socialization centers cover less than 2% of this population segment. Press articles suggest that residential care is the service with the highest supply shortage, with waiting lists exceeding 15,000 elderly (or >25% of the current capacity).

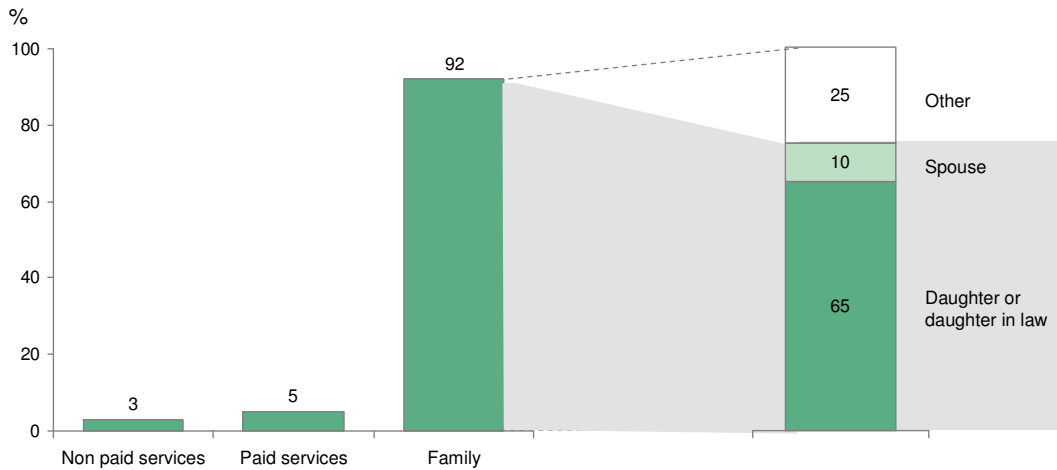
The development of the elderly care industry in Portugal has been influenced by cultural aspects. As most people maintain strong bonds and relationships with their relatives throughout adult life, elderly in need typically reach out to family members for support before considering other care options.

Even though the Government provides few financial aids for taking care of the elderly, according to the 2001 Census, ~90% of the dependent elderly received care from family members and ~2% of the total population took care of an elderly person. Major family care providers tend to be daughters or daughters-in-law (~65%) and spouses (~10%).

In Portugal, elderly care services are provided by both the public and the private sector. The public sector, following the principle of subsidiarity, dominates the provision of elderly care services (controlling >80% of the capacity available in the market) and is targeted at low-income elderly people. On the contrary, the private sector (comprising both formal and informal players) still plays a minor role, and focuses on a medium-high and high-income segment.

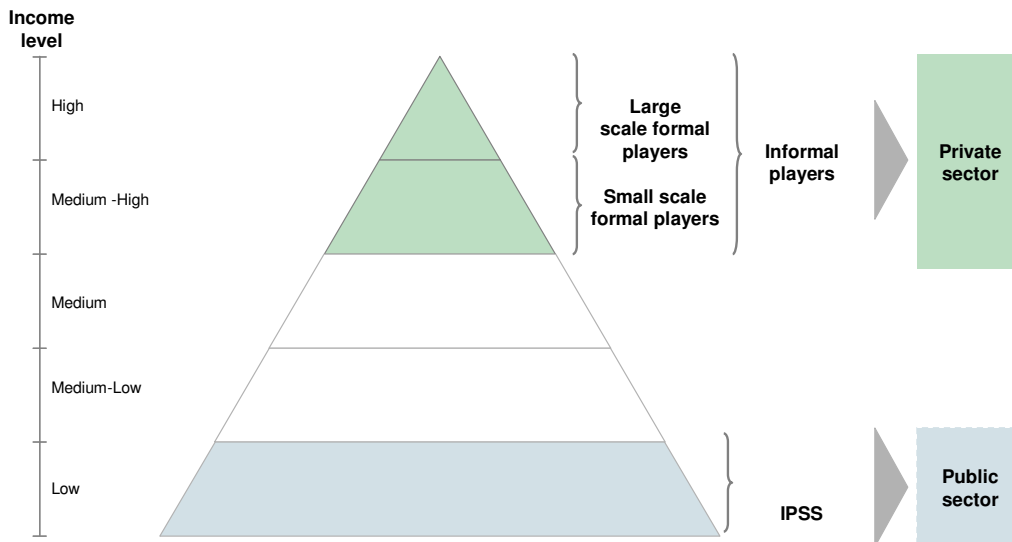
This results in the poor fulfillment of the needs of a large share of the population, as is illustrated in **Figure 53**. In fact, public and not-for-profit organizations do not own the capacity to fully cover the medium and medium-low income segment, and formal players offer their services at prices that are not affordable for most of these people (also with insufficient capacity). As a result, the group of the medium and medium-low income elderly segment is served by private informal players and by the public sector, but with severe disruptions.

Figure 52. Major care providers, 2002 (%)



Source: *Tratar e cuidar de um idoso dependente, problemas e soluções* (Working Paper, 2002).

Figure 53. Target consumers of major elderly care providers



Source: BCG analysis.

1.2. The role of the State in service provision to seniors

The end of the 1990s was marked by profound changes in the social protection provided by the State for the different social groups and particularly for the elderly. These changes were designed to respond to the need to prepare the social protection system opportunely for the significant changes resulting from the demographic ageing process, from the new family realities, from the growing unemployment and complexity of the situations of poverty and social exclusion. This awareness led to important reforms with an impact on the interventions carried out by the State itself.

One of the remarkable changes in the last years was the crisis of the sustainability of the social security system, as a consequence of the changes in demography and in the economy, which took the lead in the decisions taken. Associated to this fact is the growing acknowledgement of active ageing in the social policies. The conjunction of these two factors has translated into the adoption of measures and programmes that contribute to keeping older workers at work for longer, with a view to increasing the working/contribution age.

Another of the more recent changes is based upon the growing acknowledgement of the principle of social justice, which has given rise to a variety of responses, depending on the specificities of its beneficiaries and on their residential areas. Integrated actions which involve an interconnection among the various fields, as well as interventions aimed at developing the individual skills of people, families and of the areas themselves are valued more and more highly. This new intervention philosophy seeks to make socially vulnerable populations increasingly more self-sufficient in structuring a new life project, so that they do not need to continually depend on the State's protection.

Added to these are countless other changes, which have progressively been consolidating the vital and irreplaceable intervention of the social partners and of the role of the family, as formal or informal caregivers to the elderly. Nevertheless, this social and family accountability has been accompanied by a more extensive and diversified support, visible in the investment and qualification of the social responses provided to the elderly. Another important factor has been the growing debureaucratization of the processes, materialized with the generalization of the internet and with the decentralization of the services in the sense of bringing them closer to citizens.

There have also been changes in the work methodologies themselves, translated into a greater concern with regular monitoring, with the participatory processes and the growing acknowledgement of the interventions at a local level.

These changes in the philosophy and intervention of the State have brought about collateral dynamics/effects: a widening and greater complementarity of the Third Sector; a greater awareness of the individuals' duties in the provision of care to parents and old people in general; a strengthening of the actual culture of volunteer work; the promotion of a greater awareness of the needs of the elderly; greater quality control in the provision of care and services to old people.

A turning point has also been observed in the programmes and projects carried out by the various Government bodies, which reflect an abandonment of the assistentialist philosophy in favour of new conceptions and a diversification of the types of programmes drawn up, aimed at responding to the growing complexity of existing situations.

Naturally, the State's intervention continues to present major limitations and constraints, the most important being funding, the shortage of human resources and the excessive bureaucratization (e.g. in processes involving the application and selection of beneficiaries).

Table 96. Analysis of the strengths and weaknesses of the State's intervention towards the elderly

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Social acknowledgement of active ageing; • Greater social justice, treating that which is not the same differently; • Diversification of the type of social risk situations covered by the programmes drawn up; • Reinforcement of the mechanisms to fight against the cyclical dependence of beneficiaries; • Acknowledgement of integrated multidimensional interventions; • Reinforcement of the Third Sector, promotion of a culture of volunteerism and of the family's involvement; • Growing debureaucratization of processes; • Greater proximity to the citizens; • Greater concern with the scope of the expected and programmed results; • Promotion of quality in the provision of care and services; • Awareness-raising of society in general to the provision of care and services to the elderly; • Synergies resulting from the establishment of many partnerships with a wide variety of players; • Innovative nature of some programmes and interventions; 	<ul style="list-style-type: none"> • Low qualifications of care-givers to the elderly of the solidary economy in general; • Complexity of the management and control structures of some programmes; • Excessive bureaucratization of some processes and exigency of the criteria for the eligibility of the beneficiaries; • Insufficient human resources; • Blockages resulting from the sharing of responsibilities associated to the partnerships; • Limited financial capacity for the interventions necessary; • Indirect promotion of the stigmatization of beneficiaries; • Excessive valuation of the financial capacity in the selection of the applications to some programmes; • Exclusion of some regions in the applications to certain programmes; • Insufficient offer of care and services for the elderly; • Lack of specific studies to promote knowledge; • Limited control actions, which therefore result in poor quality in the provision of care and services to the elderly.

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> Encouraging the intervention of the private sector, brining about a diversification of the offer of care and services; Concern with the sustainability of the funding of programmes; Multiplying effects on the economy resulting from the execution of some programmes. 	

1.2.1. Central programmes/policies for the senior population

The goal of the analysis below is to objectively describe and analyze each of the Programmes or Projects that are developed on a national level by the Central Administration and which are specifically focused on the senior population (target-population) or on the population in general. In tandem with the descriptive parameters presented in each project file, an evaluation is made by the Technical Team, which has been supported by previous meetings held with the *Direcção-Geral da Saúde* (DGS) - (Directorate-General for Health) and the *Instituto de Segurança Social* (ISS) - (Social Security Institute), whenever possible, with the experts responsible for each project. Subsequently, a few of the many projects developed by the Local Administration for the Portuguese senior population will be presented as an example.

PROGRAMME	NATIONAL HEALTH PROGRAMME FOR SENIORS		
PROMOTING ENTITY	High Commissioner for Health	TYPOLGY	Health
STARTUP	2004	SCOPE	National
TARGET POPULATION	Residents in Portugal aged 65 years or over	STATUS	On-going
FINANCIAL OUTLINE	Information unavailable		
POPULATION SERVED	Information unavailable		
PARTNERSHIPS	Directorate-General for Health; Permanent Scientific Interlocutor: the Portuguese Society of Geriatrics and Gerontology.		
DESCRIPTION	<p>Approved in June 2004, this project was issued by the DGS and will run until 2010.</p> <p>The general purpose of the Programme is to obtain benefits in terms of autonomous life years and depends on three intervention strategies:</p> <p>i) Promoting an active and healthy ageing process;</p> <p>ii) Adjusting the health care services to the specific needs of this population;</p> <p>iii) Promoting the cross-sector development of environments, which enable autonomy and independency for the elderly population.</p> <p>The Programme aims to contribute to the dissemination and implementation of the concept of an active ageing process for the elderly, as proclaimed by WHO.</p> <p>The National Programme for Health of Elderly People is to be executed by professionals at the Health Centers Network, Hospital Network and Continuing Health Care Network and will be complemented, whenever convenient, through expert guidance by the DGS.</p> <p>The National Programme for Health of Elderly People will be carried out at regional and local level by the dependent services of the Health Regional Administrations that must define Action Plans, bearing in mind this Programme's guidance, the local and regional diversities, encouraging partnerships and taking advantage of the existing resources.</p>		
EVALUATION	<p>Three years after its approval, it is evident that this Programme is a well-structured, long range strategy. Nevertheless, it has been difficult to apply, because the knowledge of its existence among local health care professionals is insufficient. In central terms, the main difficulties for this Programme are linked to financial limitations and lack of human resources.</p> <p>It is necessary to point out that in the DGS there are no other projects/programmes for the senior population besides this one, although important work has been carried out in terms of health promotion and illness prevention on different levels and in the several stages of the life cycle, which naturally has its impact on the senior population's health. This Programme is of the utmost importance and it represents significant progress in this area.</p>		

STUDY TO ADDRESS THE NEEDS OF SENIOR PEOPLE IN PORTUGAL

PROGRAMME	AGE-FRIENDLY CITIES PROJECT		
PROMOTING ENTITY	High Commissioner for Health	TYPOLGY	Health
STARTUP	Work plan developed by the Directorate-General for Health (December 2007)	SCOPE	Cities (national level)
TARGET POPULATION	People aged 65 years or over	STATUS	Project
FINANCIAL OUTLINE	Information unavailable		
POPULATION SERVED	Information unavailable		
PARTNERSHIPS	Did not apply		
DESCRIPTION	<p>The DGS developed a work plan to promote the Age-Friendly Cities project, an initiative of the WHO. The DGS's initiative is the result of the increasing awareness to the strong concentration of elderly people in urban areas. It is, therefore, essential to develop a plan for the cities, which takes into account the adjustment of its services and structures to the requirements of an ageing population, with different needs and capacities, making them more accessible and inclusive. The estimated measures are: elimination of physical and environmental obstacles; educating society towards a greater respect for the elderly; adapting homes to the needs of this population.</p> <p>Through a survey which collected primary information all over the world, supplied by elderly people, caregivers and/or service providers, WHO defined an age-friendly city as one which stimulates an active ageing process, through an optimization of health, participation and safety opportunities, so as to increase the quality of life of ageing people. It also drew up a Guide that helps the cities, in their different stages of development, to self-evaluate through a senior citizen's point a view, in order to evolve as places that are prepared for these inhabitants. This Guide focuses on eight key-elements: i) buildings and public spaces; ii) transportation; iii) housing; iv) social participation; v) respect and social inclusion; vi) civic participation and employment; vii) communication and information; viii) community support and health services. Nowadays, this Guide is being used in several countries as an instrument for the development of the Programme in various cities. The creation of these networks is crucial for the cooperation between cities in terms of good practices and mutual aid while solving similar problems.</p>		
EVALUATION	<p>Although in its initial phase, this is an innovating project, because it is not focused on health and services issues, as usual, but on health determinants and it is based on surveys to the target-population. On the other hand, it is also important because it conveys international practices which portray a greater awareness towards questions concerning the elderly in urban environments.</p>		

PROGRAMME	RECREATE THE FUTURE		
PROMOTING ENTITY	Ministry of Labour and Social Solidarity	TYPOLGY	Social
STARTUP	2000	SCOPE	National
TARGET POPULATION	Final beneficiaries: People in the final stage of their active lives and in retirement situations, although it can be extended to the population in general.	STATUS	On-going
FINANCIAL OUTLINE	No financial involvement of the promoting entity		
POPULATION SERVED	None		
PARTNERSHIPS	Companies, Unions, Entities with Training Responsibilities and, possibly, all entities with a relevant interest		
DESCRIPTION	<p>Created in 2000, its purpose is to prepare people for retirement, in accordance with a preventive and inclusive approach and guided by principles such as: lifelong development and learning; active ageing and empowerment. The need for such a project derives from a progressive increase in longevity, associated to the population's lack of understanding of retirement as an important and growing period of life.</p> <p>The Programme has two main goals:</p> <ul style="list-style-type: none"> ▶ To promote personal, social and business development through the creation of project-plans, preparing people for retirement; ▶ To promote a more humane and ethic management of human resources, in which people are valued throughout their careers, namely by emphasizing the need to prepare for the retirement period. <p>To these, three more specific goals can be added:</p> <ul style="list-style-type: none"> ▶ To enable the workers' transition and to promote their adjustment to a new stage of their life: the retirement period; ▶ To promote personal development and satisfaction throughout life, by raising awareness and training skills which can be used to draw up life projects tailored to each individual; ▶ To provide technical documentation and information which promotes social inclusion and participation. <p>To make available information about healthy life habits, rights and occupational alternatives that promote well-being, like associativism, voluntary work and/or other paid activities.</p>		
EVALUATION	<p>The impacts and results of this project so far are very modest, which seems to be a consequence of a reduced participation from the promoters. The fact that they do not receive an effective financial support from Social Security discouraged them from participating actively.</p> <p>However, the recognition of such inadequacies and constraints from the managing entity (ISS) foresees a short-term restructuring of this Programme, which will seek to maintain a similar nature and objectives, though with a more focused role of ISS in its promotion.</p>		

STUDY TO ADDRESS THE NEEDS OF SENIOR PEOPLE IN PORTUGAL

PROGRAMME	PROGRAMA DE APOIO INTEGRADO A IDOSOS (PAII) - INTEGRATED SUPPORT PROGRAMME FOR SENIORS		
PROMOTING ENTITY	Ministry of Labour and Social Solidarity / Ministry of Health	TYPOLGY	Social
STARTUP	1994	SCOPE	National
TARGET POPULATION	Population aged 65 or over, families, neighbors, volunteers, professionals, the community in general and non-profit entities.	STATUS	On-going
FINANCIAL OUTLINE	According to data from the ISS, the expenditure/2007 allocated to this Programme was 3,497,849.67€. PAII's effective funding amount between 1994 and 2006 was of 84,662,288€. The allocation of funds for specific projects between 1995 and 2005 was: Public Transports Senior Passes (23,435,351€); Health and Thermal Senior Programme (9,894,541€); STA - Telealarm Service (1,805,084€); Senior Tourism (6,372,143€); Domiciliary Care Service (SAD) (26,404,651€); Support Centers for Dependent People (CAD) / Multidisciplinary Resources Centers (4,561,570€); Human Resources Training (FORHUM) (1,085,051€).		
POPULATION SERVED	In 2006, 90 local promotion projects were in progress. Regarding central promotion projects: STA (approximately 700 users); Health and Thermal Senior Programme (4,956 participants); Public Transports Senior Passes (no information).		
PARTNERSHIPS	Health Services; Social Security District Centers; Local Authorities (Municipalities, Civil Parish Councils); Congregation of Holy Houses of Mercy; IPSS; NGO; <i>PT Comunicações</i> , Portuguese Red Cross; Security Services (PSP and GNR); Fire Brigades; Schools; Voluntary Organizations; Companies.		
DESCRIPTION	<p>The PAII includes a set of innovative measures, which aim to improve the elderly's quality of life, preferentially in their homes and daily environment. It is implemented through projects at a central and local level. Its goals are:</p> <ul style="list-style-type: none"> ▶ To promote the autonomy of the elderly or people in situations of dependency, mainly in their daily environments; ▶ To establish measures that seek to improve mobility and access to services; ▶ To implement solutions that support families who care for people in situations of dependency, specially elderly people; ▶ To promote and support formal and informal caregivers, as well as volunteers and other members of the community; ▶ To develop measures to prevent isolation and exclusion; ▶ To promote: solidarity between generations; a society that includes all ages; the development of innovative and integrated solutions (health/social services); partnerships that enable job creation. <p>This Programme went through some modifications along the years, especially in 2006, as a result of changes in the way the net revenues from social games belonging to <i>Santa Casa da Misericórdia de Lisboa</i> (SCML) - (Lisbon Holy Houses of Mercy), the financing source of the Programme, are distributed.</p> <p>There are different projects being promoted within the scope of the PAII, at a central and local level.</p> <p style="text-align: center;">CENTRAL PROMOTION PROJECTS</p> <ul style="list-style-type: none"> ○ Remote Alarm Service (STA) - Based on telecommunications, this additional project is currently undergoing a restructuring period. By pushing an alarm button, a person can quickly contact a social services network and this constitutes an effective response to individual needs; ○ Passes for Senior Citizens - Its aim is to eliminate time restrictions for users aged 65 years or over in public urban and suburban transportation in the Lisbon and Oporto areas; ○ Health and Thermal Activities for Senior Citizens - This project managed by <i>Instituto Nacional de Aproveitamento dos Tempos Livres</i> (INATEL) - (Leisure Time National Institute) aims not only to grant access to senior citizens with less financial resources to thermal treatments, but also to enable them to come into contact with a different social context. It also seeks to prevent isolation. Since its creation in 1997 and until 2006 more than 40,500 elderly people have benefited from it. <p style="text-align: center;">LOCAL PROMOTION PROJECTS</p> <ul style="list-style-type: none"> ○ Household Service (SAD) - Its purpose is to allow elderly people, or people in situations of dependency, to be assisted in their daily environment, close to their families, neighbors and friends. It also aims to broaden the current coverage (to 24h/day), while seeking to improve the quality of the services offered, through an adjustment of the home environment to the needs of elderly people; ○ Human Resources Training (FORHUM) - Its aim is not only to train families, neighbors and volunteers, but also professionals, namely in the health and social services areas, and other members from the community, preparing them to be formal or informal caregivers; ○ Support Centers for Dependent People / Multidisciplinary Resource Centers (CAD) - Local resource centers that are open to the community and offer a temporary support. Their aim is the prevention and rehabilitation of dependent people, guaranteeing support and differentiated care, so as to promote greater autonomy and a more active life. These centers are based in pre-existent structures and can have a confinement component in small family units and in collaboration with the household service. 		
EVALUATION	<p>Among the Programmes which are currently underway, PAII stands out for having been the first to be created and for having developed integrated and innovative initiatives.</p> <p>The most positive aspects of the Programme are:</p> <ul style="list-style-type: none"> ▶ Fill territorial coverage including the Autonomous Regions of Azores and Madeira; 		

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PROGRAMME	PROGRAMA DE APOIO INTEGRADO A IDOSOS (PAII) - INTEGRATED SUPPORT PROGRAMME FOR SENIORS		
	<ul style="list-style-type: none"> ▶ A wide range of partnerships; ▶ It helped to implement new and more modern programme management and planning strategies; ▶ It has a broad scope as it helps to improve the quality of life of a larger number of elderly people. <p>Programme weaknesses:</p> <ul style="list-style-type: none"> ▶ With two representatives from the Ministry of Labour and Social Solidarity and two other from the Ministry of Health, the Programme's management became more complex and not as efficient; ▶ There are Programme inadequacies due to long-lasting implementation, such as regulations, financing and eligible typologies; ▶ There is a reduced impact of the Remote Alarm Service, to be substituted by Telehomecare Service. 		

PROGRAMME	COMPLEMENTO SOLIDÁRIO PARA IDOSOS (CSI) - SOLIDARITY COMPLEMENT FOR SENIORS - CSI		
PROMOTING ENTITY	Ministry of Labour and Social Solidarity	TYPOLGY	Social
STARTUP	2005	SCOPE	National
TARGET POPULATION	Population aged 65 or over, with less financial resources	STATUS	On-going
FINANCIAL OUTLINE	According to data from the ISS, the expenditure/2007 allocated to this Programme was 39,249,895.32€.		
POPULATION SERVED	Currently, almost 17,000 elderly people aged 80 years or over are beneficiaries. It is foreseen that, in 2009, it will reach 300,000 elderly people.		
PARTNERSHIPS	Civil Parish Councils; NGO and IPSS;		
DESCRIPTION	<p>It consists of an additional financial benefit to fight poverty within the elderly population. It has the following goals:</p> <ul style="list-style-type: none"> ▶ To act upon greater need and impairment situations through an income surplus that allows a significant reduction of deprivation levels for elderly people; ▶ To focus the available resources on the lower income elderly segment; ▶ To apply a "positive discrimination" principle as an instrument of social justice; ▶ To define the benefit bearing in mind the dimension and characteristics of the households; ▶ To activate family solidarity as an instrument of social cohesion. <p>The Programme adds a complement to the basic income, close, by reference, to the income's limit which is attributed bearing in mind, for example, the main characteristics and the entire income of the elderly's households. This Programme went through a restructuring process that led to an enlargement of its target-population. In addition, its base structure consisted of a <i>Rede Solidária</i> (Solidarity Network), which is composed of a group of partners from all over the country (NGO, IPSS, Civil Parishes and Associations), whose Human Resources received specific training by the ISS.</p>		
EVALUATION	<p>In the context of contemporary social policies, the CSI is seen as a very relevant programme as it constitutes an extraordinary means of fighting poverty among the elderly. It has a direct financial impact upon poverty reduction, one of the major weaknesses associated to the ageing process because it deprives the elderly of basic needs. It is also fundamental to bear in mind that poverty has a considerable dimension among the Portuguese elderly population. The ISS determined that there are approximately 1 million elderly citizens with pensions below 300€, 30% of which are on the verge of poverty. The fact that the Programme initiated a new strategy of social minimums, concentrating its resources on the elderly population with the lowest incomes, guarantees that these funds are given to those who need them the most, thus rapidly reducing poverty among this population. Nevertheless, the Programme has its weaknesses, the most relevant of which is connected to the fact that the determination of the applicant's resources contemplates: a) his/hers and the spouse's income, or the person with whom he lives as a couple; b) solidarity among families, according to the incomes of the children for tax purposes, as well as the composition of the household.</p>		

PROGRAMME	PROGRAMA DE CONFORTO HABITACIONAL PARA PESSOAS IDOSAS (PCHI) - HOME COMFORT PROGRAMME FOR ELDERLY PEOPLE		
PROMOTING ENTITY	Ministry of Labour and Social Solidarity	TYPOLGY	Social
STARTUP	2007	SCOPE	Beja, Bragança and Guarda districts
TARGET POPULATION	People aged 65 or over	STATUS	On-going
FINANCIAL OUTLINE	According to data from the Social Security Institute, the expenditure/2007 allocated to this Programme was 21,000.00€.		
POPULATION SERVED	Around 600 potential beneficiaries.		
PARTNERSHIPS	Civil Parish Councils, Congregation of Holy Houses of Mercy, NGO and IPSS or similar Entities, District Centre, Local Authorities' Councils		
DESCRIPTION	<p>This Programme aims to support investments (structures and/or equipment) and comfort improvements in elderly homes, so that they can remain for as long as possible in a familiar environment, with positive effects on their quality of life, the prevention of home accidents, situations of dependency and poverty, thus avoiding or delaying institutionalization. To fully accomplish these ambitious goals, PCHI is financed by earnings from social games (SCML).</p> <p>The PCHI is aimed at elderly aged 65 years or over, with a monthly income <i>per capita</i> below the social supports index (IAS) and that meet the following requirements: i) people who live in their own homes and who lack</p>		

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PROGRAMME	PROGRAMA DE CONFORTO HABITACIONAL PARA PESSOAS IDOSAS (PCHI) - HOME COMFORT PROGRAMME FOR ELDERLY PEOPLE
	<p>conditions given the situation they are in; ii) people who benefit from domiciliary services or whoever depends on a home qualification to receive them; iii) people who live alone, with another elderly person, under aged or family members with disabilities; iv) exceptionally, people that do not benefit from household services can benefit, as long as their situation is properly justified.</p> <p>Currently, the Programme is being implemented in three inland districts. For 2008, six other new districts will also be added (including Castelo Branco).</p>
EVALUATION	<p>The PCHI has faced several constraints, which have led to a negative evaluation of its results:</p> <ul style="list-style-type: none"> ▶ Residual number of direct beneficiaries until now caused by problems associated to the eligibility criteria of the Programme; ▶ Several difficulties related to the role of the local authorities (e.g. financing). <p>Among the positive aspects of the Programme, the large number of protocols signed between the ISS and the majority of local authorities from the three initially chosen districts for the pilot-project, which reflects the Local Authorities' acknowledgement of the Programme's objectives.</p>

PROGRAMME	SENIOR TOURISM PROGRAMME		
PROMOTING ENTITY	Ministry of Economy and Innovation / Ministry of Labour and Social Solidarity	TYPOLGY	Leisure/Social
STARTUP	1995/1996	SCOPE	National
TARGET POPULATION	Population aged 65 or over.	STATUS	On-going
FINANCIAL OUTLINE	Co-financed by Ministries of Economy and Innovation / Labour and Social Solidarity		
POPULATION SERVED	More than 500,000 participants since its first edition and until 2007		
PARTNERSHIPS	Holy Houses of Mercy, Municipalities;		
DESCRIPTION	<p>This Programme is managed by the National Workers Leisure Institute (INATEL). Its purpose is to allow seniors to visit places with tourist and cultural interest in Portugal and, since 1997 in Spain, thanks to a collaboration protocol between INATEL and its Spanish correspondent - <i>Instituto de Migraciones y Servicios Sociales</i> (IMSERSO). The prices are low (payment according to the income level) and the safety conditions are suited to the elderly. The advantages of this Programme are of a social, economic and cultural nature, because:</p> <ul style="list-style-type: none"> ▶ It improves the seniors' quality of life; ▶ It maintains and creates jobs in tourist areas during the off-season; ▶ It allows hotels to maintain the level of occupation and the activities it involves during the off-season; ▶ It gives the elderly a chance to get to know the Portuguese regions. <p>Among those which already participated in the Programme it is possible to find a broad range of social, economic and demographic profiles.</p>		
EVALUATION	<p>From a social perspective, this Programme has played a relevant role in redefining tourism practices by the elderly, because:</p> <ul style="list-style-type: none"> ▶ It gives many seniors the chance to spend their holidays in an environment other than their homes; ▶ It allows the participants to go on holidays (perhaps the only time during the whole year); ▶ It stimulates tourism, making the holidays a habit (within the Programme's context or not). 		

1.2.2. Other relevant central programmes/policies for the senior population

PROGRAMME	REDE NACIONAL DE CUIDADOS CONTINUADOS INTEGRADOS (RNCCI) - NATIONAL NETWORK OF INTEGRATED AND CONTINUOUS CARE		
PROMOTING ENTITY	Ministry of Health / Ministry of Social Solidarity and Work	TYPOLGY	Health/Social
STARTUP	2006	SCOPE	National
TARGET POPULATION	Older people with functional dependency; people with chronically developing illnesses and serious functional dependency as a result of a physical, psychic, progressive or permanent disease; terminally-ill patients; people who suffer from a form of insanity; people with a disease in a transitory situation.	STATUS	On-going
FINANCIAL OUTLINE	According to data from the ISS, the expenditure/2007 allocated to this Programme was 2,270,560.45€.		
POPULATION SERVED	February 2008: 1,867 operational beds (2,229 new beds with protocol already signed). In 2016 the Programme is expected to attain its full coverage: 2,782 convalescence units; 3,091 medium-term units; 7,728 long-term units; 2,318 day and autonomy promotion units; 927 palliative care units; 40 palliative care hospital teams; 50 palliative care community teams; 90 discharge management teams (1 in each hospital);		
PARTNERSHIPS	Hospitals, Health Centers, Regional and Local Social Security Services, Solidarity Network and Municipalities		
DESCRIPTION	<p>Integrated and continuous care is a set of sequential health and/or social support interventions, resulting from a joint evaluation, based on global recovery and seen as a therapeutic and social support process, which is active and continuous. Integrated care, which is included in the NHS and in the social security system, is based on the paradigms of global recovery continuation for a certain period of time, not only in cases of treatments in acute stages of illness or within the preventive intervention, but also afterwards.</p> <p>The main purpose of this Network is to provide continuous and integrated care to people in situations of dependency. The specific goals are:</p>		

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PROGRAMME	REDE NACIONAL DE CUIDADOS CONTINUADOS INTEGRADOS (RNCCI) - NATIONAL NETWORK OF INTEGRATED AND CONTINUOUS CARE
	<ul style="list-style-type: none"> ▶ To improve the living conditions and welfare of those in situations of dependency through continuous health care and/or social support; ▶ To support, whenever possible, those with loss of functionality, or at risk of losing it, at home, through domiciliary services, so as to ensure that the therapeutic care and social support necessary for the provision and maintenance of comfort and quality of life are given; ▶ To take action through suitable technical support, follow-up and admission; ▶ To persistently improve the quality of continuous health care and social support services; ▶ To support the families or caregivers through qualification and care services; ▶ To articulate and coordinate the care network in different services, sectors and differentiation levels; ▶ To prevent gaps in services and infrastructures, through the progressive coverage, at a national level, of the needs in terms of integrated and palliative care for people in situations of dependency. <p>This Network consists of units and continuous health care and social support teams and of palliative care and actions based on community local services, which include hospitals, health centers, district and local social security services, the Solidarity Network and the local municipalities.</p>
EVALUATION	<p>The RNCCI is an important advance in terms of care providing, autonomy promotion and improvement in the living conditions of the elderly population.</p> <p>However, the Network stills needs to develop both the number and typology of answers, weaknesses mainly due to its recent implementation. Although it has been growing steadily and at a good pace, the Network is still far from the number of beds that should already be available.</p>

PROGRAMME	NATIONAL SOCIAL EMERGENCY LINE		
PROMOTING ENTITY	Ministry of Labour and Social Solidarity	TYPOLGY	Social
STARTUP	2001	SCOPE	National
TARGET POPULATION	Population in social emergencies: victims of domestic violence; endangered children and youngsters; homeless; neglected elderly.	STATUS	On-going
FINANCIAL OUTLINE	According to data from the ISS, the expenditure/2007 allocated to this Programme was 2,237,914.26€.		
POPULATION SERVED	In 2007 the Line received 28,783 calls		
PARTNERSHIPS	<i>Portugal Telecom</i> , Public Security Police (PSP and GNR), IPSS, Pensions/Lodging and other local partners.		
DESCRIPTION	<p>The National Line of Social Emergency is a free public service created within a national context, managed by the ISS. This service, available through the number 114, seeks to protect and safeguard the people in Social Emergency situations 24 hours a day, throughout the whole year.</p> <p>Its main purpose is to create an immediate social response in situations of social emergency and to ensure the access to a subsequent social guidance and follow-up, in an integrated and autonomous context.</p> <p>Misuse of the service led to the fact that it was driven by means of disease and not only because of its social character of emergency led the ISS to establish a protocol with <i>Portugal Telecom</i> for the creation of a telephone line, in which the types of calls are filtered by staff trained by the ISS. After this filtering, only the situations of social emergency are directed to the ISS telephone line, whose team is comprised of psychologists, social experts and a lawyer.</p> <p>In 2007, a total of 244,827 calls were received, 87.4% of which were considered non-useful calls. However, the real situations of social emergency amounted to 28,783 calls, a figure which illustrates the importance of the answers given.</p>		
EVALUATION	<p>The main potentiality of this service is the wide platform of partners involved, who are gifted with quite diverse skills, which is an essential condition to secure the success of the answers given in social emergencies. However, other factors are equally relevant, namely whole year and free access to the service.</p> <p>The main critical factors are: a misunderstanding from the users of what its function is, which leads to a misuse of this service, compromising its efficiency; lack of human resources due to the fact that the number of calls has increased tremendously.</p>		

PROGRAMME	RENDIMENTO SOCIAL DE INSERÇÃO (RSI) - SOCIAL INTEGRATION INCOME		
PROMOTING ENTITY	Ministry of Labour and Social Solidarity	TYPOLGY	Social
STARTUP	2003	SCOPE	National
TARGET POPULATION	Individuals and families in a situation of serious economic lack of resources and presenting a set of pre-established conditions.	STATUS	On-going
FINANCIAL OUTLINE	According to data from the ISS, the expenditure/2007 allocated to this Programme was 345,709,136.71€.		
POPULATION SERVED	In 2005, 202,100 RSI beneficiaries were registered		
PARTNERSHIPS	State (social structures), Individuals, Families, Institutions, Communities and Social Groups.		
DESCRIPTION	<p>Along with the <i>Rendimento Mínimo Garantido</i> (RMG) - (Guaranteed Minimum Income), the predecessor of the RSI, new concepts and procedures for fighting poverty and for social integration arose. The purpose of these new tools is to guarantee the availability and the right to minimum means of support by everyone who lacks resources, combined with a set of measures of social and economic integration of the beneficiaries.</p> <p>The RSI was created with the purpose of granting the Programme higher efficiency and to strengthen its transitory</p>		

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	<p>nature.</p> <p>Like RMG, the RSI consists of a payment in money (of a transitory nature and a variable amount), and an integration Programme "so as to give people and their household members support which is tailored to their personal situation and which contributes to the fulfillment of their basic needs. It also favours a progressive professional, social and community integration". The RSI's Integration Programme is thus comprised of a set of actions aimed at a gradual social integration, not only of its beneficiaries, but also of their household members.</p>
EVALUATION	<p>The RSI has been consolidated as an important instrument of social policy with a national extent by promoting an effective fight against poverty. According to the "Impact Evaluation of the RMG" (2002), one can observe that these people have a negative and passive vision of the world, along with a dependency on institutions.</p> <p>The RSI is a new social policy with several positive aspects, namely the fact that the income is regularly given to the families, allowing them to support fixed and basic expenses and, subsequently, helping them to guarantee minimum quality of life patterns. It also promotes a significant increase in self-esteem, motivation, development of social and professional skills and in developing their sociability and affections.</p> <p>A weakness of this measure is the fact that it generates the stigmatization of its beneficiaries.</p>

PROGRAMME	SOCIAL NETWORK		
PROMOTING ENTITY	Ministry of Labour and Social Solidarity	TYPOLGY	Social
STARTUP	1997	SCOPE	National
TARGET POPULATION	Community; individuals in poverty and social exclusion situations	STATUS	On-going
FINANCIAL OUTLINE	Co-financed by the European Social Fund (ESF).		
POPULATION SERVED	According to data from the ISS, the expenditure/2007 allocated to this Programme was 2,051,371.85€.		
PARTNERSHIPS	Not applicable.		
DESCRIPTION	<p>Municipalities, public and private entities without profit means</p> <p>The Social Network's purpose is to promote the unification and integration of efforts between local authorities and public and/or private entities, in order to contribute to the eradication or reduction of poverty and social exclusion, in a context that promotes and supports social development.</p> <p>Social Networks are composed by <i>Comissões Sociais de Freguesia</i> (CSF) - (Civil Parish Social Commissions) and <i>Conselhos Locais de Acção Social</i> (CLAS) - (Local Social Action Councils), and they manage/approve the Internal Regulations that assure the application of the Social Network principles.</p> <p>Strategic goals for the Social Network include:</p> <ul style="list-style-type: none"> ▶ Development of an effective and dynamic partnership, with the integrated social intervention of the various local agents; ▶ Promotion of systematic and integrated planning, that supports synergies, competences and resources at a local context; ▶ Improved efficiency in terms of social responses between municipalities and civil parishes. <p>The methodological proposal for the implementation of the Social Network is based on a participated planning strategy that includes, in a first phase, a social diagnosis and, in a second phase, the creation of a <i>Plano de Desenvolvimento Social</i> (Social Development Plan), which contains the purposes and strategies for this intervention, the action plans that are to be carried out in the short and medium-terms and the definition of the evaluation process that must be executed afterwards.</p>		
EVALUATION	<p>The Programme, as it has been stated in the "Social Network Programme Evaluation - Synopsis report" (2005), stands out from the traditional forms of intervention in social issues, not only because it aims at developing a multidimensional approach to social problems, but also because its actions have a territorial focus, bearing in mind the social and cultural specificity of each context. On the other hand, the Social Network conceives the development as a result of an integrated intervention from different stakeholders. It stands as an ambitious and innovative programme in the field of the social policies, which calls for a new global conceptualization of intervention.</p>		

PROGRAMME	PROGRAMA PARA A INCLUSÃO E DESENVOLVIMENTO (PROGRIDE) - INCLUSION AND DEVELOPMENT PROGRAMME		
PROMOTING ENTITY	Ministry of Labour and Social Solidarity	TYPOLGY	Social
STARTUP	2004	SCOPE	Mainland Portugal
TARGET POPULATION	Groups facing exclusion, delinquency and persistent poverty	STATUS	-
FINANCIAL OUTLINE	According to data from the ISS, the expenditure/2007 allocated to this Programme was 13,076,373.67€.		
POPULATION SERVED	(awaiting information)		
PARTNERSHIPS	Non-profit private entities that operate in the social solidarity area and Municipalities		
DESCRIPTION	<p>Its purpose is to act within a context of poverty and social exclusion. To allow a wider intervention scope, not only are projects drawn up by local authorities accepted, but also those by non-profit private entities that act within a social solidarity context (e.g. IPSS, Holy Houses of Mercy and NGO).</p> <p>The Programme has a multidimensional approach towards these problems and aims at integrated interventions. Its main goals are:</p> <ul style="list-style-type: none"> ▶ To promote social inclusion in marginalized and degraded territories, to fight demographic isolation and depletion and to prevent exclusion in heavily depressed territories; ▶ To actively intervene within specific groups that are persistently confronted with exclusion, marginality and poverty situations. 		

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	In order to fulfill these goals, the Programme is made up of two different measures: it supports projects fighting serious exclusion phenomena (in territories seen as a priority); it supports projects which promote inclusion and improvement of the living conditions for some specific population groups
EVALUATION	PROGRIDE presents a set of weaknesses: the need for a major effort in terms of territorial cohesion, as a result of the exclusion of more depressed territories (lack of dynamics from the local institutions and inadequacy among means, actors and partners in terms of the established generic goals); the lack of intervention in the Autonomous Regions of Azores and Madeira; the erratic geographical distribution of the projects.

PROGRAMME	PROGRAMA COMUNITÁRIO PARA AJUDA ALIMENTAR A CARENCIADOS (PCAAC) - FOOD AID COMMUNITY PROGRAMME		
PROMOTING ENTITY	European Commission (EC)	TYPOLGY	Social
STARTUP	1986/1987	SCOPE	European Union
TARGET POPULATION	Families/people and institutions/users whose situation of social and/or economic dependency may be seen and proven.	STATUS	On-going
FINANCIAL OUTLINE	According to data from the ISS, the expenditure/2007 allocated to this Programme was 222,615.31€.		
POPULATION SERVED	In Portugal, the PCAAC has about 1,700 mediating entities		
PARTNERSHIPS	Institutions, ISS.		
DESCRIPTION	<p>The PCAAC is annually promoted by the EC and it supplies food products that exist in the EC intervention storage facilities and distributes them after transformation and/or packing to those in need.</p> <p>The Council, in agreement with the goals of the Common Agricultural Policy - namely the reduction of stocks to a normal level - established "the general rules for the supply of certain organizations in terms of food products from intervention stocks to be distributed by those in need within the Community".</p> <p>The beneficiaries of PCAAC are families/people and institutions/users, whose situation of social and/or financial dependency is established and recognized based on the approved Eligibility Criteria.</p>		
EVALUATION	<p>An evaluation of PCAAC reveals that this is an important programme as it aims to put an end to basic needs. However, its applicability has faced some problems:</p> <ul style="list-style-type: none"> ▶ The list of food items available is not diversified; ▶ The criteria established to choose the target-population that can be served by this Programme are ambiguous, since they sometimes consider situations and people whose effective poverty does not seem to be real; ▶ The complex and slow management of the Programme; ▶ PCAAC's assistential approach; ▶ The Programme can reach a much larger number of people than those currently registered. <p>However, the Programme also presents a set of potentialities:</p> <ul style="list-style-type: none"> ▶ Its large scope; ▶ A vast platform of partners; ▶ The Programme's monitoring process, in order to make it more efficient and to increase its impacts. 		

PROGRAMME	PROGRAMA DE ALARGAMENTO DA REDE DE EQUIPAMENTOS SOCIAIS (PARES) - PROGRAMME FOR THE EXPANSION OF THE SOCIAL INFRASTRUCTURES NETWORK		
PROMOTING ENTITY	Ministry of Labour and Social Solidarity	TYPOLGY	Social
STARTUP	2006	SCOPE	National
TARGET POPULATION	IPSS and Municipalities	STATUS	On-going
FINANCIAL OUTLINE	According to data from the ISS, the expenditure/2007 allocated to this Programm was 363,344.36€.		
POPULATION SERVED	First applications of PARES included 275 new services, which correspond to 9,097 new places, in social infrastructures for the elderly.		
PARTNERSHIPS	Public and Private.		
DESCRIPTION	<p>In the years to come, on a national scale, the network expansion of social infrastructures will be centred on the PARES. PARES plans the need for social infrastructures at a territorial level, through the funding of selected projects within areas with a low coverage rate and that appear more vulnerable to social exclusion. This aims to correct geographical imbalances of the already implemented network. Simultaneously, its purpose is to stimulate private investment, mainly projects that have their own funding, through partnerships between institutions and their local partners.</p> <p>The network expansion of social infrastructures has the following objectives in terms of capacity increase: Children and Young People (50% increase); Elderly People (10% increase); People with Disabilities (10 to 30% increase).</p> <p>The Programme should be implemented through partnerships with the Solidarity Network, composed by the IPSS and such. There will also be an innovative incentive for the profitable private sector, through an autonomous process that supports investments.</p> <p>Thus, in the context of the Solidarity Network, the projects that are to be co-financed may involve: building from scratch; enlargement or improvement of the already existing infrastructures (as long as they generate new places); purchase of properties or portions and purchase of tangible assets necessary for their functioning. Within the Private Network, the Programme supports the payment of interests related to acquired credit to build and the purchase of new equipment or renovation of those already being used.</p>		
EVALUATION	<p>An on-going evaluation of the Programme reveals the existence of an important set of positive aspects, namely:</p> <ul style="list-style-type: none"> ▶ The acknowledgment of present and future needs facing current insufficient supply and growing demand; ▶ Innovative Programme in terms of spatial planning, shared responsibilities and selection criteria; 		

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PROGRAMME	PROGRAMA DE ALARGAMENTO DA REDE DE EQUIPAMENTOS SOCIAIS (PARES) - PROGRAMME FOR THE EXPANSION OF THE SOCIAL INFRASTRUCTURES NETWORK
	<ul style="list-style-type: none"> ▶ The typology of the financing of the Programme is also an aspect to bear in mind, since it allows the sustainability of financing in the future, adjusted to the typology of the projects; ▶ Job creation. <p>Despite the positive aspects of the Programme, it also presents some weaknesses to be taken into account:</p> <ul style="list-style-type: none"> ▶ The fact that in the beginning it was meant for only three target groups, excluding other groups with weaknesses; ▶ Lack of ambitious expansion goals for the elderly population (10%), clearly insufficient facing current and future needs; ▶ The exclusion of the Autonomous Regions of Azores and Madeira.

PROGRAMME	PROGRAMA DE APOIO AO INVESTIMENTO EM EQUIPAMENTOS SOCIAIS (PAIES) - SUPPORT FOR INVESTMENT IN SOCIAL INFRASTRUCTURES PROGRAMME		
PROMOTING ENTITY	Ministry of Labour and Social Solidarity	TYPOLGY	Social
STARTUP	2006	SCOPE	Mainland Portugal
TARGET POPULATION	Private entities (with or without profitable aims), excluding Private Social Solidarity Institutions or alike.	STATUS	On-going
FINANCIAL OUTLINE	<p>The Programme is financed by earnings of social games granted by the MTSS.</p> <p>The estimated global investment for this Programme is around 13 million euros of which: 360,000 euros for residential nursing homes; 2,600,000 euros for nursing homes; 10,180,000 euros for nursing schools.</p> <p>The total amount of investment will create 6,260 new places within social infrastructures.</p>		
POPULATION SERVED	-		
PARTNERSHIPS	IPSS and private entities.		
DESCRIPTION	<p>In the context of the PARES, the PAIES is meant for private entities (non-profit or not), excluding IPSS or alike, because these can benefit from the PARES Programme.</p> <p>The support for investments in the PAIES context is aimed at the creation of new places. The typology of the projects is: building from scratch; enlargement or improvement the existing building or part of it; full or partial building purchase.</p> <p>The PAIES main goal is to support the network development of the social infrastructures through the concession of investment incentives in a private initiative context. The results are a benefit to children, elderly people and people with disabilities.</p>		
EVALUATION	<p>A brief evaluation of PAIES, although conditioned by the fact that it is a rather recent Programme, allows us to identify a set of potentialities:</p> <ul style="list-style-type: none"> ▶ The nature of the Programme itself, by acknowledging the need to invest in the supply of social infrastructures; ▶ The sustainability of the financial schemes, adjusted to the project's time frame; ▶ The fact that the Programme promotes public/private investment. <p>As a weakness of the Programme we can point out the exclusion of the Archipelagos of Azores and Madeira, since the Programme is aimed exclusively at Mainland Portugal.</p>		

PROGRAMME	TELEHOMECARE SERVICE		
PROMOTING ENTITY	Ministry of Labour and Social Solidarity	TYPOLGY	Social
STARTUP	(on hold)	SCOPE	-
TARGET POPULATION	People in at-risk situations, due to age, incapacity or limited autonomy.	STATUS	Ex-ante
FINANCIAL OUTLINE	Information unavailable.		
POPULATION SERVED	In the first year of its implementation, 5,000 beneficiaries should receive support from this programme.		
PARTNERSHIPS	Contract with a private company to render the service		
DESCRIPTION	<p>This service, managed by the ISS, allows people in at-risk situations due to "their age, disability or autonomy limitation" to have access to a system of permanent home surveillance and, simultaneously, to request assistance in case of emergency situations. The service is provided via telephone line or communication equipment, which allows individuals to get connected with the Care Delivery Central, everyday of the year, 24 hours a day. There will also be a mobile unit in a pilot experience to be held in the district of Setúbal.</p>		
EVALUATION	<p>Although this service has not been implemented yet, in an ex-ante context of evaluation, two aspects have to be pointed out.</p> <p>The first critical factor has to do with the fact that some of the Programme's aims (result pointers) are very ambitious, namely the fact that during the first year of its implementation 5,000 beneficiaries are expected to receive support from this Programme. It should also be borne in mind that a very significant percentage of the elderly Portuguese population is highly illiterate, resistant to innovation and does not embrace new Information and Communication Technologies (ICT).</p> <p>A second critical factor is the fact that the Programme has not been implemented until now due to questions related to the process of the international public tender already launched (appeal and contestation from several applicant companies), which has systematically postponed the formulation of the Programme.</p>		

PROGRAMME	PROGRAMA DE APOIO A DOENTES ESTRANGEIROS (PADE) - FOREIGN PATIENTS SUPPORT PROGRAMME		
PROMOTING ENTITY	High Commission for Immigration and Intercultural Dialogue (ACIDI) / Social Security Institute (ISS)	TYPOLGY	Social/Health
STARTUP	December 2007	SCOPE	International
TARGET POPULATION	Patients from PALOP who come to Portugal for medical treatment	STATUS	Ex-ante
FINANCIAL OUTLINE	Information unavailable.		
POPULATION SERVED	8 patients, but it is possible to increase this number. One of the aims of this Programme is to grant 75 annual social support subsidies.		
PARTNERSHIPS	-		
DESCRIPTION	<p>The implementation of the Programme acknowledges that there is no support structure for temporary immigrants who come to Portugal to receive medical care.</p> <p>The aim of the Programme is to support the temporary accommodation and financial needs of foreign patients coming from PALOP, during the period of time they are going to stay in Portugal for treatment. It also provides support to those who accompany the patients, as long as the embassies can prove the effective support capacity of these citizens.</p>		
EVALUATION	<p>Bearing in mind that the PADE is still in its initial stage, its evaluation is relatively limited. However, there are already some critical and positive aspects that can be pinpointed.</p> <p>This Programme allows the follow-up of citizens from the PALOP in a closed circuit. This intervention has a double impact, since it has direct positive effects on the efficiency of the medical treatment and also because it fights illegal immigration in Portugal.</p> <p>A close monitoring process is previewed with the aim of overcoming possible weaknesses identified throughout the process.</p> <p>The fact that during their stay the Programme's beneficiaries live in the same house for logistic (concentration of services and support) as well as for financial purposes, can become a critical factor: people with different types of pathologies living together may compromise recovery. However, this can also be seen as a potential opportunity for the sharing of experiences and individual support among citizens who have a common life history, either because they are all immigrants, or because they all suffer from a pathology.</p>		

1.2.3. Local Programmes for the senior population: some examples

"Amadora Multiserviços" (Amadora Multi-services)

Created in 2007, the *Programa Amadora Multiserviços* (Amadora Multiserviços Programme), (*one ring is enough* 800 207 632) was developed in partnership with the Municipality of Amadora and Amadora's Intercultural School of Professions and Sports (EIPDA).

The objectives of the "Amadora Multiserviços" initiative are:

- ▶ To provide the project beneficiaries with minor repair/adaptation services in their homes;
- ▶ To promote the improvement of the beneficiaries' quality of life;
- ▶ To ease the socio-professional integration of less favoured publics in proximity services;
- ▶ To support the permanence of people at home, catering for needs such as mobility, safety and comfort;
- ▶ To obtain a complementary response for the support caregiver Institutions.

By a simple phone call to the service's phone line, answered by specialized staff, the following services are provided: carpentry, construction works, blacksmith work, electricity, communications, plumbing, isolation, waterproofing, as well as the moving of furniture within the house, the replacement of broken glass, and antiskid tape for the stairs, among others. Beneficiaries with mobility impairment or over the age of 65 might benefit from household delivery of essential goods, including medication. The service is aimed at a target-population of elderly people over the age of 65, but also for people with disabilities and people in a situation of dependency, living in the municipality with low financial resources (*per capita* income equal to or lower than the social pension).

Cartão Sénior Municipal Estarreja (Municipal Senior Card)



This Programme essentially benefits those who have a reduced income, without forgetting all individuals aged 65 or over.

The municipal initiative intends to encourage social gatherings, frequenting cultural and leisure spaces, local trade and the improvement of the seniors' economic situation. It proposes to ease the solitude of the municipality's elderly, promoting leisure moments and reinforcing thus participation, contributing in this way to the improvement of their living conditions.

The Senior Card has two modes: general and specific and it is targeted at holders whose *per capita* income does not exceed 70% of the national minimum wage.

The benefits are granted in several areas, from culture and leisure to sports and even basic infrastructures (water and sanitation), health and trade.

General benefits of the Senior Card:

- ▶ Free tickets (limited and predefined) for venues and cultural activities promoted by the Municipality of Estarreja;
- ▶ Exemption from payment in the municipal swimming-pools;
- ▶ Possibility of exemption from payment in cultural and sports events of the Municipality's Communities that might in the future enter into cooperation protocols with the Municipality;
- ▶ Discounts in stores, in goods and/or services provided by local companies that might achieve cooperation protocols with the Municipality in the future.

Specific benefits of the Senior Card (for holders whose *per capita* income does not exceed 70% of the national minimum wage):

- ▶ Exemption from paying water consumption for domestic purposes and sanitation tariffs up to 3m³;
- ▶ 50% reduction in the costs of the domestic water connection, including the connection to the water counter;
- ▶ 25% of the non-contributory part by the NHS and up to the annual limit of the social pension, medication with prescription;
- ▶ Should the senior suffer from a chronic disease, the contribution will go up to the amount of two social pensions.



Programa Nacional de Desporto para Todos (National Programme of Sports for All)

The improvement in health and in the quality of life of the Portuguese population is the *Programa Nacional de Desporto para Todos* (National Programme of Sports for All) mission and its goals are the following:

- ▶ To motivate the sedentary population to include physical activity in their daily routines;
- ▶ To increase knowledge about the health benefits;

- ▶ To increase public awareness to the importance of physical activity for health reasons;
- ▶ To increase the knowledge that all people, irrespective of their age or socio-economic status, can and should be physically active and should make physical activities part of their daily lives;
- ▶ To increase the knowledge that it is possible to start or re-start this practice at all ages;
- ▶ To emancipate citizens for physical activities by disseminating information/education.

Through the *Programa Mexa-se* (Move Yourself Programme), the Portuguese Sports Institute seeks to encourage the regular practice of physical activity and sports, in a cooperation with the associative movement and local municipalities, as well as other Central Administration structures. The main goal of Move Yourself Programme is to promote the generalization of the moderate practice of physical activity so that it becomes part of the daily routine for most people. The expected results are better quality of life, increased productivity and a decrease in health care costs.

Carta Social (Social Charter)

The Social Charter (the Municipality's Infrastructures and Social Services Charter) is a guiding document of the investments in infrastructures and social services at a municipal level that occur after a process of territorial, social and institutional diagnosis and the application of different methodologies of strategic planning and programming of social infrastructures and services. Bearing in mind the (still) low coverage rates of infrastructures and social responses, at a national level, it is crucial to set up a proper Social Network, so as to outline the action of private and cooperative actors.

Go farthest away in the rediscovery of the local history

This project is targeted at the elderly population over the age of 65 living in the municipality of Oliveira de Azeméis. Its main goal is to give older people the "opportunity of rediscovering the cultural, historical and landscaping potential of the region", stimulating social gatherings and fighting social isolation (of which many of them suffer). For this purpose, tours are arranged to different places in order to acquaint the participants with the local history.



Physical Activity Programme for the Senior Population of the Municipality of Viseu.

Targeted at residents over the age of 60, the Senior Activity Programme - Physical Activity Programme for the senior population of the municipality of Viseu seeks to educate the population on the risks of sedentary habits and on the important role that physical activity can play in the creation and maintenance of this age group's well being.

This Programme is a result of the collaboration between the Municipality of Viseu, the *Associação de Desenvolvimento e Investigação de Viseu* (ADIV) - (Association for Development and Research of Viseu) and the *Escola Superior de Educação de Viseu* (ESEV) - (Teacher Training College of Viseu) in the organization and achievement of a course specialized in Physical Activity for Seniors, for the degrees in Physical Education and Sports, that will provide the monitors that participate in these projects with the desired quality and safety. Other partners in this project will be the Parishes and IPSS.

1.3. The Third Sector: the networks in-between

The Third Sector is made up of civil society organizations (set up on the initiative of citizens) with the aim of keeping up the traditional charity practices, based on the voluntary and non-profit-seeking participation of citizens.

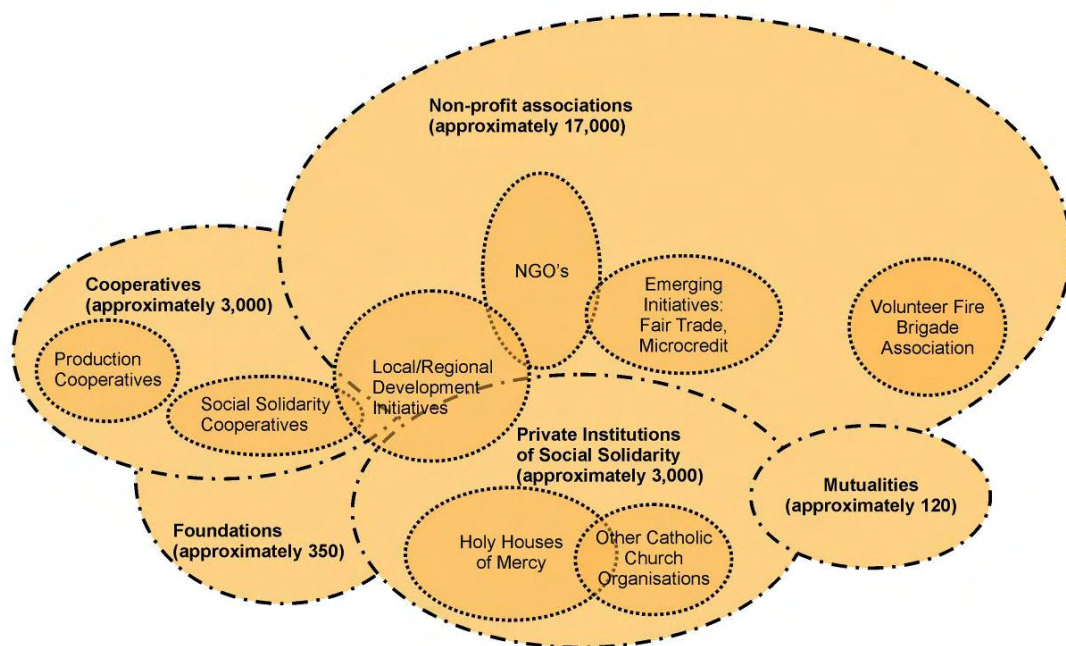
The period following the 25th of April 1974 events gave rise to many associative movements that defended a wide variety of causes, ranging from quality of life, better working and housing conditions and better care and services for the most vulnerable. It was in this context that in 1979 the bye-laws of the IPSS were approved, initially as social service providers, but as from 1983 they also began providing health, education and housing services, among others. The accession of Portugal to the EC in 1986 gave rise to a new phase of this sector as the arrival of structural funds demanded not only greater responsibility towards the underprivileged but also the accession assumed the creation of a new type of institutions (Franco, 2005). This led to the consolidation and diversification of associative movements in the Portuguese society.

At present, the Third Sector in Portugal is structured as follows:

- ▶ **Associations:** This is the area of the Third Sector that covers the greatest number of institutions (approximately 17,000) and complexity of realities. NGO, regional and local development initiatives, volunteer and other recently emerging initiatives, such as microcredit, free trade and several types of associations: fire brigade, consumer protection, student, immigrant, family, women, youth, environment protection, reading and cultural. It is worth mentioning that some of these Associations have an IPSS status.
- ▶ **Mutual Societies:** It is estimated that there are approximately 120 Mutual Societies in Portugal, in the more restricted area of the Third Sector. These are IPSS, with an unlimited number of members and whose main purpose is to assure its members of social protection and health benefits;
- ▶ **Cooperatives:** Considering that there are around 3,000 Cooperatives in the Portuguese society, along with the IPSS this is the second biggest area of the Third Sector. Cooperatives are autonomous legal persons with a variable share capital and composition, which promote cooperation and self-help among its members with the goal of satisfying their aspirations and economic, social and cultural needs from a non-profit-seeking point of view. In Portugal, there are different types of Cooperatives, namely, consumption, marketing, agricultural, credit, housing and construction, factory production, craftsmanship, fisheries, culture, services, education and social solidarity. It is worth mentioning that some of these Cooperatives have an IPSS status;
- ▶ **Foundations:** It is estimated that there are approximately 350 Foundations in Portugal, making it a relatively recent reality, having been introduced in the Civil Code only in 1867. As with the cooperatives, these are legal persons, which, according to Portuguese law, require the existence of sufficient funds to structure and carry out their missions. Currently, the existing Foundations have a variety of intervention areas, although the main ones are education, science and technology, art and charity, among others. It is worth mentioning that some of these Foundations have an IPSS status;
- ▶ **Holy Houses of Mercy:** These are among the most ancient non-profit organizations in Portugal. This organization is, since its beginning, connected to the Catholic Church. The first Holy House of Mercy ever created was in Lisbon, in 1498 and it still keeps its activity, although as a Public Institution, with a unique status. Holy Houses of Mercy receive financial support from the State through their IPSS status (some Holy Houses have an IPSS status) to which most of them has resorted. These are about 400, distributed along the country and are mostly concentrated in the areas of social and health assistance, being represented by the Holy Houses of Mercy Union, which defends these institutions' common interests.

Although in Portugal the Third Sector is made up of five major areas, its interventions are not isolated but rather relational, due not only to the non-profit-making nature but also to the principles and objectives pursued. The structure of the Third Sector in Portugal is thus supported by these five legal institutions, to which can be added a sixth domain: the IPSS, which is not a legal institution, but only a status (Quintão, 2006). The IPSS are non-profit-making organizations, designed to give organizational expression to the protection of moral rights, solidarity and justice among individuals in society. They may take on different forms, however the religious presence - namely of the Catholic church - among them has a significant weight. Currently, there are more than 3,000 IPSS in Portugal, with very different objectives.

Figure 54. Structure of the Third Sector, in Portugal.



Source: Adapted from Carlota Quintão, 2006.

1.3.1. Non-profit organizations

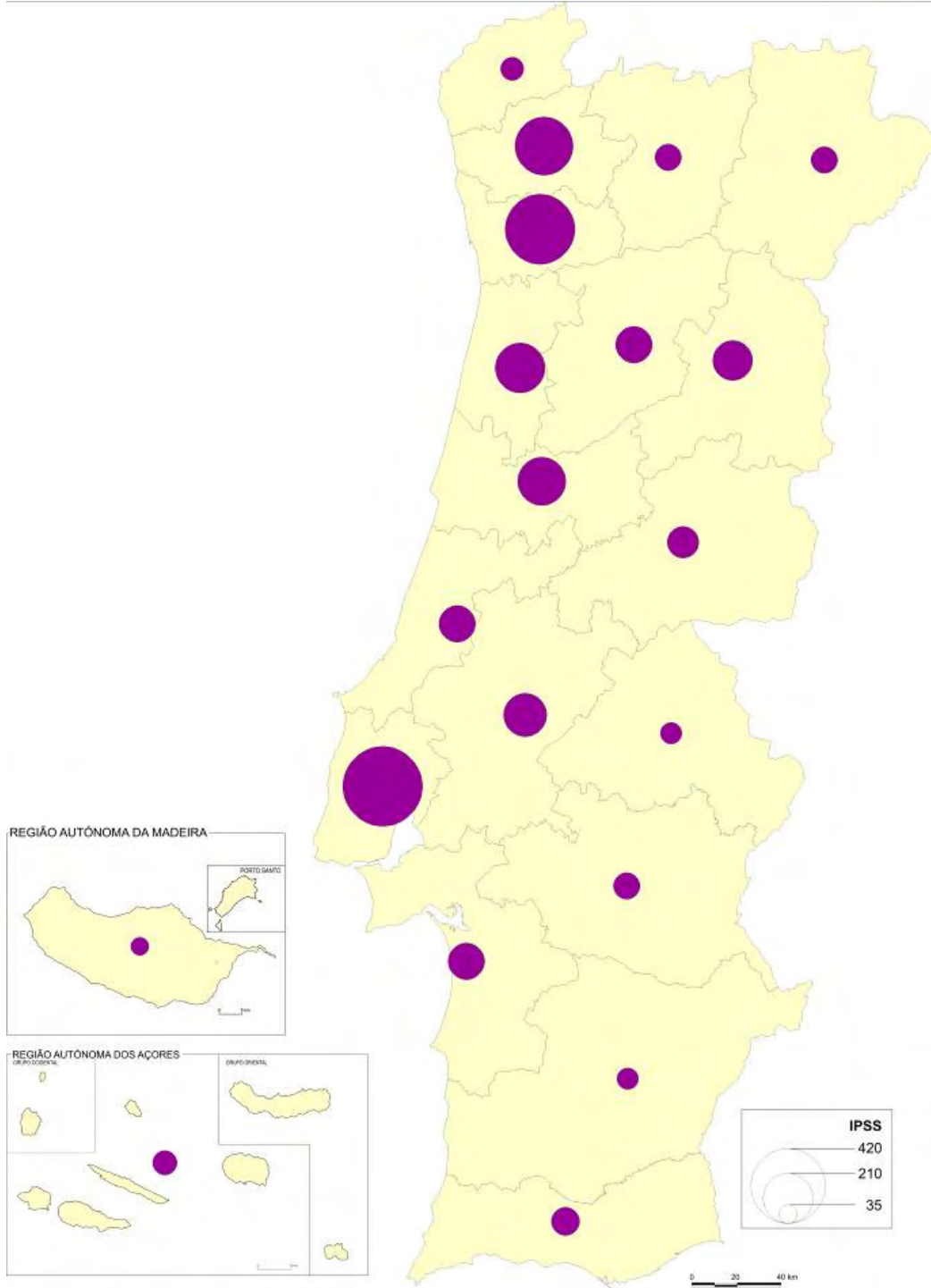
1.3.1.1. Private Institutions of Social Solidarity (IPSS)

The name IPSS emerges in the 1976 Constitution, as a solution/attempt to create hosting conditions for the growing number of senior citizens and people in need, in a joint effort between the State and the Civil Society. Thus, the IPSS present themselves as “institutions without any lucrative purposes, created by private entities, which aim for an organized materialization of solidarity and justice values among individuals”. One of its main goals is to “protect the senior and disabled citizens in situations where there is a significant lack of means (or no means at all) of subsistence or working ability”. In 2007, there were an estimated 3,500 solidarity institutions with social services, with different target-groups, among them, the elderly (*Figure 55*).

Nowadays, the IPPS’ intervention towards the elderly has an even wider perspective of its social purpose, no longer restricted to the traditional domains of protection and basic support needs of the seniors. A holistic vision that must be expected from actions targeting the elderly population, the IPSS currently develop a praiseworthy performance in subjects that - although not essential - are relevant in

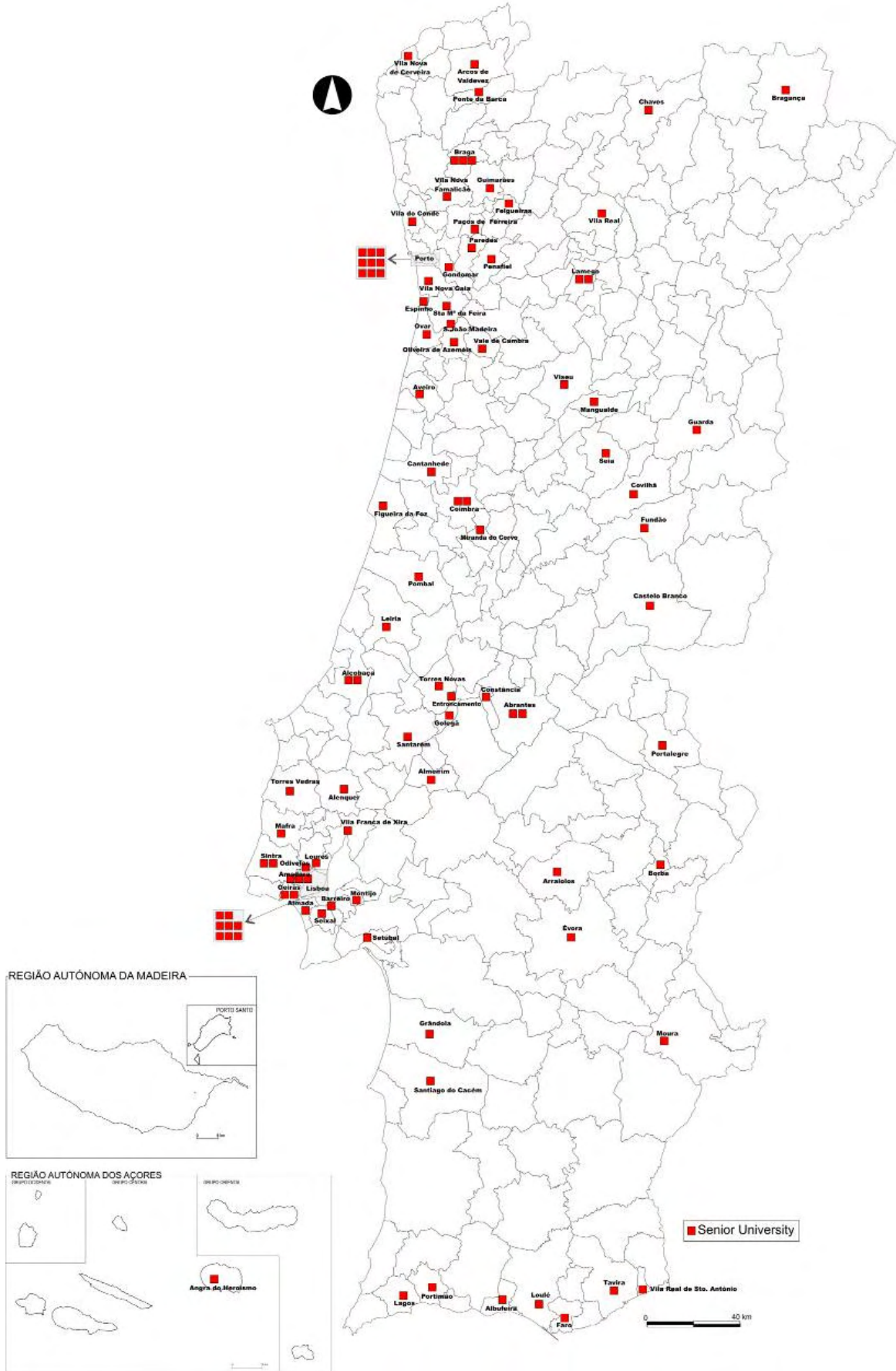
the promotion of this population's wellbeing and quality of life, such as culture, sports or leisure. As an example, it is worth mentioning *Rede de Universidades da Terceira* (RUTIS) - (Senior Universities Network), whose main goal of promoting active ageing and community and individual development has been accomplished in the support to the implementation of a national network of senior universities (*Figure 56*).

Figure 55. Number of Private Institutions of Social Solidarity, 2007 (N.)



Source: CNIS.

Figure 56. Senior Universities, 2007 (N.)



Source: Rede das Universidades da Terceira Idade.

Cooperation agreements (direct granting of benefits), as well as management agreements between the State (Central or Local Administration) and the IPSS can be established (in which the latter assume the services' management and State infrastructures). The IPSS can also receive State support for the construction or remodeling of social infrastructures, through *Programa de Investimentos e Despesas de Desenvolvimento da Administração Central* (PIDDAC) - (Central Administration's Development Investments and Expenses Programme) or other specific programmes. These partnerships between the State and the IPSS have proven to be fundamental in the implementation and accomplishment of an effective policy of support to elderly people.

IPSS have a second level of organization - the District Unions - that defend IPSS' interests before the political power. Furthermore, it provides several kinds of support, such as legal advice and accounting services, as well as a third level, the IPSS Confederation, that represents the District Unions.

Besides the IPSS, there are other non-profit private entities that can carry out various social support activities within the scope of social services, in relation to different target-groups, namely the elderly. These are subject to licensing, inspection and supervision by the State's competent authorities.

Table 97. Financial amount allocated by the Institute of Social Security to Social Security Private Institutions (IPSS), 2007

	Financial amount allocated to IPSS		Financial amount allocated to IPSS aimed at senior care provision	
	€		€	%
COOPERATION				
Current Management	1,049,395,282.00		414,279,256.97	39.5
Programme	17,108,939.00		5,464,240.47	31.9
SUBSIDIES				
Eventual Subsidies	2,699,597.85		2,699,597.85	100.0
PROGRAMMES/PROJECTS				
Total	24,071,213.09		3,994,139.67	16.6
BENEFITS				
Integration Social Income	12,346,265.32		-	0.0

Source: ISS, IP. - *Departamento de Gestão Financeira*, 2008.

Holy Houses of Mercy

Santas Casas da Misericórdia (Holy Houses of Mercy) are IPSS. The first one was created in Lisbon (1498), as a result of the intervention of Queen Leonor, with the aim of helping to solve social problems which arose in the country's major urban centers following the maritime expansion and battles. The pioneering example of Lisbon was followed by other districts in that same year. In the subsequent year, charity organizations were created in two important cities: Oporto and Évora. Until the death of Queen Leonor, 1,525 charity organizations were created. Nowadays, there are 377 Holy Houses of Mercy throughout the country.

Holy Houses of Mercy are coordinated by the *União das Misericórdias Portuguesas* (UMP) - (Congregation of Holy Houses of Mercy), established in 1976, following the social changes that occurred after the revolution of 1974. The UMP is governed by its own bye-laws as a civil legal entity under canon law and it is composed by the group of Holy Houses of Mercy that voted in favour of the bye-laws and by all those that ended up joining the Union.

The provision of senior care by Holy Houses of Mercy was initially directed towards those who were discharged from hospitals and therefore needed greater social and health care. The awareness of the elderly as a growing target public and the fact that other entities revealed very little interest in providing them with care, preferring other target groups, urged Holy Houses of Mercy to start building residential homes in the 1960's. However, at that time, the average life expectancy was lower and the levels of autonomy and subsequent mobility were greater, giving rise to shorter periods of institutionalization.

Nevertheless, in the 1990's, the scenario was quite different: as associated to the increase in the average life expectancy of the Portuguese population, the period of time during which the elderly remained in residential homes of the *Holy House of Mercy* - frequently very dependent old people - went up, causing these infrastructures to become rather unattractive places for those with greater autonomy.

Portuguese Holy Houses of Mercy, driven by the UMP, have strived to diversify their offer of services to the elderly population. Nowadays they offer diversified social responses, such as retirement homes, day-care centers, neighborhood centers, assisted residences, domiciliary care services and more recently, different types of services that make up the network of continued health care.

Seeking to direct and structure the activities of the Holy Houses of Mercy, the UMP created *Turicórdia*, a structure with the purpose of creating a *Rede de Turismo Social* (Network of Social Tourism) in Holy Houses of Mercy. Among the multiple dimensions of social, youth, cultural, religious and business tourism is the senior section, which is once again evidence of the growing concern on this population.

According to data recently presented in a study by the Congregation of Holy Houses of Mercy (Lemos, 2005), at national level, and that was based on the results of a survey to 47% of all of the Holy Houses of Mercy in the country, it is possible to acknowledge the large scale of these entities.

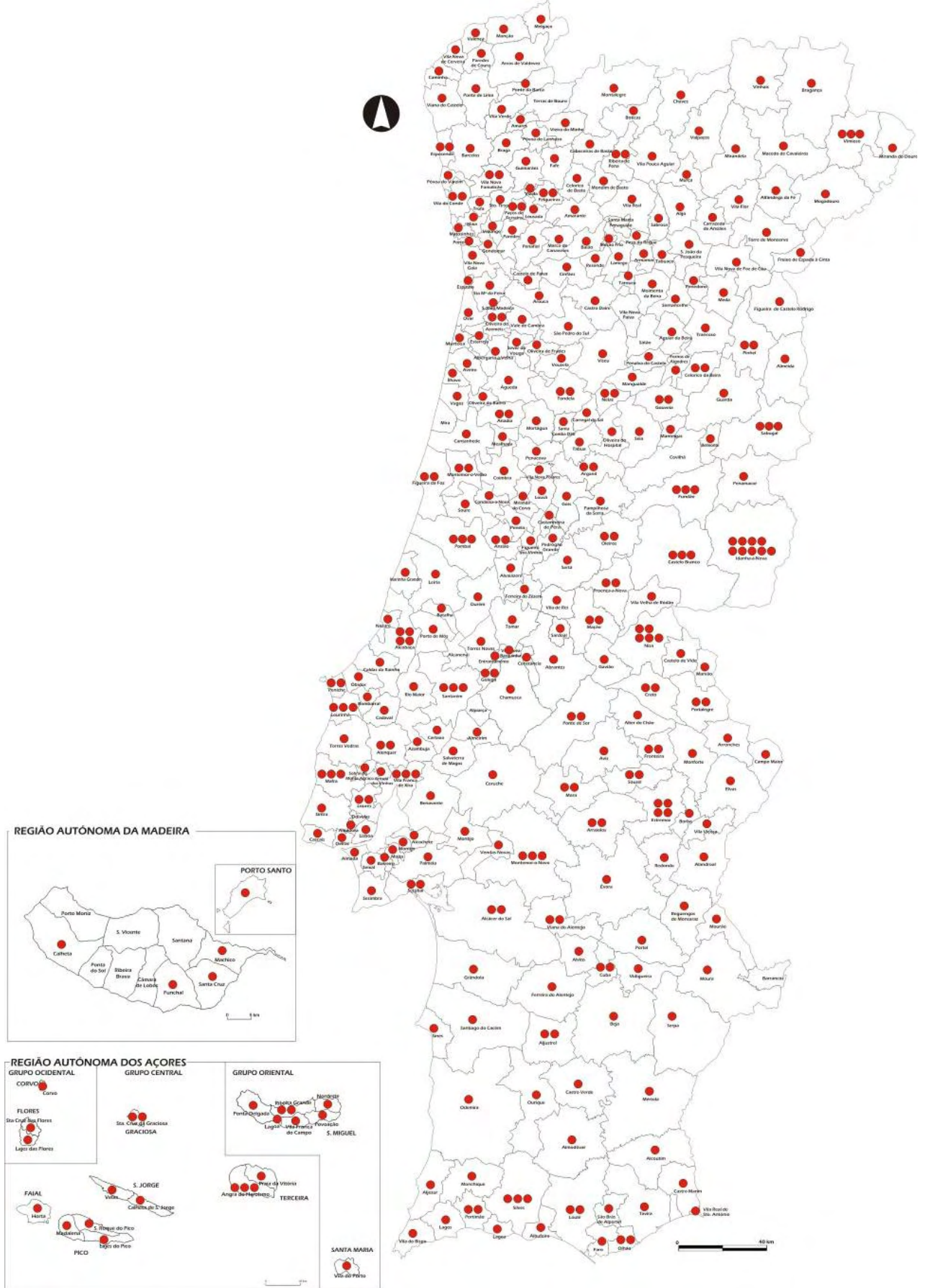
The main social responses provided to the elderly by the Holy Houses of Mercy are: family fostering, domiciliary care; day centers; great dependency retirement home (on the whole, there are 712 social responses). The capacity of these social entities is of 30,720 vacancies; the entities with higher capacities are retirement homes (11,835 vacancies); domiciliary care (9,254 house calls) and day centers (6,631 vacancies). The number of users is also higher in retirement homes (11,499 users), in domiciliary care (8,344 users) and day centers (6,568 users). The total number of users of the Holy Houses of Mercy is 29,096. Despite the high response capacity of the Holy Houses of Mercy, they present a total of 17,567 users on waiting lists. Retirement Homes are the social responses with higher demand (14,679 users on waiting lists), followed by domiciliary care (1,273 elderly on waiting lists).

Table 98. Global statistics related to the social responses in Holy Houses of Mercy, 2005 (N.)

Responses	No.	Capacity	Users	Seniors on a waiting list
Family Fostering for Seniors	0	0	0	0
Domiciliary care	210	9,254	8,344	1,273
Day Centre	205	6,631	6,568	233
Great Dependency Retirement Homes	21	849	838	757
Retirement Homes	195	11,835	11,499	14,679
Assisted Residencies	18	503	578	394
Others	63	1,648	1,269	231
Total	712	30,720	29,096	17,567

Source: *As Misericórdias Portuguesas na Assistência aos Idosos*, 2005.

Figure 57. Settlement Pattern of the Holy Houses of Mercy, in Portugal, in 2008



Source: Statistics of the Union of Portuguese Charity Institutions.


This study states that the average cost by user/month varies according to the degree of autonomy/dependency. Thus, in general, the greater the degree of dependency, the higher the user's average costs per month. Likewise, the average costs reaches the higher average amount in the great dependency retirement homes (722€ on average), followed by the social response assisted residencies (614€ on average) and subsequently retirement homes (482€ on average). In the remaining social responses, the average costs per month by user are substantially lower.

Table 99. Average cost by user/month, according to the degree of autonomy/dependency, by social response, 2005 (€).


Responses	Self-sufficient	Partially Dependent	Dependent	Greatly Dependent	Average
Family Fostering for Seniors	-	-	-	-	-
Domiciliary care	185.00	197.00	205.00	216.00	201.00
Day Centre	152.00	175.00	211.00	224.00	191.00
Great Dependency Retirement Homes	712.00	681.00	695.00	802.00	722.00
Retirement Homes	435.00	456.00	484.00	551.00	482.00
Assisted Residencies	546.00	615.00	627.00	667.00	614.00
Others	173.00	164.00	248.00	423.00	252.00
Total	1,549.00	1,586.00	1,631.00	1,674.00	1,610.00

Source: *As Misericórdias Portuguesas na Assistência aos Idosos, 2005.*

Nowadays there are approximately 400 Holy Houses of Mercy in Mainland Portugal and on the islands. Their settlement pattern reveals that there is a particularly relevant concentration along the coastal Atlantic area and in NUTS II North and Centre as one of the main specificities, which contrasts with the paucity in NUTS II Alentejo. In this region the ageing issue is rather concerning, as there is a large proportion of elderly people, most of whom live alone. In addition, this is a very poor region, with a weak social and economic initiative.



Misericórdia de Lisboa. Por boas causas.



Case Study
Santa Casa da Misericórdia de Lisboa (SCML)
(Lisbon Holy House of Mercy)

Background

The SCML was the first Portuguese Holy House of Mercy, founded in August 1498. As a consequence of political, economic and social changes, SCML underwent profound changes which affected its course of action. During the eighties, the reform of the bye-laws of SCML was therefore started and subsequently approved in 1991. It was established that the Institution pursues social action objectives in a humanitarian and well-deserving manner, providing health care, education and culture and promoting quality of life, particularly as regards the underprivileged. In this context, emphasis should be placed on its charitable works, namely in the following areas: family, maternity and infancy, unprotected minors, the elderly, social situations of extreme poverty, primary and differentiated health care, payment of the expenses resulting from donations, inheritances or bequeathed by their benefactors.

Intervention

Within the context of Portuguese Charity Institutions, the Holy House of Mercy has a unique legal nature, for it is a corporate body with administrative public utility within the State sector. This close articulation between the Lisbon Holy House of Mercy and the State is embodied in a group of duties and rights, such as the fact that it is responsible for the Government's Social Service in the city of Lisbon and it has a Government-designated Administrative Board.



Case Study
Santa Casa da Misericórdia de Lisboa (SCML)
(Lisbon Holy House of Mercy)

In the social action context, children, young people and the elderly are the main target publics of the SCML's interventions. Within the scope of the elderly population, this intervention is characterized by the existence of a variety of social responses, such as basic and integrated domiciliary care, socialization centers, day centers, retirement homes, assisted residences and temporary residences. These social responses are scattered throughout the city of Lisbon, retirement homes prevailing. In 2006, SCML supply of social responses for the elderly was:

Retirement homes

No. of users: 286; No. of infrastructures: 116; Overall occupancy rate: 94%.

Day centers

Capacity: 2,125; No. of users: 1.340; No. of infrastructures: 81; Occupancy rate: 63%.

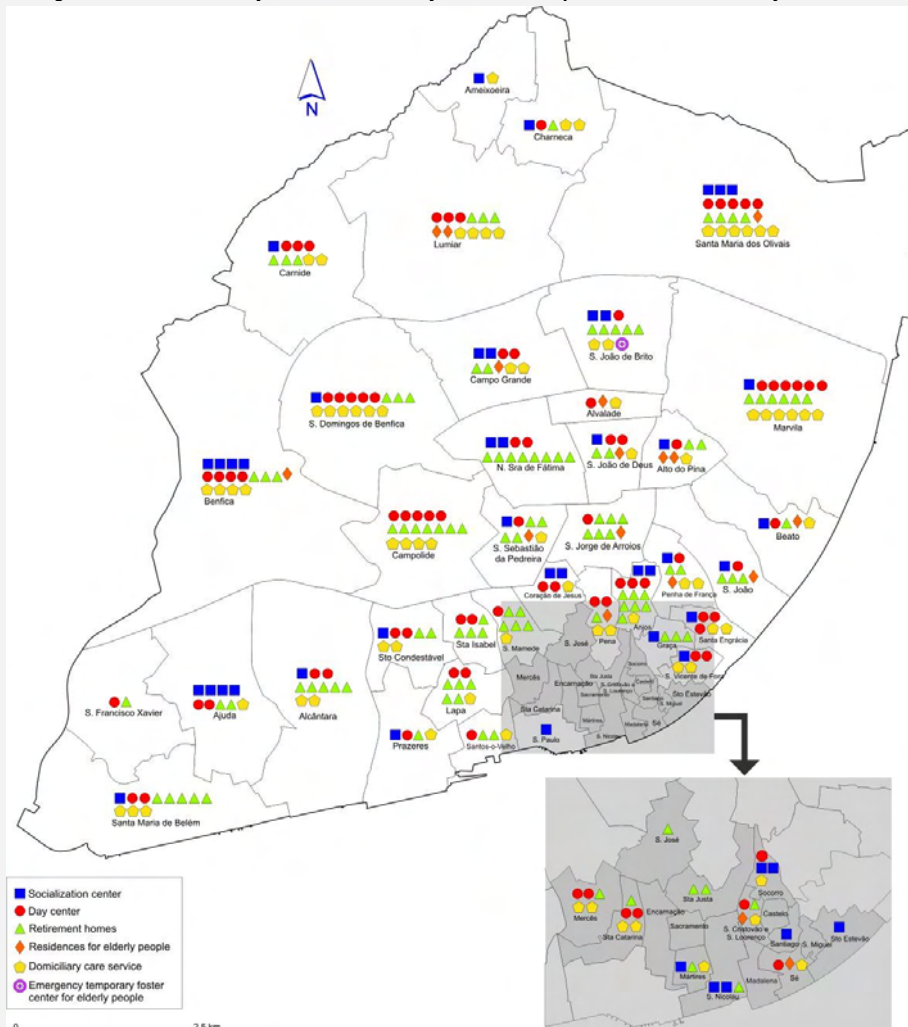
Socialization centers

Capacity: 280; No. of users: 224; No. of infrastructures: 47; Occupancy rate: 80%.

Domiciliary care

Capacity: 1,720; No. of users: 1,570; No. of infrastructures: 79; Response capacity: 98%.

Figure 58. Lisbon Holy House of Mercy's social responses for the elderly in Lisbon



Source: Lisbon Holy House of Mercy Statistics.



Case Study
Santa Casa da Misericórdia de Lisboa (SCML)
(Lisbon Holy House of Mercy)

Along with these social responses, the SCML has developed several other types of interventions targeted at the elderly, including a series of outsourced research in recent years.

It has also developed numerous projects for the elderly population (exclusively or not), which were carried out through the establishment of multiple partnerships:

- ▶ **Cartão de Saúde (Health Card)** - This project involved a partnership with the Lisbon and Vale do Tejo Regional Health Administration. This card is issued according to 4 contribution levels, depending on the evaluation of the social and economic profile of each elderly person, where the 1st level grants the beneficiary free access to health services. Although this project is not exclusively directed at the elderly, it is of crucial importance to this target public due to the high consumption of health care services and products by this age group;
- ▶ **Programa Partilhar ("Share" Programme)** - This project is the result of a protocol established with the Portugal Telecom Foundation and it is aimed at the dissemination of new technologies among those with mobility difficulties, namely isolated old people and young people supported by the SCML. Within the scope of this project, infrastructures and services are distributed, permitting this population greater socialization through permanent contact via video, voice and text, either among themselves or with the SCML's day centers that provide them with support;
- ▶ **Programa Mais Voluntariado, Menos Solidão ("More Volunteers, Less Loneliness" Programme)** - Developed by SCML in partnership with the *Associação Coração Amarelo* (Yellow Hearth Association) and the *Delegação de Lisboa da Cruz Vermelha* (Lisbon Delegation of the Portuguese Red Cross), and further includes the collaboration of partners such as parish councils, parishes, health centers and the police forces. The objective of this Programme is to support people over the age of 65 who find themselves in a situation of loneliness, dependence and/or isolation, without any kind of help, through voluntary actions aimed at providing them with a better quality of life. The Programme's area of influence is the city of Lisbon and the actions are carried out by volunteers who receive initial and specific training on a regular basis. The volunteers support the elderly in their access to basic health, cultural and religious infrastructures, as well as in the development of occupation and leisure activities designed to enhance their emotional stability and feeling of safety. (See also case studies of the Yellow Heart Association and the Portuguese Red Cross);
- ▶ **Projecto Qual Idade** - This project started in January 2005 and it was approved by the EQUAL Community Initiative Programme. It is based on a partnership between the SCML (lead partner with the EQUAL Management Office), the Congregation of Holy Houses of Mercy, the *Instituto Português de Qualidade* (Portuguese Quality Institute), CEQUAL and the Arruda dos Vinhos Holy House of Mercy. Considering the lack of articulation between the desired levels of qualification and the reality observed in most of the existing infrastructures and services, the goal of this project is to analyze the degree of adaptability of the *Modelos de Avaliação da Qualidade* (Quality Evaluation Models) designed by the ISS (in the case of retirement homes and domiciliary care services) and by the DGS (in the case of Continued Care) with the aim of: i) producing recommendations that will enable the improvement of the Reference Models proposed; ii) drawing up tools to facilitate and support the implementation and development of Quality Management and Evaluation Processes in the infrastructures and services related to the referred social responses;
- ▶ **Observatório do Envelhecimento (OE) - (Ageing Observatory)** - Created in 2006 by the SCML, the Ageing Observatory (AO) arose from the internal need to systematize the knowledge on the practices, intervention methodologies and profile of the users (and of their families and/or informal care-givers) and to monitor the evolution of the ageing phenomenon. The AO seeks to gather and systematize information on the activity of the SCML's services and infrastructures directed at the elderly population. It aims: to assess and improve responses; to obtain and update information on the factors of social exclusion of the elderly population and of the territories and communities in which they are integrated; to improve procedures, assisting in the decision-making of the SCML's Social Action Management and in the definition of more

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CASA**

Misericórdia de Lisboa. Por boas causas.



Case Study

Santa Casa da Misericórdia de Lisboa (SCML) *(Lisbon Holy House of Mercy)*

adjusted forms of intervention, seeking the sustained improvement of the processes and provision of services that are more suited to the beneficiaries. During 2007, AO developed a wide range of activities, namely: i) organizing sessions for the sharing of experiences and results of the intervention, therefore promoting dissemination of best practices; ii) setting up databases based on research; iii) publishing and disseminating a Newsletter; iv) establishing formal and informal partnerships, at national and international level; v) carrying out thematic studies (namely, a study in collaboration with a centre of academic research called "Prospective study on the suitability of responses to the needs of the informal care-givers of elderly users of the SCML"); vi) support in improving management of internal information, with the ongoing implementation of a *Sistema de Informação Geográfico (SIG)* - (Geographical Information System) that will provide the AO with geo-referenced databases on infrastructures, services and users of the SCML, incorporating a variety of external information at different levels; vii) constructing and disseminating publications in the form of guides/manuals;

- ▶ **Banco de Ajudas Técnicas** - This Technical Assistance Bank (TAB) of the SCML's Social Action arose from the awareness of the difficulty to obtain timely technical assistance so as to develop rehabilitation, maintenance and prevention processes in terms of autonomy and quality of life. The TAB seeks to optimize the existing technical assistance in some social responses, concentrating the management of all of the technical assistance in a single service. The TAB will be based in an accessible store in Lisbon, where there will be an area for demonstrations. It will however be possible to clarify doubts via telephone or at home (some of the types of technical assistance available in the TAB: folding beds, lifting cranes, wheelchairs, swivel bath chairs, walking frames, caliper-crutches, adapted cutlery, inter alia). Training will also be given to the formal (family assistants of the SCML) and informal (relatives, legal persons responsible and neighbors) caregivers. The added value of this new quality service is the fact that the loan of technical assistance is provided free of charge and that the store is open to the public in general so as to inform and raise the awareness of the population.

On-going Evaluation

The intervention of the SCML *vis-à-vis* the elderly population is marked by a set of positive aspects, the most important being the fact that this entity has a vast field experience with this population - making it highly knowledgeable - a very positive aspect for the development of more effective actions. Closely associated to its long past as a body providing social care and support, the SCML is nowadays a remarkably mature entity, which explains the existence of a complex and well-planned technical structure, equipped with resources with multidisciplinary skills that enable it to process information in a systematic and integrated manner and to develop new intervention strategies, eliminating identified weaknesses and incorporating innovative concepts.

Another factor to be borne in mind is the establishment of partnerships with different entities in the development of projects and services for the elderly population. Given that each partner possesses specific experience and knowledge, its articulation makes it possible to complement and take advantage of relevant synergies, each one of them adding value to the intervention.

The development of interventions in diverse fields of action (social action, health, ICT, management and evaluation of the quality of the infrastructures and services, among others) is another of the SCML's potentialities. It reveals a holistic view of the needs of the elderly population and of the factors necessary to promote and improve their quality of life, enabling it to assert itself as a state-of-the-art entity in the provision of quality responses and services.

Next, two case studies will be presented: the *Caritas Diocesana de Setúbal* and the S. Vicente de Paulo Parish Social Centre. Both cases are IPSS services providers to elderly connected to the Catholic Church.



Background

Cáritas is an official body of the church that promotes social action. *Cáritas Portuguesa* is a national federation which includes the 20 diocesan *Cáritas* associations spread throughout Mainland Portugal and the islands. As IPSS, they are governed by the same doctrine as the church and respond to the most extreme situations of poverty, social exclusion and emergency, resulting from natural or public disasters. Its objectives are to provide assistance in situations of emergency or dependency, to foster autonomy and the full development of each individual and to bring about change in the social and environmental areas in accordance with Christian values and principles. *Cáritas* has many intervention areas, namely mother and child support, child and youth support, support for senior citizens and women victims of domestic violence, and social exclusion in a range as wide as possible (ethnic minorities, drug dependents, HIV carriers and alcoholics). Based on these assumptions, which are crosscutting to all of the national *Cáritas* associations, each of them develops their own specific interventions.

The *Cáritas de Setúbal* is a service of the diocesan church that promotes social action, the main activity being the animation of the social activity of the church that aims to set up parochial services in order to understand the associated problems. One of its target publics are the elderly living in the cities of Almada and Setúbal, where activities are carried out by a large number of collaborators.

Cáritas intervention among the elderly population falls into two components: a) in terms of social response, it provides retirement homes, day-care centers, neighborhood centers, domiciliary and night-care centers; b) it also develops activities for this population and for the civil society's participation in general.

Intervention

The main funding sources for the development of its field of interventions is the financial support from the State and the contributions from families, which tend to be limited given that *Cáritas* works essentially with socially and economically vulnerable target groups. However, it also receives other sources of funding, albeit irregular, such as material or financial donations from the civil society and amounts of money won through competitions and Programmes promoted by the Central Administration or the community.

Cáritas de Setúbal's activity benefits from voluntary actions that, although not very common in the Portuguese society, provide considerable support to the *Cáritas* social responses. It should also be stressed that this organization has developed its activities in partnership with various actors, particularly the Central and Local Administration, local schools and health centers.

On-going evaluation

Reflecting a little the reality underlying the other Portuguese *Cáritas* associations, the interventions of the *Cáritas de Setúbal* face relevant critical factors, which represent important bottlenecks to the development and success of these activities.

The main critical factors can be grouped into two major areas: a) in terms of human resources, the main drawbacks are: poor qualifications, advanced age (where the incorporation of young people would be very positive due to the inter-generational contact), weak motivation to work in the field of gerontology (conversely to that registered, for example, in the childhood and youth area, both because the work is physically more demanding and requires greater effort to manage one's personal life as some of the social responses directed at old people operate on a full-time basis); b) as far as financial resources are concerned, *Cáritas* has very few sources of funding, associated to the socio-economic profile of the households of its users and the fluctuations of donations, which compromises the overall functioning of the service and makes it almost impossible to invest in human resources, both in terms of training actions and in offering more attractive salaries.

These limitations have negative multiplier effects, giving rise to new limitations, with a cyclical effect: i) the



Caritas Diocesana de Setúbal

Case Study

Cáritas / Cáritas Diocesana de Setúbal

inability to create the necessary conditions to retain human resources, which is difficult to manage in the context of the institutionalized elderly, as they need a benchmark social provider; ii) financial inability to invest in the modernization of the infrastructures makes it difficult to improve the quality of the service, which in turn prevents the Institution from meeting the prerequisites of the applications to certain public protocols and programmes; iii) and, the most direct consequence, the reduction in the rate of coverage of the elderly served.

However, it is also possible to identify positive factors in the actions of the Institution, the most important being the effort and capacity to manage the scarce human and financial resources available so as to respond to as many deprived old people as possible. In tandem with this factor is the proactive attitude of the Institution in the participation of a wide number of local actors and of the civil society itself in the interventions directed towards the elderly, subsequently promoting a greater awareness and respect for this target group.



Case Study

S. Vicente de Paulo Parish Social Centre

Background

The S. Vicente de Paulo Parish Social Centre took root in 1920, although it was only established in 1959. The S. Vicente de Paulo Parish Social Centre has developed its charity work in the Liberdade and Serafina neighborhoods, which experience social, housing and economic difficulties.

This Institution's goal is to develop its intervention as an integration and social inclusion venue. For that purpose, it has created several infrastructures to respond to the countless needs of a depleted, aged and excluded population.

The S. Vicente de Paulo Parish Social Centre is a IPSS of a religious nature that is oriented by the Lisbon's patriarchy and in accordance with the Catholic Church's Social Doctrine.

After the Revolution of 1974, social service in Portugal suffered a loss of dynamism and a degradation of the building heritage. From 1977 onwards, with the appointment of a new parish-priest, the activities of the S. Vicente de Paulo Parish Social Centre experienced a new strength, focusing their attention on the elderly.

Intervention

In the last 25 years, the S. Vicente de Paulo Parish Social Centre has made a significant important effort in the promotion of care provision, services and support to the community's elderly population. In 1980, a pre-fabricated building was installed to work as a day centre and to provide domiciliary support. By then, its capacity was of 60 elderly users, but in 1992 a new infrastructure with a higher capacity (100 users) was inaugurated, and it was a safeguard for the day center's response. The year of 1992 was of the utmost importance to the history of social services of the S. Vicente de Paulo Parish Social Centre because its actions were crucial: a residential home for terminally ill seniors, domiciliary care for 100 users and a physical therapy service extensible to the entire population, among other activities. In 1996 a gymnasium, an auditorium and a residential home for more 25 elderly was built. In addition, in 2000, the second floor was inaugurated for an additional 40 terminally ill seniors. Nowadays, the intervention focused on the elderly population includes the following social responses:

- ▶ **Domiciliary support:** This service relies on the help of domestic assistants and consists of helping the elderly in daily tasks such as: personal hygiene care, housework, preparation of meals, shopping, laundry and taking them to health services. Its goal is to ensure the elderly's autonomy and permanence in their homes. In some situations, this service is also available at weekends and nowadays it tends to about 80 users on a daily basis;
- ▶ **Day centre:** It seeks to encourage socialization within the community, providing inter-institutional interaction and to break the routine, isolation and solitude of many elderly people. This service has its own transportation and



Case Study

S. Vicente de Paulo Parish Social Centre

thus takes seniors from their homes to the day centre. Currently, it tends to about 65 elderly from the Liberdade and Serafina neighborhoods and the area surrounding the Campolide Civil Parish;

- ▶ **Foster home:** This is an intermediate social response between a domiciliary care/day centre and a retirement home for dependent elderly. This retirement home takes in those who are not capable of being alone at their homes, and some were dislodged by the Municipality of Lisbon and chose this service in detriment of a residence out of these premises. Currently it has 25 users;
- ▶ **Retirement home for dependent elderly:** This is the most requested social response. Its priorities are families with difficulties in having an elderly in bed at home. This service is expensive, however, as this is a Private Institution of Social Solidarity, it benefits from a protocol with the State. The retirement home for dependent elderly has presently a capacity for 85 users.

Besides the aforementioned social responses, there are others such as: a physical therapy clinic, which assists users from the retirement home and from the day centre; a stomatology clinic, open to the entire community and whose priority is the population with greater economic difficulties; distribution of goods obtained from the *Banco Alimentar* (Food Bank) to 50 families of the community.

The development of these activities is supported by 155 employees and a wide range of volunteers. In fact, voluntary work is crucial in the Institution's activity, whether in administrative or operative tasks:

Activities	N. of volunteers
Support to meals preparation of the retirement homes' users	10
Lunch distribution for users in domiciliary care	4
Support in activities including children	20
Support in activities including teenagers	25
Decoration, cleaning...	10
Offering products to the Institution	40-70
Visits to patients	11
Assistance in the preparation of parties	60
Support in the preparation and distribution of goods from the Food Bank	6
Support to general services	10
Administration	5
Supervisory Council	3
Permanent Secretariat	7
Church Council	27

On-going evaluation

The S. Vicente de Paulo Parish Social Center's intervention is presently facing a set of weaknesses that limit its results. The following are among its most relevant limitations:

The greatest constraint is the incapacity to respond to the last few years' increasing demand caused by the rapid demographic ageing process of the population of the City of Lisbon (and particularly in some areas, of which Campolide is a good example). However, its limited financial capacity has prevented the Institution from investing in its infrastructures and services.

Furthermore, the incipient volunteer culture in the Portuguese society emerges as another constraint. Although the S. Vicente de Paulo Parish Social Centre has a considerable amount of volunteers, it is still very limited for the needs of the local community, which lacks social support.

The Institution's third constraint is its limited financial capacity. Although it benefits from a protocol with the State, financial support is rather scarce, and only covers fixed expenses. Additionally, its users have low levels of education, meager economic resources and some situations of unstable families. The articulation of these two realities - social and economic frailties - limit the Institution in terms of investments in the enlargement of its



Case Study

S. Vicente de Paulo Parish Social Centre

infrastructures and services network, but also in the diversification of activities promoted for its target-audience.

Nevertheless, the S. Vicente de Paulo Parish Social Centre presents important strong points. Firstly, it was the pioneer in terms of domiciliary care in Portugal. Its past pro-active attitude remains in the present, and the Institution does not agree with the dominating pattern of support in the country: the fact that it is a non-permanent service, disrupted at weekends and that it is carried out by teams that are not truly multidisciplinary.

Furthermore, the Institution promotes support to the elderly population, which is supervised throughout the different stages of the ageing cycle and thus responds to their needs. This procedure pattern makes it possible for the elderly to stay in their daily environments throughout their lives, a major concern of this population.

Finally, it is important to point out the high level of participation of the community in this reality. In the course of life, their members become crucial in the Institution's performance whether as care providers or as users. Thus, this Institution is strongly embedded in the local society and is an important actor in the local denomination, one of the main reasons that has enabled the Institution to adjust to the different contexts throughout the years.

1.3.1.2. Non-governmental organizations (NGOs)

The NGOs are not at all bound to the State, but still have social and political functions within their communities (without any profitable purposes). Currently, there are several active NGO in Portugal and some of them directly support the elderly population: Doctors of the World Portugal (MdM), International Medical Assistance (AMI), Portuguese Red Cross, among others.



Case Study

Cruz Vermelha Portuguesa **(Portuguese Red Cross)**

Background

The origins of the Portuguese Red Cross date back to 1865, when it was still called the "Provisional Committee for Providing the Wounded and the Sick with Aid during War", having officially been recognized in 1868 and admitted to the International Red Cross and Red Crescent Movement in 1919. As a non-governmental humanitarian institution of public utility, it is entitled to the benefits of the institutions of public utility and IPSS. The Red Cross carries out its activity under the international Geneva conventions, independently from the State, in observance of seven principles: humanity, impartiality, neutrality, independence, volunteerism, unity and universality.

In Portugal, the Portuguese Red Cross pursues its activity as the only National Red Cross Society in a variety of fields, namely social work, health, aid, training, teleassistance and research.

Intervention

The intervention of the Portuguese Red Cross among the elderly populations is one of the most important activity areas within the scope of social work. In the last years, social work has been oriented by two structuring areas: the promotion of active ageing and the autonomy of seniors and providing support in terms of dependency. Its response to seniors has undergone significant changes aimed at keeping up with the growing needs resulting from the increasing population ageing and has given preference to the development of interventions designed to keep seniors within their family and residential environment.

Currently, the social responses and services which the Red Cross provides to this segment of the population are the following:



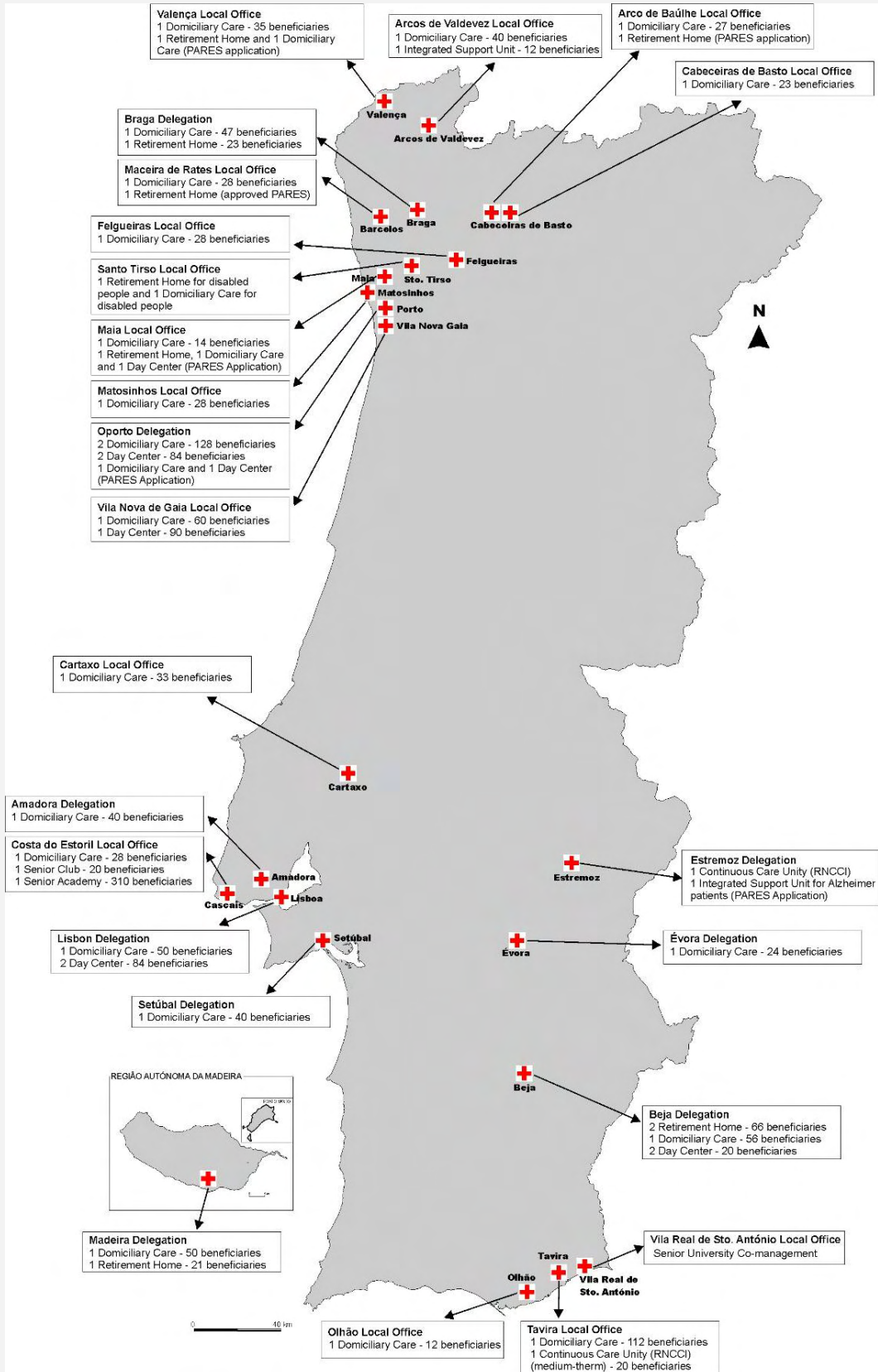
Case Study
Cruz Vermelha Portuguesa
(Portuguese Red Cross)

- ▶ **Telealarm service:** a service that operates through a protocol of cooperation between the *Comissão de Gestão do Programa de Apoio Integrado a Idosos* (Management Committee of the Programme of Integrated Support to the Elderly), the company *PT-Comunicações, S.A.* and the Portuguese Red Cross. This service is based on an innovative telecommunications system made up of a call centre, a special telephone installed in the home and a medallion with a built-in alarm button;
- ▶ **Domiciliary Services (SAD) and Integrated Domiciliary Support:** services funded by the Social Security and Solidarity District Centers in articulation with the Regional Health Administration/Health Centers. At a national level, there are currently 21 SAD with 853 beneficiaries. The Red Cross has two Integrated Support Units, a social response falling under continued care, currently with 12 beneficiaries but with the capacity for 30 beneficiaries each;
- ▶ **Mobile Units.** These were acquired with the funding of the *Programa Saúde XXI* (Health XXI Programme) and operate in protocol with the Health Centers, providing pluridisciplinary domiciliary care (Murça Local Office and Arcos de Valdevez Local Office);
- ▶ **Adapted Transport and Technical Aid.** The adapted transport is designed to facilitate the accessibility of people with mobility problems, providing them with transport for purposes of work, study and access to health care. These services are currently located in 11 Delegations throughout the country. The Technical Aid is a service provided by most of the Delegations/Local Offices and consists of a traditional Red Cross service. It is estimated that 2,500 people/year benefit from this service in Portugal.



Case Study
Cruz Vermelha Portuguesa
(Portuguese Red Cross)

Figure 59. Portuguese Red Cross Network of social services for the elderly (N. of beneficiaries)



Source: Portuguese Red Cross.



Case Study
Cruz Vermelha Portuguesa
(Portuguese Red Cross)

- ▶ **Retirement homes and day centers.** These social responses, available at a national level, operate in protocol with the Social Security and Solidarity District Centers. Currently, the Red Cross has 4 retirement homes in Portugal for elderly and dependent people, with a total of 110 beneficiaries and 9 day centers/senior clubs;
- ▶ **Senior academy.** This is one of the less traditional social responses for seniors of the Portuguese Red Cross. It aims to promote a new form of leisure activities for the senior population. At present there are only two such academies in Portugal, with a total of 310 beneficiaries. The Costa do Estoril Local Office is considered to be a model of success in terms of innovation and integration of competences, giving rise to the need to disseminate this experience throughout the country in the short- and medium term.

It is further highlighted that the Red Cross has an on-going programme specifically addressed at the elderly, in articulation with the SCML and the Yellow Heart Association: "More Volunteer Work, Less Loneliness".

It should further be noted that in addition to these social responses, services and programmes, the Red Cross carries out occasional projects for seniors, such as health education actions.

Many of the activities that the Portuguese Red Cross has developed are supported by partnerships, namely the State. However, many interventions are also carried out with several local bodies.

Its funding is obtained essentially through protocols established with the Social Security and from the financing of public projects and programmes funding lines to which it applies. The senior academy is self-financed through fees paid by its users.

On-going Evaluation

The intervention of the Portuguese Red Cross among the senior population is currently faced with a set of challenges. First of all, because it is felt that there has been a disinvestment of the State in this sector, which brings about a reorganization of its traditional forms of action. Secondly, because although it is a growing population segment and therefore an expanding intervention area, it is increasingly faced with the intervention of a large number of actors. Associated to the increase in this segment is the diversification of needs, which also require a diversification of responses, services provided and forms of action, with higher and more specific quality standards.

The intervention of the Red Cross is faced with an important weakness, resulting from the fact that it does not have its own funds, which would enable it to widen its intervention and provide its target public with a more diversified support. However, it does bring together a set of undeniable and specific potentialities. The fact that it has a long tradition in the development of this type of activities is from the outset an important added value. In addition, there are other factors such as: its level of organization, given that this is an Institution with a wide field of action and of national scope; and a rather strong culture of volunteer work.

Currently, the Portuguese Red Cross has a set of investment proposals to broaden the scope of its activities among the elderly population. Among them, the most important is the need to increase the support provided after discharge from hospital (in situations where the network of continued health care does not respond) and the dissemination of the senior academy social response throughout the country.



Case Study
Médicos do Mundo (MdM) Portugal
Doctors of the World

Background

Doctors of the World is a NGO which provides non-partisan or religious humanitarian aid and co-operation for development. It was created in France in 1980 with the main purpose of providing medical assistance to the most vulnerable and/or deprived populations, in a situation of humanitarian emergency and/or social exclusion. Presently they have projects in 88 countries and an international network of 12 autonomous delegations, 10,000 partners, 2,500 volunteers and 600 paid workers. In Portugal since 1999, the projects developed focus essentially on two of the countries metropolitan areas (Lisbon and Oporto), where the main objective is to provide health care to the most vulnerable populations, be it for social, psychological, economic or medical reasons. As such, although they have a wide target group, they give preference to immigrants, the elderly and the homeless.

Intervention

The action of the MdM directed at the elderly in Portugal arose from the awareness that many old people experienced multiple constraints, such as: social isolation, economic scarcity, chronic illnesses and the absence of formal and informal support networks, leading to situations of poverty and social exclusion. The growing dimension of this set of problems gave rise to national interventions targeting the elderly population which, despite each one's specificities, aim at fighting isolation overall, reinforcing the voluntary support networks and carrying out cultural and literacy activities, as well as the prevention of typical illnesses arising among these age groups.

ON-GOING PROJECTS

"VIVER SAUDÁVEL" PROJECT (HEALTHY LIVING)

Key references:

Project startup: Informally in 1999/2000 and formally in 2002.

Intervention Area: Bairro da Picheleira, civil parish of Beato, municipality of Lisbon.

Partnerships: São João Health Centre; Parish of Espírito Santo; Salvation Army; Beato Parish Council.

Funding Sources: Calouste Gulbenkian Foundation; Programme of Integrated Support to the Elderly (PAII).

Target-population: Residents over 60 years old or in a confirmed situation of socio-economic exclusion and/or difficulty in accessing the country's health care systems.

Brief description

The intervention in this field came about as a result of the large number of elderly people with a high illiteracy rate, most of whom live alone in rented apartments of cooperatives, with low pensions and high monthly costs with medication, in an area with a deficient transport and social support network.

With the core objective of providing easier access to health care through a closer relationship with the NHS, its specific goals are:

- i) To execute actions promoting health and prevention of illness so as to bring about a change in behaviors;
- ii) To contribute towards an improvement in the quality of life (physical, psychic and social well-being) of



Case Study
Médicos do Mundo (MdM) Portugal
Doctors of the World

the elderly, promoting active ageing;

iii) To contribute towards the adoption of healthy behaviors.

In order to meet these goals, the project takes the following activities into account:

i) Health care (outpatient care, medical and nursing advice, referral to the NHS; Domiciliary Care, where basic nursing care, psycho-social support, assistance in daily tasks, as well as vigilance and referral to the NHS are provided);

ii) Socio-cultural and leisure activities;

iii) Activities promoting physical exercise;

iv) Distribution of food and occasionally clothes;

v) The carrying out of studies.

The execution of this project benefits from partnerships with various entities, some of which have already provided this population with services and support in the past, prior to the intervention of the MdM. The project's partners are the São João Health Centre, the Espírito Santo Parish, the Salvation Army and the Beato Parish Council.

With regard to the financing of the project, in 2002 it was financed by the Calouste Gulbenkian Foundation, which made it possible to act in other intervention areas and not just in terms of domiciliary care. In 2003, the continuation of the project was ensured by the PAII, in the domiciliary care measure, which financed the project until September 2005. In July 2006, a protocol was signed with the Social Response Nucleus of the Social Security Institute, which made the funding of the Domiciliary Support Service (to provide hygiene to the home and to the user) feasible, besides the support that was already provided.

The activities and scope of the project have therefore changed over time, largely due to the financial support. Currently, domiciliary support is provided to approximately 12 users and there are around 60 users in the other activities.

On-going evaluation

An evaluation of the results expected at the start-up of the project *vis-à-vis* the results achieved reveals the importance of the project, without which this population would certainly have a much lower quality of life in general, even if the goals were not completely fulfilled. This is partly a consequence of the weaknesses with which it is confronted, namely resulting from the lack of continuity in terms of funding and volunteers. These factors limit the number of users to be supported and brings about a certain amount of instability.

"TERCEIRA (C)IDADE" PROJECT (THIRD AGE)

Key references

Project startup: 2005.

Intervention area: S. Mamede de Infesta and Leça do Balio, Municipality of Matosinhos, District of Oporto.

Partnerships: Centro de Apoio à Terceira Idade (CATI), Abel Salazar Secondary School, S. Mamede de Infesta Parish Council, UNINORTE (União Cooperativa Polivalente da Região Norte, CrI), ULSM (Unidade Local de Saúde de Matosinhos) and the S. Mamede de Infesta Health Centre.

Funding Sources: S. Mamede de Infesta Parish Civil Council.

Target-population: Elderly population, in situations of loneliness, isolation and social exclusion.



Case Study
Médicos do Mundo (MdM) Portugal
Doctors of the World

Brief description

The intervention in this field came about as a result of the identification of a vast set of problems, the most urgent being the difficulty in accessing health services, the strong incidence of health problems among the most disadvantaged population and the existence of insufficiencies in social and health responses, particularly in terms of social responses of crucial importance when fighting against loneliness.

In fact, the project's general objective is to improve the bio-psycho-social state of the elderly and has the following specific goals:

- i) To improve the access to health care;
- ii) To provide psycho-emotional follow-up;
- iii) To ensure entitlement to the services of the social network;
- iv) To ensure safety conditions in the home.

In order to meet these goals, the project has the following activities:

- i) Domiciliary visits by volunteers (accompanying the elderly person to the National Health Service, to the garden, when they go shopping and during leisure activities and also keeping them company) and by medical or nursing staff;
- ii) Socio-cultural and leisure activities, more specifically organizing social teas and dinners among elderly people and volunteers from the project, as well as group dynamics with the elderly people.

Currently, the project responds to the needs of 24 elderly people and 3 informal care-givers (relatives).

On-going evaluation

In practice, this project reveals some implementation difficulties as a result of its financial limitations. Consequently, it ends up providing only domiciliary care, as the other activities are developed only occasionally.

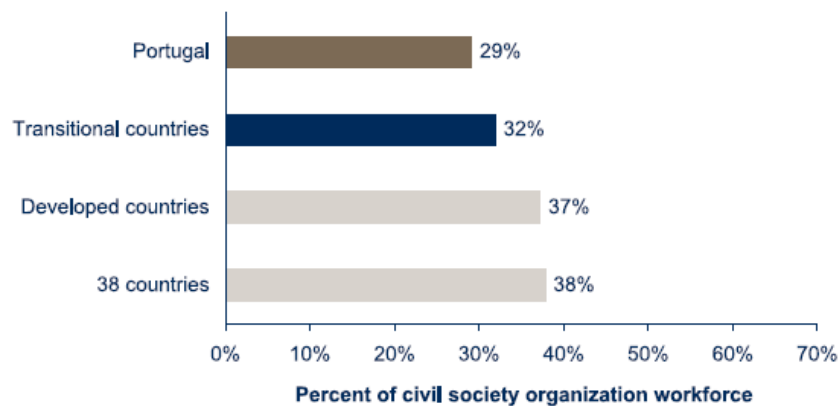
1.3.2. Voluntary sector

Voluntary services are understood to be “the set of actions of social and community interest, performed by people in an impartial manner within the scope of projects, programmes and other forms of intervention at the service of individuals, families and the community, developed by public and private entities on a non-profit-making basis. Excluded from these are those actions which, albeit performed in an impartial manner, are isolated or sporadic or are determined by family, friendship and neighborly reasons.” (Art. 2 of Law no. 71/98, of 3 November).

Volunteer work has a growing importance in the Portuguese non-profit sector: “The Portuguese civil society sector engages the energies of nearly a quarter million full-time equivalent (FTE) workers (including those in religious worship activities), two-thirds (70%) in paid positions and the remainder as volunteers. This represents about 4.2% of the country's economically active population (EAP), and about 5% of its non-agricultural employment. The value of volunteer effort alone, estimated at 675€ million, contributes more than 0.5% to the nation's GDP.” (*Raquel Campos Franco et al., “O Sector Não Lucrativo Português Numa Perspectiva Comparada”, 2005, Universidade Católica Portuguesa/Johns Hopkins*

University. In another perspective, “The volunteer share of the non-profit sector workforce in Portugal is lower than it is both internationally and in the other developed countries for which we have data”).

Figure 60. Volunteers as a share of the civil society organization workforce (%)

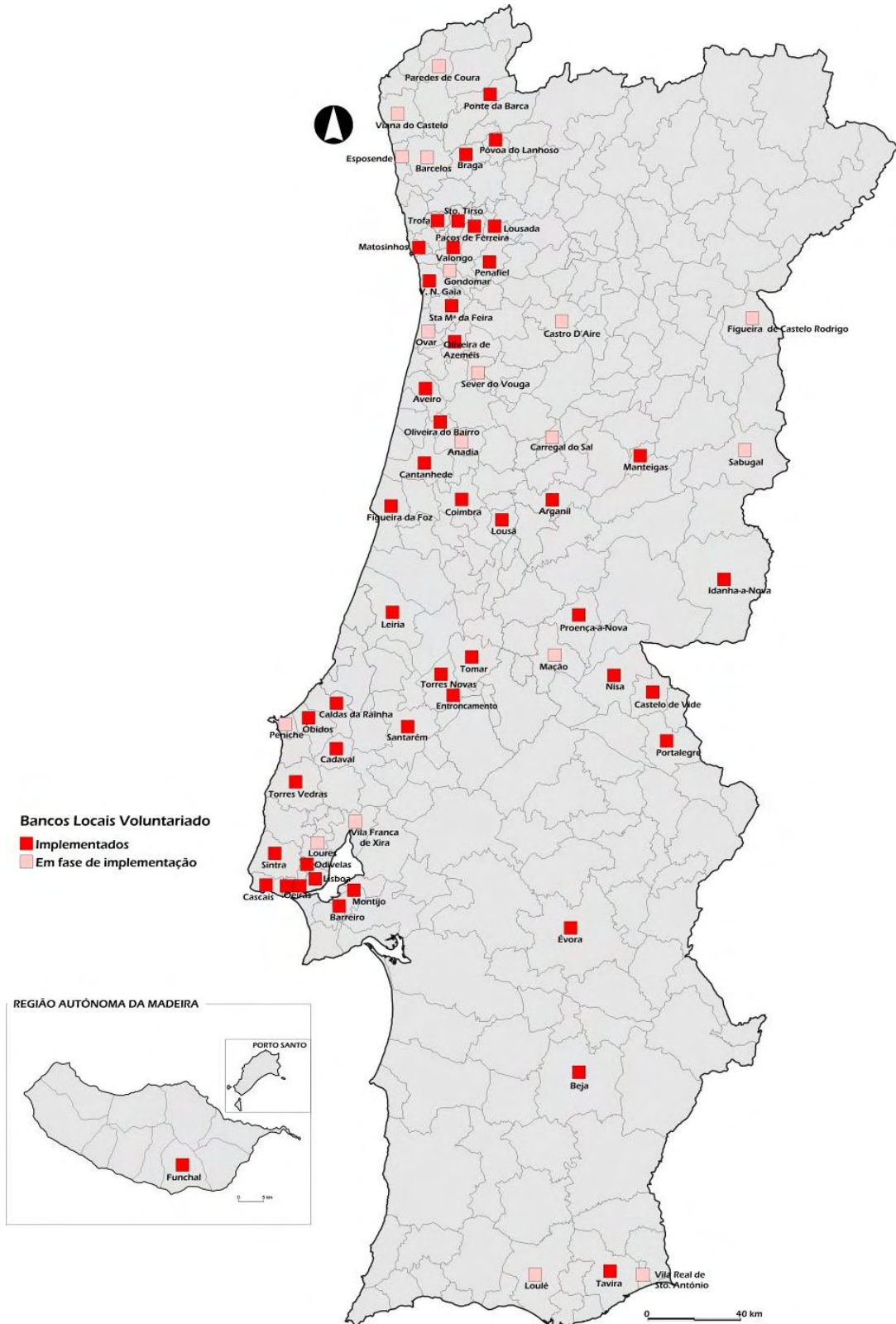


Source: John Hopkins Comparative Nonprofit Sector Project, 2005.

According to another source - *Conselho Nacional para a Promoção do Voluntariado* (CNPV) - (National Council for the Promotion of Voluntary Work) - although volunteer work is a relatively recent dynamic in Portugal, it was estimated that, in 2005, there were around 1,6 million volunteers. The increase in the number of volunteers - both individuals and institutions - registered in the Pool of Volunteers, created in 2006, reveals this growing mobilization: when it was created, there were 200 individual volunteers and 39 institutions; at the end of 2007, it included almost 5,000 volunteers and 447 participating bodies. The current geographical distribution of *Bancos Locais de Voluntariado* (Local Voluntary Service Councils) also demonstrates the good rhythm and widespread territorial coverage of the volunteer action (**Figure 61**).

The problems surrounding voluntary services place us face-to-face with the dilemma of how we should regard these services and therefore the degree of exigency that we should demand, i.e. should they be “...more than just good will”, where we expect professionalism, availability, commitment and dedication or should voluntary services represent a “pleasant occupation of free time” (Father Feytor Pinto). In either case, voluntary services should be duly incorporated under the host institutions, making them more acceptable, more effective and therefore beneficial to all: volunteer, institution and beneficiary.

Figure 61. Local voluntary service councils, in Portugal



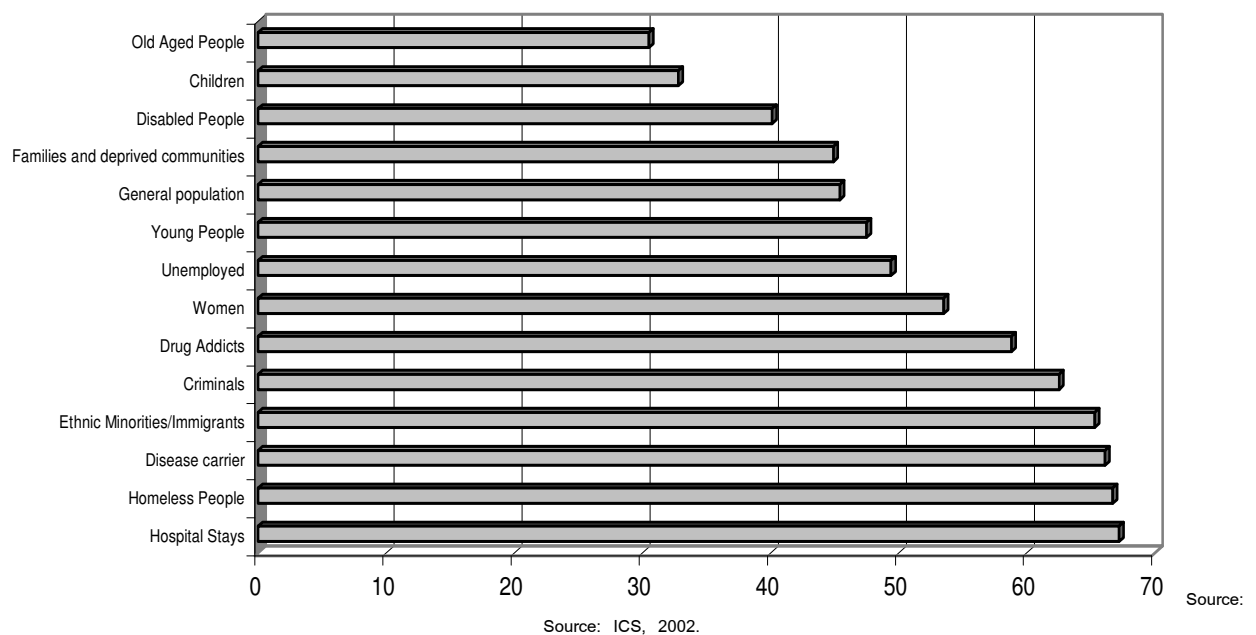
Source: National Council for the Promotion of Voluntary Work (<http://www.voluntariado.pt/left.asp?04.01.03>).

The non-profit-making status and the social solidarity objective of the Associations and Co-operatives determine that the duties carried out in their social bodies be of a voluntary nature and that voluntary board members should therefore be present in most of these bodies.

According to the study *Caracterização do Voluntariado em Portugal* (Characterization of Volunteer Work in Portugal), the presence of volunteers is a dominating characteristic in the more relevant types of organizations that provide elderly care: hospital voluntary services; NGO for Development; parish centers/religious organizations; social solidarity associations; charitable organizations; social solidarity co-operatives and foundations (CNAIV/ICS, 2002). It should however be mentioned that in the social action types of voluntary services, service type volunteerism (volunteers - either individually or supported by paid workers - who directly support the users) is less common, as a result of the funds available and the demand for more specialized tasks, which require the recruitment of paid workers.

A relevant aspect for the objectives of this study is the fact that, from among a wide range of types of beneficiaries, service type volunteerism is the one that least participates in helping the elderly, revealing greater preference for other target segments.

Figure 62. Voluntary service by main types of beneficiaries, 2002



Among the entities that are included in the Third Sector in Portugal, overall there is very little integration of voluntary work. This characteristic is however less common in institutions of a religious nature, where voluntary work (particularly service type volunteerism) has a more significant presence. According to Hespanha (1997) "...the reason for this fact may in part reside in the organizational structures of the institutions, very focused on the functional competencies and obligations resulting from social security agreements (regularity and technical requirements of the provision of the service, professional competence and technical qualification of the staff, etc.)".

The main arguments put forward for the scarcity of voluntary services in the organizations are:

- ▶ Reduced number of volunteers;
- ▶ Specificity of the tasks (requiring specialized professionals);
- ▶ Financial availability to recruit professionals;
- ▶ Negative appreciation of voluntary service (irregular availability; less qualified; potential generator of insecurity for the beneficiary; potential conflicts with the professional staff).

There is a dual evaluation of the performance of the volunteers who carry out tasks that directly support the users:

- ▶ An important resource to do away with several insufficiencies, with relevant comparative advantages (cost, motivation, adaptability, values);
- ▶ Resource with a supplemental function, with performance deficits, and which “activation” reflects the financial condition of the institutions.

An important conclusion of the study mentioned above is the relation observed between the socio-economic profile and the practice of voluntary work; the greater the individual’s/family’s economic capacity, the more time can be dedicated to non-compulsory, non-essential tasks, such as voluntary work. The results of CEDRU’s survey enable us to reach a similar conclusion because, as can be seen in the table below, the proportion of volunteers increases the higher the income brackets.

Table 100. Senior volunteers by income level, 2007 (%)

Income Bracket	Carries out voluntary work	
	Yes	No
> 300 €	3	97
301-750 €	4	96
751-1,500 €	9	91
> 1,500 €	20	80

Source: CEDRU Surveys, 2007.

Another field of analysis in which the benchmark study and this study coincide is the correlation, equally positive, between religious practices and voluntary work. This relation is simultaneously a cause and a consequence for a higher proportion of volunteers in religious institutions. These act as bodies that “integrate the community, generating interaction among the members and disseminating opportunities for volunteers to participate in and the needs and problems of the potential beneficiaries. (ICS, 2002).

Table 101. Senior volunteers by religious practice, 2007 (%)

Goes to church	Carries out voluntary work	
	Yes	No
Never	2	98
Rarely	3	97
Regularly	6	94

Source: CEDRU Surveys, 2007.

Participation of seniors in voluntary actions

In global terms, individuals who perform voluntary actions/tasks are characterized by remarkable equilibrium regarding gender, contradicting the preconceived idea that these types of actions are generally performed by women. In terms of the age profile of volunteers, the studies consulted do not confirm another common idea that these are mostly of advanced age, as voluntary work is most expressive in the 46-65 age group. Just as in other international reference frameworks, in the Portuguese population there is a rise in voluntary actions towards the end of active life and immediately before retirement, dropping again as age and several limitations progress. Therefore, it is the young seniors (55-64 years) who participate more actively in voluntary actions since this tendency declines as from the age of 65.

From a generational point of view, it is expected that the growing involvement of young people and adults in voluntary actions be reflected in a greater inclination towards voluntary work when they reach senior age. The current context of societal dynamics further enhances this tendency of growing

mobilization of seniors towards voluntary work: increase in the elderly population; active ageing strategies; promotion of socialization mechanisms in the third age.

Table 102. Senior volunteers by age group, 2007 (%)

Age	Carries out voluntary work	
	Yes	No
55-64	13.0	87.0
65-74	4.5	95.5
75-84	4.0	96.0
> 85	7.5	92.5

Source: CEDRU Surveys, 2007.

The increase in life expectancy, along with the growing levels of autonomy of seniors, also eliminates the arguments of those who point out weaknesses in senior volunteers, such as greater absenteeism (contradictory to a greater prevalence of regular voluntary actions in this segment) or less flexibility and ability to adapt to rules. Notwithstanding this picture - of effective yet contained participation, of anticipated growth that is not exempt from peculiarities - for the various institutions that benefit from/depend on voluntary services to achieve their objectives of social providers, "... this growing contingent of potential elderly volunteers could be a group that is worth capturing, developing specific programmes and incentives, access channels to voluntary services, tasks and activities suited to their interests and capacities." (ICS, 2002).

Within the sphere of the senior volunteerism, the ENTREAJUDA work stands out. This pioneer Institution in Portugal provides support to Social Solidarity Institutions, working in organizational and management domains, in order to improve the Institution's performance and efficiency and therefore providing support to people in need. ENTREAJUDA "proposes solutions, mobilizes partners and volunteers, implements solutions and evaluates impacts and performances" (www.entreajuda.pt). Entreajuda's voluntary body includes all age groups: active, retired and unemployed. The creation of the Pool of Volunteers (www.bolsadovoluntariado.pt), one of ENTREAJUDA's main projects, is supported by one of the most important Portuguese banks (Caixa Geral de Depósitos) which, among other purposes, seeks to mobilize its collaborators so that, "in a voluntary regime and according to their availability, they provide support in IPSS, selected by ENTREAJUDA and proposing an interesting life alternative for retired and pre-retired collaborators".



Case Study
Associação Coração Amarelo
(Yellow Heart Association)

Background

The Yellow Heart Association is a IPSS established in 2000. Its appearance is associated to the growing and rapid ageing process of the population in the city of Lisbon over the last decades and to a growing awareness that the elderly population is more and more isolated, an important factor of social exclusion.

The activity of the Yellow Heart Association is based on voluntary work and its main objectives are: i) to foster initiatives aimed at supporting people in a situation of loneliness and/or dependence, particularly the elderly; ii) to promote initiatives designed to raise the awareness of the responsible bodies to the need to improve the quality of life of people; and iii) to boost the development of solidarity and cooperation actions in articulation with volunteers who are willing to offer their time and knowledge.

The Association is based in Lisbon and has four other delegations located in Oeiras, Leiria, Oporto and



Case Study
Associação Coração Amarelo
(Yellow Heart Association)

Alcobaça.

Intervention

The interventions of the Yellow Heart Association are carried out by volunteers. From the moment they are recruited and during the performance of their duties, the volunteers attend a number of training actions, namely initial training and continuing training, and participate in thematic meetings so as to ensure the quality and rigorousness of their services.

The actions carried out by the volunteers are essentially of two types: taking care of the old people that benefit from their services in their own home, keeping them company and performing minor tasks of leisure and distraction; accompanying them whenever they wish to leave their homes in order to participate in some type of leisure activity, go to doctor's appointments, etc.

At present, the Association has the support of 254 volunteers (17 in Cacém, 20 in Cascais, 152 in Lisbon and 55 in Oeiras) and has 241 beneficiaries (15 in Cacém, 30 in Cascais, 136 in Lisbon and 60 in Oeiras).

Of the services that are currently provided to the elderly population, the most popular ones are the outings and mini holidays and the "More Volunteer Work, Less Loneliness" Programme, in partnership with the SCML and the Portuguese Red Cross. This Programme, which dates back to 2006, is based on a protocol of collaboration and counts on local partners of the city of Lisbon: Civil Parishes, Ecclesiastic Parishes, Health Centers and the Local Police.

Table 103. Civil parishes allocated to the three institutions, within the framework of the "More Volunteer Work, Less Loneliness" Programme

Institutions	Civil Parishes Involved
Yellow Heart Association	Ajuda, Alcântara, Alvalade, Beato, Benfica, Campo Grande, Campolide, Carnide, Nossa Senhora de Fátima, São Domingos de Benfica, São João de Deus, São Sebastião da Pedreira, Santa Maria de Belém, Santa Maria dos Olivais.
Lisbon Holy House of Mercy (SCML)	Anjos, Castelo, Coração de Jesus, Encarnação, Graça, Lapa, Lumiar, Madalena, Mártires, Mercês, Pena, Penha de França, São João, São Cristóvão e São Lourenço, São Jorge de Arroios, São José, São Miguel, São Nicolau São Paulo, São Vicente de Fora, Sacramento, Santa Catarina, Santa Engrácia, Santa Justa, Santiago, Santo Estêvão, Sé and Socorro.
Portuguese Red Cross	Prazeres, São Mamede, Santa Isabel, Santo Condestável.

This Programme is made up of: a Management Team that falls under the Social Work Assistant of the SCML; an operational team that integrates the representatives of the SCML, Yellow Heart Association and the Lisbon Delegation of the Portuguese Red Cross; and a local follow-up commission where the local partners are represented. The actions are carried out by volunteers who receive initial training and who periodically take part in specific training actions. Their actions are aimed at i) facilitating the access to basic health, religious, leisure and festive infrastructures; ii) facilitating relations with the community and with persons of reference; iii) contributing to emotional stability and security; and iv) providing leisure activities.

In addition to this programme, the Yellow Heart Association carries out other actions such as the hosting of university students who wish to undergo internships via protocols established with higher education bodies and the organization of conferences targeted at raising the awareness of society in general to the question of old people living in a situation of isolation and dependence, to their needs and to the promotion of a culture of



Case Study
Associação Coração Amarelo
(Yellow Heart Association)

volunteer work.

The financial resources of the Association are obtained mainly from the payment of annual fees by its associates, from protocols set up with the Social Security, given their status of IPSS, from applications submitted to public funding lines for the development of programmes and projects, and from a set of actions carried out with the objective of obtaining funds, such as the organization of leisure and cultural events and the publication and sale of books.

Their interventions count on several partnerships with both public and private bodies, which enable them to enrich their activity. The most important partnerships are the town Councils of the localities where they have Delegations; Parish Councils; Universities; some NGOs, IPSS and companies.

On-going evaluation

In its day-to-day activities, the Yellow Heart Association is confronted with a number of difficulties, which to a certain extent limit their power to act. Among the main constraints, the most important in operational terms are the financial difficulties and the difficulty in acquiring premises for their delegations. An additional difficulty is ensuring the training of their volunteers, a vital condition for them to collaborate with the Association. As far as their intervention *vis-à-vis* their beneficiaries is concerned, one of the main difficulties in the initial phase of working with each elderly person is being accepted into the beneficiary's home until a relationship of trust has been built up.

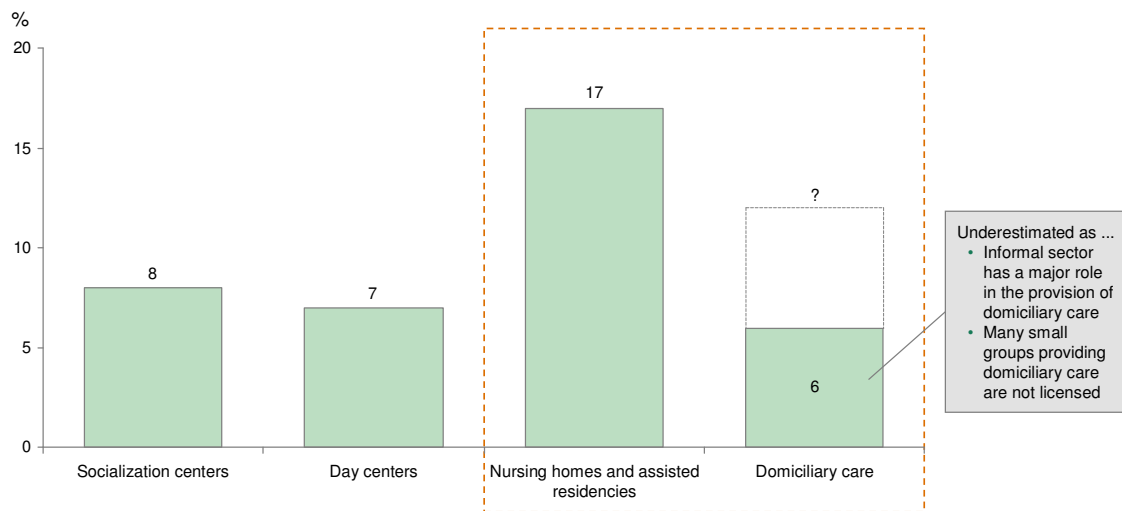
The intervention of the Association also has significant potentialities, however, namely the fact that its target public is a growing segment of the population and the fact that the family structure plays an increasingly less active role and is less capable of providing all of the care required by the old person. There are, however, other virtues, making it a case of good practices, especially as regards the organization and provision of care under a new format, based on meeting the expectations of the users; their intervention relies exclusively on volunteer actions; their volunteers benefit from continuing training actions, which is a turning point in the traditional conception of volunteer actions and which enables them to carry out their duties with quality.

The main added value of this intervention model is the personal growth of the volunteers themselves and above all the positive impacts on the beneficiaries, which translate into an improvement in the health and personal relationships of the elderly, greater self-esteem and quality of life in general, and the fact that they are able to raise the awareness of and mobilize more and more people for volunteer actions.

1.4. The role of the private sector

The private sector - comprising both informal and formal players - still plays a minor role in the provision of elderly care services. In addition, it focuses mostly on residential care.

In 2006, only ~17% of the total residential care capacity was provided by the private sector. For the other key elderly care services, the private sector accounted for less than 10%. Nevertheless, the participation of this sector in domiciliary care is usually underestimated by official statistics, since these services are mostly provided by informal players or unlicensed formal players.

Figure 63. Importance of the private sector in the provision of elderly care services, 2006 (%)

Source: *Carta Social*, 2007, MTSS.

Informal players - who tend to focus on domiciliary services - are believed to be the major private elderly care providers. The formal sector - which focuses on residential services, although also offering domiciliary care - is dominated by small scale players and has been gaining space gradually.

1.4.1. Informal sector

Because informal care services allow the elderly to stay at home longer and are less expensive than most formal services, they tend to represent families' first resort and preferred care option.

Informal paid care services have, as a rule, a social nature and are provided by women who accumulate housekeeping tasks (e.g. house cleaning, laundry, meal preparation). However, this accumulation does not only occur when the elderly reach very advanced stages of dependency.

Some years ago, informal paid services boomed as a result of the rise in the employment rate of women. Women's employment forced families to gradually assume a more supervisory and funding role. Yet, families remained the pillars of emotional support to the elderly.

Informal paid care services are usually provided on a daily basis (or from Monday to Friday). The amount of service hours contracted mainly depends on three factors: i) the income of the elder's family; ii) the elder's degree of dependence; and iii) the elder's living arrangements. These services can reach as much as 24 hours a day.

According to the Eurofamcare National Background Report for Portugal, in the 80's and 90's, care providers were traditionally Portuguese women with a low income and qualification. More recently, elderly care has been provided by immigrants from both the former colonies (such as Angola, Mozambique, S. Tomé and Brazil) and Eastern Europe (such as Ukraine and Moldavia). These immigrants usually have lower salaries, are more flexible in terms of working hours (as many live away from their families) and have slightly higher qualifications.

The report mentioned above also states that the informal sector is characterized by many irregular and illegal situations. According to this report, most care providers do not have "formal" contracts or declare the earnings received through their activities. Furthermore, some immigrant care providers are undocumented.

More occasionally, informal paid services have a medical nature. In convalescence periods or in terminal stages, some elders opt for in-home hospitalization. Medical services are typically provided by nurses who are already retired or work in parallel for public or private medical units and complemented by physicians' or therapists' domiciliary consultations. Due to the high costs associated, medium-high and high income families are the major consumers of informal medical paid services.

1.4.2. Formal sector

Four main factors are the most probable explanations for the minor role of the formal sector in the provision of elderly care services:

- ▶ The existence of much cheaper elderly care services provided by the informal sector (e.g. services rendered by immigrants);
- ▶ The major role given by the Government to the UM and the IPSS in the provision of elderly care services for lower income elders;
- ▶ The high operational costs associated with the provision of elderly care services, which makes it difficult for the private sector to provide services at affordable prices for low income elderly people (e.g. monthly costs of residential care per person are on average ~850€);
- ▶ The shortage of governmental programmes that co-finance the investment and/or operational costs related with the provision of elderly care services to medium and high income elderly.

In addition, some prejudice in the Portuguese society against elderly care facilities and services still prevail. According to many formal players interviewed, residential care centers continue to be seen as “deposits for old people”, and the use of formal paid services is interpreted as a sign of “abandonment” by the family.

The formal sector is highly fragmented and dominated by small scale players. These players typically run one, less frequently two, nursing homes together with family members or a few partners. More recently, small scale players have become more active in the provision of domiciliary care.

The participation of large scale players in the elderly care industry is scarce and recent. Entering the business in the early 2000s, most large players began by providing domiciliary care and only proceeded to provide residential care at a later stage.

1.4.3. Small scale players

1.4.3.1. Residential care

Small scale players have traditionally focused on the provision of residential care. According to interviews, there are two main motivations to enter the business: 1) professional background in social services (e.g. social workers) or in medical services (e.g. physicians and nurses); or 2) negative experience with the institutionalization of a relative.

Being an industry with low “attractiveness” and high emotional distress, the elderly care sector has not succeeded in capturing “talent”. Thus, most small scale players have limited business and technical (e.g. gerontology) skills.

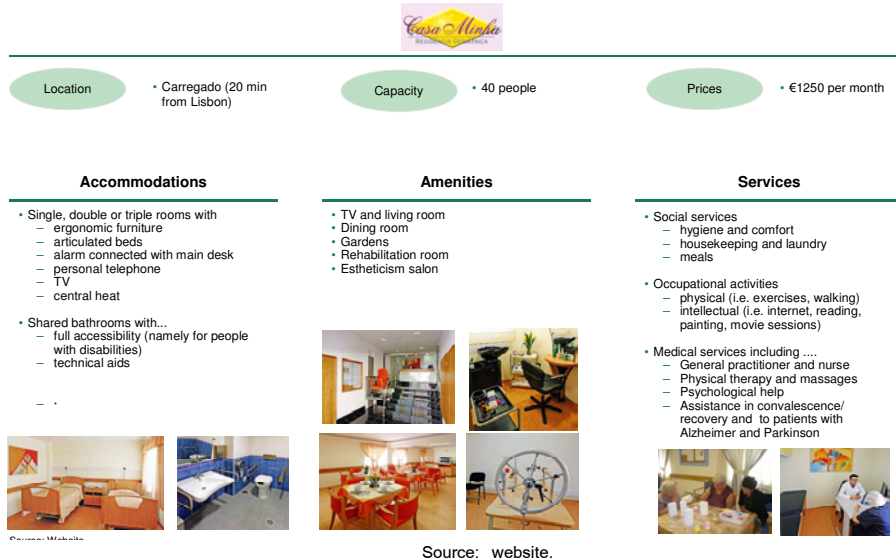
The older residential centers are very small scale (<25 people) and are commonly located in adapted infrastructures. The assisted residence Solar de São Gião, founded in 1995, illustrates this reality in *Figure 64*. More recently, higher scale built-on purpose residencies (30-40 people) have emerged. Casa Minha, illustrated in *Figure 65*, is an example of built-on-purpose residencies that opened in 2005. Both case studies also indicate the typical range of services provided by small private operators. Small

residential care centers rarely offer day centre services due to space restrictions (in common amenities such as living and dining rooms), complicated logistics (e.g. the need to create a transport service) and low demand.

Figure 64. Solar de São Gião (founded in 1995) case study

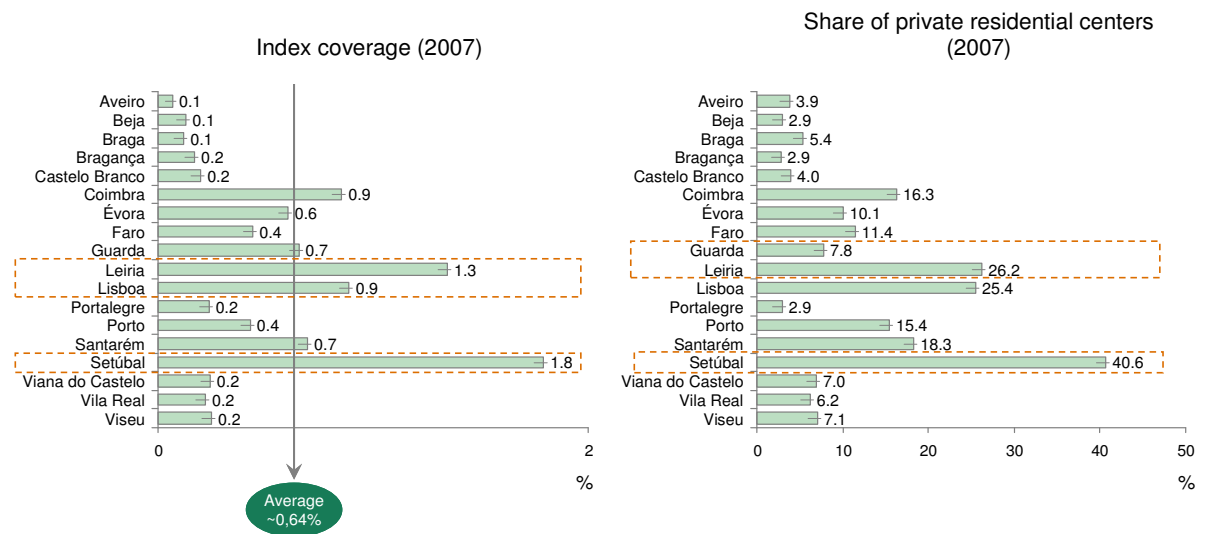


Figure 65. Casa Minha (founded in 2005) case study



Small private residences are unequally distributed across the national territory. On average, the coverage index of private residential care is ~0.6%. Setúbal, Leiria and Lisbon have the highest coverage indexes (1.8%, 1.3% and 0.9% respectively) and private participation (41%, 26% and 25% respectively).

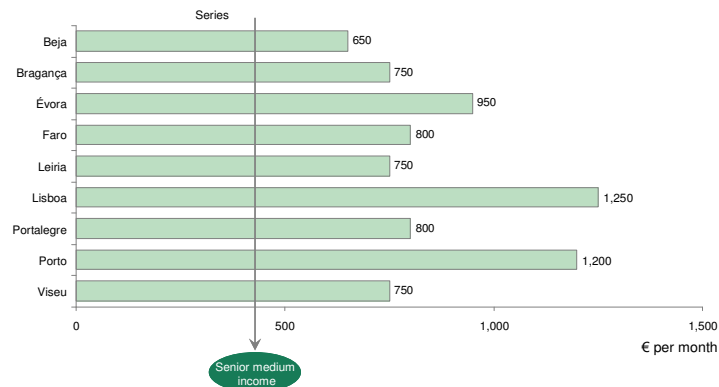
Figure 66. Geographical presence of the private sector, 2007 (%)



Source: DGEEP; INE; BCG analysis.

Private residential care is very expensive with monthly fees varying across Portugal and ranging from 650€ to 1,250€. Monthly fees exceed by far the elder’s average income, which is lower than 400€. Thus, it is only affordable by the medium-high income segment. Very often, relatives (mainly adult children) make significant contributions to the payment of residential care.

Figure 67. Average monthly costs of private residential care centers per district, 2006 (€)



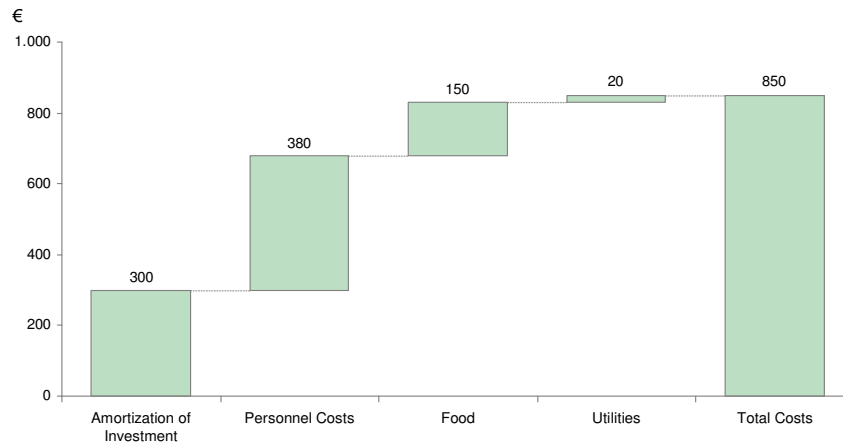
Note: prices refer to nursing homes located in each city and exclude medication, diapers and special medical care
Source: Phone interviews.

Residential care fees are mostly determined by the location of the care home, being much more expensive in the Lisbon and Oporto regions and in coastal urban areas. Other factors which influence the price of residential care include: 1) the privacy as well as the decoration of accommodations and bathrooms; 2) the variety of available amenities (such as gardens, gymnasiums, pools); 3) the diversity of services provided (such as outings, classes); and, in some cases, 4) the degree of dependence of the resident.

Due to the high investment requirements (~45,000€ per bed), most small players face difficulties to expand the business. Given that Social Security estimates that the minimum scale of a nursing home is 23 (occupied) beds, a minimum investment of 1€ million is required to build an economically viable nursing home. If players required an 8% return on investment, each elderly person would have to pay ~300€ per month just to repay the initial investment.

In addition, residential care is characterized by high operational costs (mainly personnel), which need to be repaid as well. Assuming a ratio of one worker per three users (costing 800€/month each), plus one doctor and one nurse (total cost of 3,000€/month), an additional 380€/month would be necessary to cover personnel costs. Food and utilities would add 170€/month to monthly costs (assuming 5€ per day for food and 20€ for utilities).

Figure 68. Estimated monthly break-even price of residential care, 2007 (€)



Source: BCG analysis.

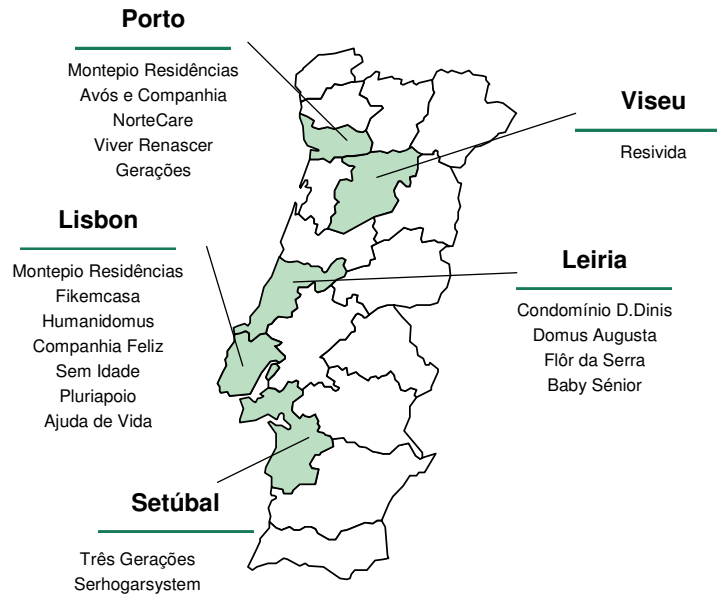
The estimated 850€/month break-even price suggests that high operational costs make it difficult for private players to provide services affordable for medium income elders. Another major conclusion of this cost estimate is that a large part of private players (those who offer services at prices below 850€ plus their profit margin) do not consider the amortization of the initial investment in their pricing strategy. This explains why they do not have the capacity to expand their business, and also partially clarifies why medium income elders are poorly served by private players.

The recent tightening of legal requirements and the stricter supervision by regulatory bodies is putting additional pressure on residential care operational costs and contributing to private players' hesitation to expand the business.

1.4.3.2. Domiciliary care

Domiciliary care provided by small formal players has, as a rule, a social nature (comprising personal hygiene, light housekeeping tasks, assistance in meals, etc.). Because most small firms operating in the market are unlicensed, the role of small formal players in the provision of domiciliary care is very hard to quantify. There are currently only 18 private firms licensed to provide domiciliary care, concentrated in few districts: Lisbon, Oporto, Setúbal, Leiria, and Viseu.

Figure 69. Licensed private domiciliary care providers, 2007



Note: Licenses entities by September 2007.

Source: Associação de Apoio Domiciliário de Lares e Casas de Repouso de Idosos (ALI), based on information provided by the ISS.

Domiciliary care firms are usually owned by 2-3 partners and tend to have a local scope. There are three main typologies of small domiciliary care firms: 1) firms focused on social services (such as Sem Idade and Dr. Carlos Rocha); 2) firms delivering medical services (such as AMETIC and Nurse 24); and 3) firms offering both types of services (such as Fikemcasa and Companhia Feliz). The company Futuro Feliz em Família is shown in Figure 70 as an example of a firm that renders a full range of services. In Figure 71, the example of Home Instead is given. This is one of the two international firms that operate in Portugal with several franchised offices spread throughout the national territory (the other is Comfort Keepers). These franchises are only focused on providing social care services.

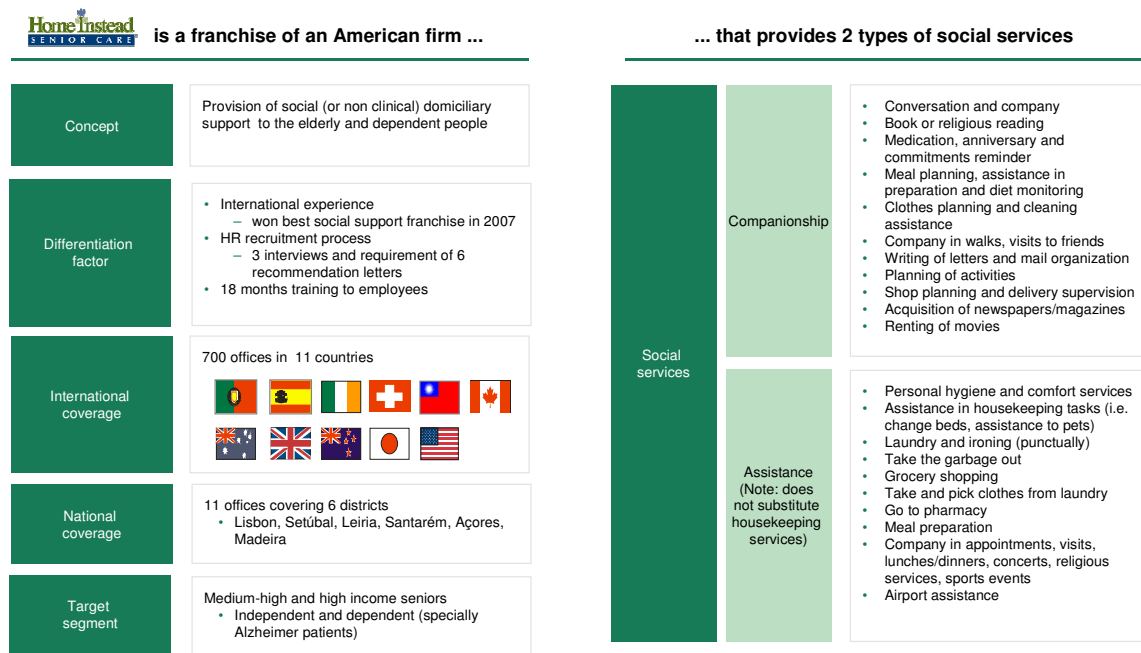
Figure 70. Futuro Feliz em Família case study

Futuro Feliz em Família is a small domiciliary support firm providing both social and medical services	
Concept	Provision of social and medical domiciliary support both to the elderly and to people with disability	Social services	<ul style="list-style-type: none"> • Psychosocial assistance • Personal hygiene and comfort services • Housekeeping • Company and conversation • Assistance in outings and visits • Meals preparation and assistance • Medication administration • Occupation activities • Grocery shopping • Bills payment (i.e. utilities, telephone) • IRS submit and payment • Hairdresser, manicure, pedicure
Differentiation factor	Qualification of HR that provide the social and medical support	Medical services	<ul style="list-style-type: none"> • Medical consultations • Medical urgencies • Nurse or medical auxiliary assistance • Exams and clinical analysis • Assistance in convalescence/recovery • Assistance to patients with special needs: Alzheimer, Parkinson, strokes, diabetes • Continuous care • Physical, speech and respiratory therapy • Therapeutic, relaxing and shiatsu massages • Acupuncture
Partnerships	Social services providers <ul style="list-style-type: none"> • Europ Assistance Medical service providers <ul style="list-style-type: none"> • Alerta Médico (Medical services provider) • Ensaio Mágico (Physical Therapy) • Fisiotaj (Rehabilitation clinic) • Cardioteste (Cardiovascular clinic) Nursing homes and IPSS <ul style="list-style-type: none"> • Fátima park • Apoio Social N. Sra das Neves (Manique) 	Other services	<ul style="list-style-type: none"> • Sale and rental of geriatric equipment • Selection of "value for money" nursing home • Studies for definition of adaptation of spaces for elderly with physical and psychological conditions
National coverage	Greater Lisbon: Lisbon, Cascais, Oeiras, Sintra, Amadora, Loures, Montijo, Almada, Barreiro Algarve: Loulé, Albufeira and Faro		
Target segment	Medium-high and high income seniors <ul style="list-style-type: none"> • Independent and dependent 		

Source: Website

Source: website.

Figure 71. Home Instead case study



To be able to offer a wider portfolio of services (mainly medical ones), firms sometimes partner with other entities or with freelancers (e.g. nurses, physical therapists). This allows them to maintain higher operating margins. Firms also collaborate with other companies, by offering preferential price conditions to their employees. Such partnerships aim at guaranteeing a larger customer base.

Domiciliary care services are targeted at medium-high and high-income elderly people. As expected for a customized service provided in-home, domiciliary care services are very expensive. Unit prices of a daily bath range from 10€ to 20€ 24-hour assistance costs at least 2,000€ (if it only has a pure social nature) and at least 3,000€ per month (if it is also of a medical nature). These prices are quite high compared to those of the formal sector. Yet, small formal players do not always offer high-quality services.

1.4.4. Large-scale players

The participation of large-scale players in the elderly care industry is almost negligible. Currently, only four large-scale players operate in the market: José Mello Residências e Serviços, Espírito Santo Saúde, Carlton Life and Montepio Residências e Serviços. Additionally, two other large-scale players have investments in the industry: Senior 3 Living and Longevity. So far, these players have invested ~250€ millions in the elderly care industry.

Figure 72. Investment of major private groups in the provision of elderly care services (€)



Source: Press; websites.

The participation of large-scale players dates from the early 2000s. Due to the high financing needs of the industry, these players are controlled either by major financial institutions (e.g. Espírito Santo Saúde) or by healthcare services providers (e.g. José Mello Residências e Serviços).

Most large-scale players began by providing domiciliary care, mainly of medical nature and leveraging on own professionals and medical infrastructures to later expand their service portfolio to residential care. Services provided by large-scale players are targeted at the upper class.

Case Study - José de Mello Residências e Serviços (JMRS)



JMRS is the largest private group operating in the Portuguese elderly care market. Owned by José de Mello SGPS (70%) and the national pharmacies association (30%), it has been operating since 2003.

The company provides residential care (nursing homes and residential homes) and domiciliary care to elderly people. It has three residential units under operation, which represent an investment of 55€ million. The current offer includes 400 beds and 68 apartments. Two of the units currently under operation provide both residential care and nursing care. The third unit only has nursing care and includes a special division for patients suffering from Alzheimer.

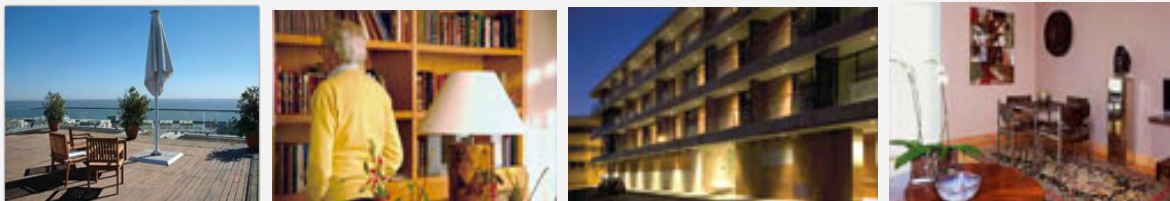
The company is focused on high-income elders. Monthly fees are 1,500€ for nursing care and 950€ for residential care (in this case, an initial fee of between 40,000€ and 60,000€ is applied). The offer in residential care units comprises:

- ▶ Apartments (T0, T1) with a private bathroom, kitchen and optionally a living room for individual or shared use;
- ▶ Amenities, such as TV and a living room, dining room, activities room, games room, library, gardens, chapel, gymnasium/rehabilitation room, pool, hairdressing salon, parking and storage;
- ▶ Social services (hygiene and comfort, housekeeping and laundry, meals);
- ▶ Occupational activities (intellectual - i.e. painting and music workshops, movies, outings and physical - such as rehabilitation, gymnastics, swimming classes);
- ▶ Medical services (general practitioner and nurse, specialist consultations (extra), therapists (extra),

preferential access to CUF units.

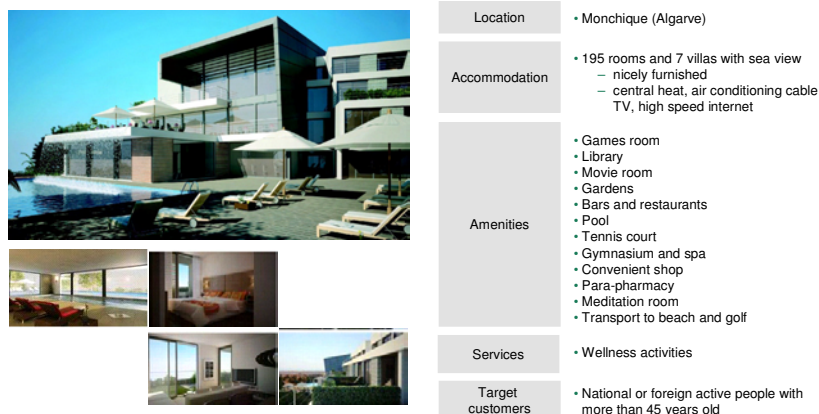
When it first entered the market, the company had an ambitious growth plan, which included the opening of several residences. But difficulties faced in reaching close-to-full occupation have delayed this plan. No new residential complexes have been opened since 2005 and no new openings have been announced.

The company began operating in the domiciliary care sector. Services offered were based on the healthcare facilities that the José de Mello group already operated (CUF clinics and Hospitals). Due to this fact, the geographic coverage is still limited to the Lisbon and Oporto areas. Services offered are mainly medical, but personal care support is also offered.



Innovative concepts are beginning to appear in the national market. The opening of the first senior resort - a concept quite widespread in Spain - is planned for 2008. Senior resorts are more real-estate than elderly care services, as they target active people and market well-being in a holiday-like environment. The investor and owner of the new project is the Longevity group.

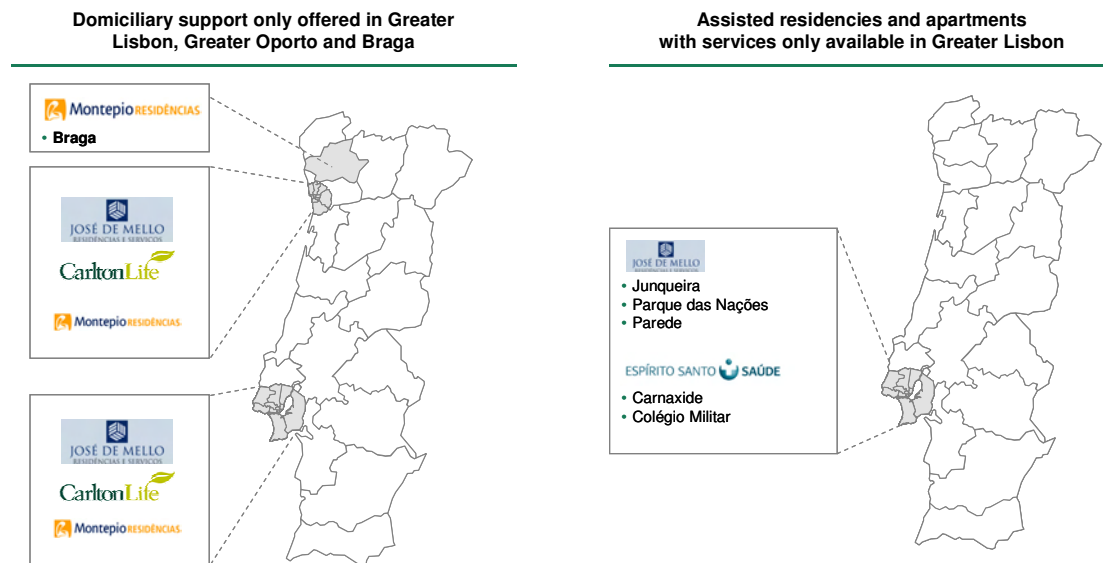
Figure 73. Monchique Wellness Resort and Spa



Source: Longevity website.

In the first years, demand and occupation rates were far below expectations, and large-scale players faced serious difficulties in capturing clients and reaching the break-even point in residential care. This probably explains why these players still provide a very low coverage of the national territory. Domiciliary care is offered in Greater Lisbon, Oporto, Setúbal and Braga and residential care is only offered in Lisbon.

Figure 74. Geographical presence of large-scale players, 2006

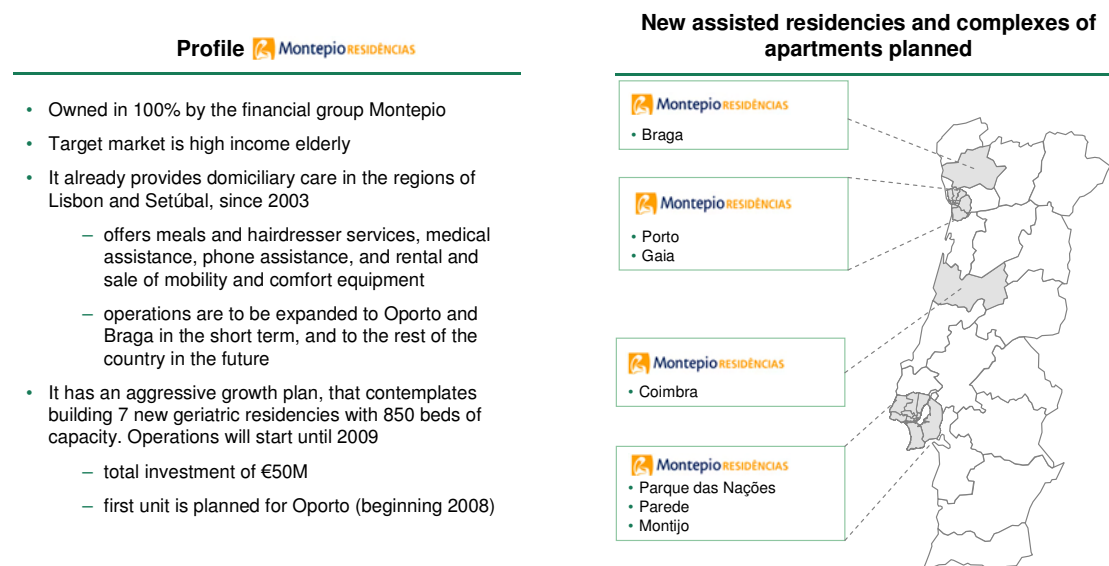


Source: websites.

Targeted at active elderly people, assisted residences were “unknown products” in Portugal. Wishing to stay in their own homes for as long as possible, the elderly did not value the “five-star hotel-like” amenities and services offered by assisted residences. In addition, they are reluctant to buy the “lifetime right of usage” of a residence, because it is not transferable and significantly diminishes the legacy they want to leave to their children. Moreover, there are cultural prejudices against residential care.

Large-scale players feel that so far they have only been learning about the business. Five years down the road, these players have different views on the potential of the industry and different growth plans. Some consider that it has a low potential and do not plan to expand further. Others believe that there is still high untapped value, namely in lower income segments. *Montepio Residências e Serviços* is optimistic about the market. It only provides domiciliary care at the moment, but it has designed a very aggressive expansion plan that has made public.

Figure 75. Montepio Residências e Serviços



Source: Website; Press.

Summary

- ▶ The private sector - comprising both formal and informal players - still plays a minor role in the provision of elderly care services:
 - Less than 20% of the existing capacity of key elderly care services - day care, residential care and domiciliary care - is controlled by the private sector;
 - The informal sector, which focuses on domiciliary care, is believed to be the major provider of private elderly care;
 - The formal sector, which concentrates on residential care, is dominated by small-scale players.
- ▶ Four main factors explain the minor role of the formal sector in the provision of elderly care services:
 - The existence of much cheaper elderly care services provided by the informal sector (e.g. services rendered by immigrants), which enable the elders to stay home longer;
 - The pivotal role of UM and the IPSS in the provision of elderly care services financed by the Government and targeted at low income elderly;
 - The high operational costs associated with the provision of elderly care services, which makes it difficult for the private sector to render services at prices affordable for the low income segment (e.g. monthly costs of residential care per elder are on average ~850€);
 - The shortage of Governmental programmes that co-finance the investment and/or operational costs related with the provision of elderly care services to medium- and high-income elders.
- ▶ Large-scale players still have a very incipient participation in the elderly care industry:
 - Only 4 large players currently provide elderly care services (*José Mello Residências e Serviços*, *Espírito Santo Saúde*, Carlton Life and *Montepio Residências e Serviços*);
 - Large players' residential care capacity accounts for less than 1% of the private capacity and is currently limited to the Lisbon Region;
 - Large players' domiciliary care is mainly provided in the Lisbon and Oporto regions;
 - As a rule, large-scale players began by providing domiciliary care of a medical nature and later on proceeded to offer residential care.
- ▶ The participation of the private sector in the provision of elderly care is unlikely to increase drastically in the near future:
 - The high financing needs of the elderly care industry are deterring small-scale players from further expanding the business;
 - Although some large players (e.g. *Montepio Residências e Serviços*) are planning to expand or enter the business, the weight of large players is not expected to increase significantly in the upcoming years.

1.5. The role of family support to the elderly

1.5.1. Theoretical and conceptual framework

This chapter's goal is to analyse the family's role as "informal caregivers" for the elderly. In this approach, family, friends, neighbors or others must be considered as "informal caregivers" who, informally and without being paid nor subjected to any kind of administrative status, provide assistance to seniors that need help in basic and daily tasks. Meanwhile, on the other hand, the concept of "family" in this context must be understood as a wide network of relatives with whom the senior interacts on a more or less intense basis.

The understanding of the family's role in senior care is an issue of increasingly social relevance that has generated a vast set of recent studies, both academic and requested by entities working in the field with the ageing population. Its importance is basically a result of two factors: in the first place, the significant ageing of the Portuguese and world society, causing new dilemmas, among which the sustainability of new social security systems, but also the creation of new categories and designations, so as to perceive the complexity of this reality; in second place, the progressive transformation of the family structures and dynamics, giving rise to new values, perceptions and family attitudes towards their ascendants.

Traditionally, the elderly played a central role in society and in the family, because they were seen as a symbol of wisdom, representatives of the continuity of history and memory, since the family was the main caregiver. The primary solidarity networks (acquaintance and group help relations based on family, friendship and/or neighborhood bonds) were of the utmost importance. However, in Western societies in general and in the Portuguese society in particular, there has been a set of transformations leading to serious changes in the family's structures and relationships. Among those changes is the integration of women in the labour market; the lack of time from descendants due to work; smaller houses and stressful lifestyles caused by urban contexts; a lower proximity between the various members of the family network; a depreciation of the traditional family values, as well as the established family duties and obligations.

Simultaneously to these serious transformations, there has been an increase of the professional services in providing care services to elderly people, promoted by various legal actors, which has caused a shift of the competences that were previously the family's responsibility - for society, IPSS and the State, encouraging and thus taking action in the unaccountability of the family as a caregiver entity.

Notwithstanding the signs of change, family care, the family to which descendants give support to their direct ascendants, is imbibed in the cultural values of the Portuguese family and it still is a crucial institution for the affective and fulfillment basis of the individual, like several authors suggest in recent studies in the area of gerontology and family sociology. This derives essentially from two factors. The first one is associated to the fact that the perpetuity of cultural values towards the social representation of the elderly in their family and social environment - in a daily interaction with their relatives, friends and neighbors - is vital for an active, affective and balanced ageing process (whereas institutionalization, although providing professional and technically superior services to those that the family might provide to the elderly, also means a rupture of the primary solidarity networks and promotes a segregation of this group, as well as a cut in inter-generational bonds). The second fact is related to social pressures and has two underlying components: on the one hand, the example that one wants to give to one's children and, on the other, because no one wants to face the censorship of neighbors and acquaintances.

1.5.2. Profile of the family caregiver and typology of the assistance provided to the senior

However, it is important to point out that within the scope of elderly care in the context of primary solidarity relationships, rights and obligations are not generally defined in a similar way. In fact, these

depend on multiple variables such as: gender, age, generation, family ties, profession, economic activity or occupation, residential proximity and even the expectations concerning the individual's behavior. As Nunes (1995) refers, "networks are selective, they create inclusions and exclusions, hierarchies and subordinations". (*in* Pimentel, 2005).

In conclusion, it is important to outline the trend profile of the family caregiver and, whenever relevant, to emphasize the Portuguese society's micro-contexts from the results of the survey carried out within the scope of this study to the elderly population in Portugal.

From the results it is pertinent to point out the importance of the family in the context of formal and informal caregivers, mostly of the help/support the senior benefits from: household tasks, personal care, financial assistance, health care, social and leisure care. The formal caregivers come in the first place: Institutions and State, with a very similar proportion among them (82 and 79 respectively), although very distant from the relevance of the family. The remaining informal caregivers (friends and neighbors) have a much-reduced expression.

Family is still the main caregiver of the elderly in all typologies and supports, except for health care, in which the State plays the chief role, as an indication of the NHS's importance in Portugal. An interpretation of the typologies reveals that family plays a more relevant part in helping the elderly in daily domestic tasks, followed by financial help, mobility, personal care, leisure and health care (the latter with lower significance).

Table 104. Supported seniors, according to support type and nature of the caregiver, 2007 (No.)

Caregiver	Type of Help/Support						Total
	Domestic Tasks	Personal Care	Financial Help	Mobility	Health Care	Leisure	
Family	174	73	91	83	56	39	516
Friends	9	0	3	4	1	18	35
Neighbors	3	3	0	1	3	1	11
Institution	14	21	1	12	24	10	82
State	0	0	12	0	66	1	79
Others	55	19	7	21	18	47	167
Total	255	116	114	121	168	116	890

Source: CEDRU Survey, 2007.

The analysis of the family's profile as caregiver is marked by several dissimilarities according to the TAU. This role is most relevant in APR when compared with urban areas, in almost all typologies of help/support. Thus, in rural contexts there is a greater respect for the primary solidarity networks, for moral values and for the importance of the family as a vital unity of the organization and functioning of society, where cultural values are still rather embedded and where the family is obliged to support its members.

The only exception is leisure, which is the only type of help/support granted by the family that has a higher relevance in AMU (10.4%), when compared to APR (6.8%). This fact reveals the importance of leisure activities in the rural context in the Portuguese society, which still tend to be associated to urban territories.

Notwithstanding these two great differences between TAU, based on the type of help/support given by the family, it is important to point out that in all of them, domestic tasks are the most relevant. The typologies of diversified help/support based on the urban area typology come in second. In fact, in APU, financial help comes in the second position, and this fact corroborates the several recent studies that have been carried out on this matter and that have confirmed the greater vulnerability of this age group in urban areas, associated to a higher risk of poverty. The *Relatório do Observatório de Luta Contra a Pobreza na Cidade de Lisboa* (Report by the Observatory for the Fight against Poverty in the City of

Lisbon) is an example of this: this report states that 28% of the population aged 65 or over is at risk of poverty. In AMU there are two kinds of help/support of equal statistic relevance: leisure and mobility. Finally, in APR, with the exception of the domestic tasks (the main help provided by caregivers to the elderly) and leisure, all of the remaining kinds of help/support present a similar relevance.

Table 105. Seniors supported by family, according to support and Urban Area Typology, 2007 (%)

Type of Help/Support	Typology of urban areas		
	APU	AMU	APR
Domestic tasks	12.0	13.5	22.7
Personal care	4.6	5.2	13.6
Financial help	5.9	8.3	13.6
Mobility	5.0	10.4	13.6
Health care	2.8	7.3	13.6
Leisure	1.8	10.4	6.8

Source: CEDRU Survey, 2007.

In the analysis of family relations in terms of care given to seniors, the gender variable takes on a double relevance, since there are great differences when it comes to the caregiver, as well as to the beneficiary of that same care, according to gender.

As far as the informal caregiver “family” is concerned, several studies have defended that family networks create hierarchies and subordinations and that the variation depends on a myriad of factors, among which the gender of the caregiver. In fact, amid the more consistent characteristics of caregivers, there is a preponderance of women (*Cuidadores Informais de Idosos*, Cidade Solidária, SCML, 2008). Vieira (1996) reinforces this characteristic by mentioning that the help granted to elderly people is mostly given by the wife, or should she not exist, by the daughters, because taking care of elderly people is still seen as a woman’s job. Another study (*Dificuldades e Fontes de Satisfação Percepcionados por Cuidadores Familiares de Idosos Dependentes Com e Sem Demência*) even quantifies this prevalence, by stating that 84.8% of family caregivers are women (Figueiredo and Sousa).

In terms of the gender of the senior that benefits from family care, there is a clear cut between two great kinds of help. In personal care, male seniors benefit from the greatest family help, whereas in terms of mobility and leisure, female seniors show a greater need for support. As for financial help and health care, there is a certain homogeneity among seniors of both genders, although the needs of women tend to be slightly higher. This scenario has underlying cultural patterns that still prevail in the Portuguese society, according to which household tasks belong to women, while, on the other hand, they have greater autonomy and mobility than men, which regulates their condition and generates further dependency and need of support from other people to fulfill certain activities.

Table 106. Seniors supported by family, according to support and gender type, 2007 (%)

Type of Help/Support	Gender	
	Female	Male
Domestic tasks	36.8	63.2
Personal care	37.0	63.0
Financial help	50.5	49.5
Mobility	63.9	36.1
Health care	51.8	48.2
Leisure	61.5	38.5

Source: CEDRU Survey, 2007.

The type of support provided by the family to its ascendants varies according to the senior population’s age group. In fact, there is a great dichotomy between age extremes, i.e.: while among younger seniors

(55-64 years old), the main help is in leisure activities, in the really aged group (85 years or over), the main help is in personal and health care. This disparity is a reflection of the loss of self-sufficiency, of biological capacities and the increase in dependency that occurs with ageing, which brings about a change in the life style and needs of individuals.

An insightful evaluation of each of the age groups clearly supports this fact, as there is a gradual transformation in the main type of support. Among the senior population aged between 55 and 64 and 65 and 74, the major help granted by family caregivers is in terms of leisure activities, closely followed by domestic tasks. In this age group, many seniors still live with their descendants. On the contrary, between 75 and 84 years old, the main type of help provided is in terms of mobility and financing, while in the group aged 85 or over, personal and health care play the chief role.

Table 107. Seniors supported by family, according to support type and age group, 2007 (%)

Type of Help/Support	Age Group				Total
	55-64	65-74	75-84	85 or above	
Domestic tasks	32.8	32.8	25.9	8.6	100.0
Personal care	23.3	31.5	31.5	13.7	100.0
Financial help	23.1	30.8	39.6	6.6	100.0
Mobility	24.1	27.7	39.8	8.4	100.0
Health care	23.2	32.1	33.9	10.7	100.0
Leisure	35.9	33.3	23.1	7.7	100.0

Source: CEDRU Survey, 2007.

Likewise, the nationality variable brings about crucial shifts in family relationships, in terms of care granted to seniors. Although domestic tasks are present in both situations and are the most important type of help that Portuguese or foreign seniors receive from their family caregivers, as far as foreigners' are concerned, financial help plays a similar role (33.3%), while among Portuguese seniors that importance is much lower (6.5%). It is pertinent to emphasize the substantial difference in terms of personal care provided by family caregivers, since while 16.7% of foreign seniors benefit from this support, in the case of the Portuguese, it does not go beyond 5.4%.

These disparities based on nationality are mostly evidence of moral values and the importance that family structure and family solidarity networks play among inborn and foreign citizens. Nonetheless, these differences are thus enhanced by the dominant profile of foreign citizens in Portugal: PALOP. Contrary to what occurs in the Portuguese and Western society, in the traditional African society, seniors still play a major role, in which the political and social systems of the villages are based on the chief's authority, who is always an elder, due to the fact that he is very knowledgeable of the ancestors' traditions and is seen as the guardian of wisdom and experience. Closely associated to cultural factors, the disparities occur at the level of financial help, because in the Portuguese society the idea that older people are supposed to help the younger one and not otherwise remains.

Table 108. Seniors supported by family, according to type of support and nationality, 2007 (%)

Type of Help/Support	Nationality	
	Foreign	Portuguese
Domestic tasks	33.3	12.9
Personal care	16.7	5.4
Financial help	33.3	6.5
Mobility	5.6	6.3
Health care	0.0	4.3
Leisure	0.0	3.0

Source: CEDRU Survey, 2007.

Finally, it is important to point out that, besides the fact that issues related to the loss of importance of the elderly people in the family context in western modern societies is increasing, as several researchers defend, the family still plays a major role as caregiver. Seniors still expect this support, for the sole reason that they belong to a generation in which family fulfilled the needs of the elderly and this was an important cultural value.

As proof of this reality, in the survey carried out to the senior population at a national level, it was possible to conclude that 41.1% of those surveyed do not intend to be institutionalized, which is clear evidence of the expectations of family support in the ageing process.

1.5.3. Trends and challenges

Nowadays, the importance of the elderly's permanence in the family environment is widely known and it is considered vital for a balanced ageing process. Furthermore, the social ideology that confers to the family the responsibility of taking care of their ascendants brings about added pressure on it, without considering the needs for effective care. This family picture is followed by political and social transformations, which induce a gradual incapacity from the State in responding to the increasing needs generated by the ageing of the population, a growingly versatile reality that implies more and more complex solutions.

Regarding this scenario, family and society are currently faced with new global challenges as far as providing care to the elderly population is concerned. Although the increasing incapacity to respond and to remove responsibility from the Welfare State might somehow be overcome with the creation of professional care providing services, the development of new solutions and execution strategies is inevitable and involves a wider set of actors.

Employers and companies are responsible for the development of strategies that enable the conciliation between professional and family life, namely of specific strategies to provide the family with care. These may be extremely diversified and nowadays there is a set of good practices at a national and international level. The following is an example of this: the strategy developed by IBM, a computer company, which provides health insurance to its employees, their descendants and ascendants; Du Pont de Nemours, an Italian company in the chemistry and energy sector with approximately 500 employees, implemented in the second half of the 80s part-time jobs at all career levels in order to allow their employees the opportunity to provide their ascendants and descendants with care; Greece's national bank, which has offered a broad health fund to employees' parents, which includes economic support and family counselling.

The State is responsible for the challenge of developing support policies and protection to family caregivers, of promoting family wellbeing, so that the provision of senior care is not a family pressure. Recently, an important effort has been made at national level in terms of social support for families with the creation and application of the PARES by the Government, which has led to an increase in the number of vacancies in day care centers, residential homes and domiciliary support services, within the scope of the social responses for elderly people. This is a crucial measure for a new generation of social policies, based on family support and on the conciliation between professional and family life and on the creation of proper conditions for more effective equal opportunities, since in general women are the most affected professionally, because the task of taking care of ascendants is typically theirs. However, this is a delimited measure. For instance, the inexistence of regional and local policies at this level, where the promotion of quality care and the development of fitting conditions for effective family care also depends on the initiatives at a local level and technical and financing capacities of the local communities.

In terms of research, whether entrepreneurial or academic, it is important to develop a deeper knowledge of the dynamics implicit in family solidarity networks of the different minority groups. Portugal

has become an increasingly important destiny for the international migration networks, which receives immigrants and ethnic minorities from various geographical origins, with distinct family cultures and values. For this reason, it will be necessary to understand its different beliefs in order to develop positive differentiation strategies in the support to family informal caregivers of several nationalities.

Social partners, namely IPSS and NGOs, must play an important role at this level, promoting awareness actions on the community in general, but also training senior caregivers, endowing them with technical quality and competence features.

Finally, in the context of family structures, it is necessary to encourage the responsibility and value of affective and family bonds in elderly care, as well as the awareness of its importance for active ageing. This must be an opposite attitude to the one that is emerging from the lack of responsibilities from the family, based on the emergence of professional services and the belief in the duty of the State.

2. Summary

- ▶ In more recent years, there has been an increasing growth when it comes to the elderly care and services offer by formal and informal caregivers;
- ▶ In the past few years, the role of the State in care provision for seniors has reinforced and consolidated the services and equipments network, the qualification of services and responses, as well as its increasing diversification. In what concerns the Central Administration, several projects and programmes have been developed, whereas when it comes to the Local Administration, a multiplicity of projects has been created;
- ▶ In Portugal there is a long tradition of Third Sector intervention in providing care and services to the senior population, involving a wide range of institutions, which include religious organizations, such as the Holy Houses of Mercy and Parish and Social Centers. Volunteer work has registered a significant growth; although it is a recent activity in Portugal it already assumes magnitude in the non-profit sector;
- ▶ The private sector, which includes formal and informal operators, still plays a lesser role in providing care to the elderly;
- ▶ The role of the family, as caregivers to the elderly, has undergone profound changes in the course of the last few years. However, the family remains the main care provider.

MODULE 3

MARKET ASSESSMENT

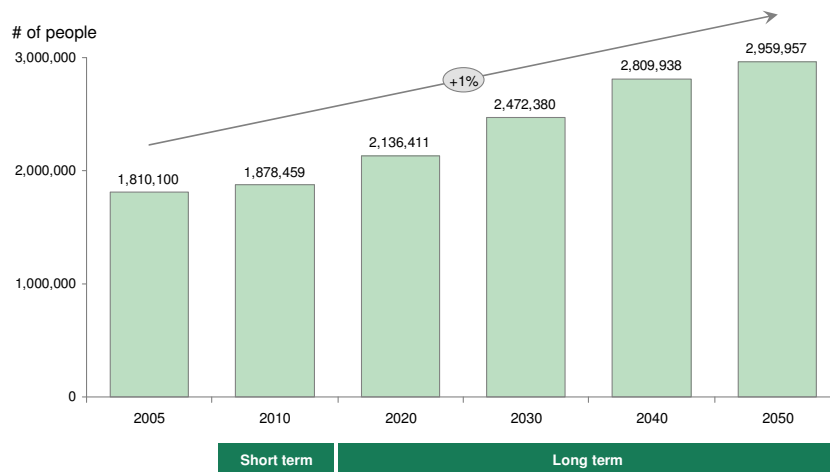
1. Demand evolution scenarios in Portugal

The demand for elderly care is expected to steadily grow in future years mainly driven by four factors:

- ▶ Population ageing;
- ▶ Changes in family dynamics;
- ▶ Cultural changes;
- ▶ Economic growth.

In Portugal, as worldwide, population ageing is an emerging trend. Until 2050, elderly population is expected to increase at 1% annually. As a result, the weight of the elderly population will rise from 16% in the 2001 census to ~32% in 2050. The boom of seniors will generate an increase in elderly care demand.

Figure 76. Projections of evolution of population with 65 years old and more, 2005-2050 (N.)



Source: INE.

On-going changes in family dynamics will also fuel the growth of the demand for elderly care, namely:

- ▶ The increase in women's employment;
- ▶ The increase in the average age of retirement;
- ▶ The gradual predominance of smaller size families;
- ▶ The rising preponderance of time-demanding jobs.

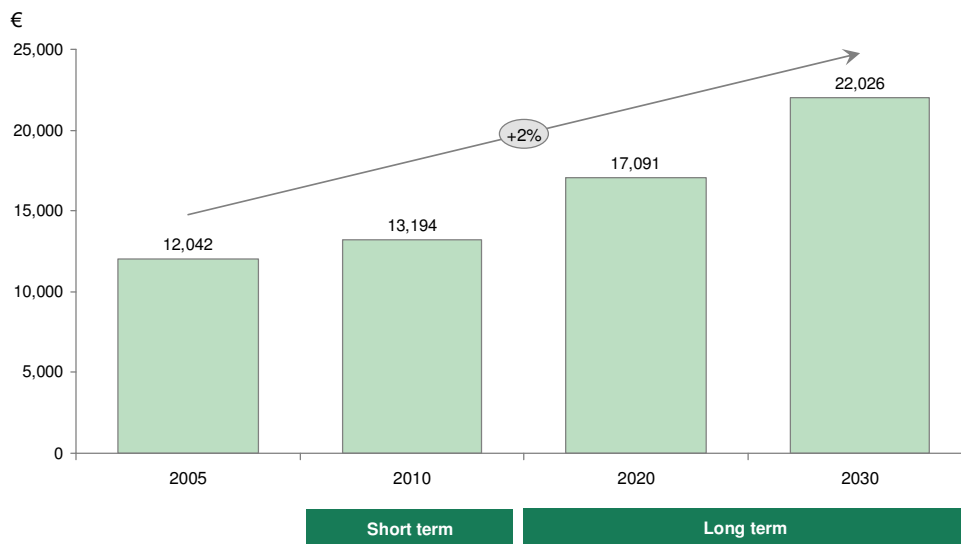
Women's employment will continue to grow in upcoming years. At the same time, the age of retirement - of both men and women - will rise, on account of the recent reform of retirement rules (namely the increase in both the minimum age and the minimum years of service for retirement eligibility). As daughters and daughters in law aged 50-65 years old are major care providers, both trends will require families to find care options alternative to family care.

In parallel, the weight of smaller families (with 1 or 2 children) will gradually increase. As historically family members - namely children - have shared elderly care provision, a much higher time commitment will be required to each family care provider. This trend together with the increasingly time commitment required by jobs, which will reduce the time availability of family members to provide elderly care, will drive the demand for elderly care solutions complementary or alternative to family care.

As to cultural changes, some will encourage too the increase in the demand for elderly care. On one hand, current middle age people accept better the possibility of using elderly care services in the future, namely, in case of dependency. On the other hand, society's prejudices against paid elderly care services (namely residential) are fading away. Thus, slowly, more families perceive paid elderly care services as suitable and advantageous care options, namely in stages of advanced dependency.

Economic growth will foster, as well, the increase in elderly care demand. Until 2030, real GDP per *capita* is expected to grow at a 2% annual rate. This growth will increase the average income of the elderly and families and, thus, not only make elderly care services affordable to more people but also increase the capacity of payment of care services by elderly, in general.

Figure 77. Projections of evolution of GDP per capita, 2005-2030 (€)



Source: Economist Intelligence.

As to the incidence of elderly dependency (which is a major driving force of elderly care demand), it is not expected to drop in the future despite the expected medicine progress. Health state of elderly people of each age bracket is expected to increase as a result of medical advances. The weight of older elderly (with higher incidence of dependency) will increase and, subsequently, the average age of elderly people will also increase. Specifically, the weight of elderly aged 80 years old or more within the 65+ age group will increase from ~23% in 2005 to ~32% in 2050.

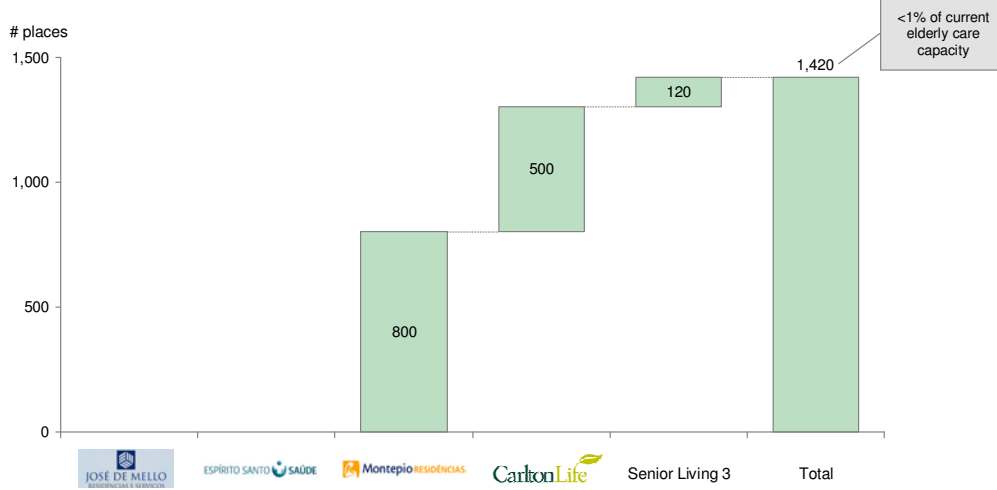
Overall, the demand for elderly care services is expected to increase in quantitative terms. In qualitative terms and, as the level of education and income of elderly population rises, they will demand elderly care services with higher quality (e.g. specialized care, qualified personnel, higher frequency care).

2. Supply evolution scenarios

All things equal, the private sector is not expected to drive the future supply of elderly care services. Because of the high operational costs of elderly care provision, private players will probably develop few

services targeted at medium or low-income elderly. In addition, a substantial increase of the services targeted at high-income elderly is improbable. On the one hand, the high investment requirements and the increasing pressure on profitability margins will deter many small players from expanding their current capacity. On the other hand, the aggressive capacity expansion planned by some large players - like Montepio Residências and Carlton Life - will have a limited impact in the aggregate elderly care supply.

Figure 78. Public expansion plans of the residential capacity of large private players , 2007 (N.)



NGO are also not expected to be important drivers of the future evolution of elderly care supply. NGO currently operating in Portugal have not announced major capacity expansions. In addition, the entry of new NGO focused on elderly care provision is not projected.

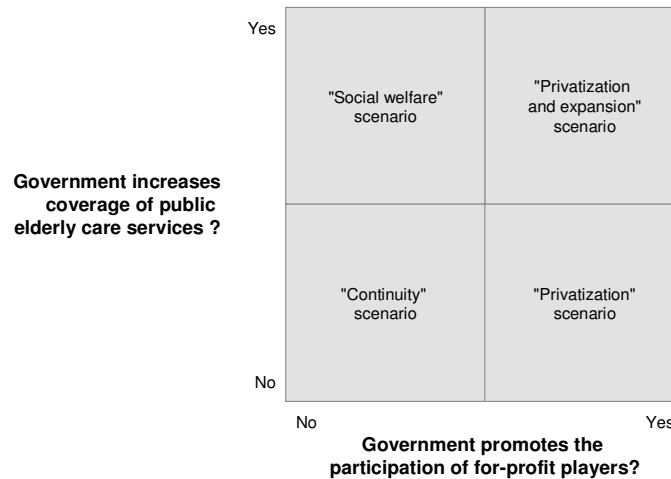
The informal sector has historically developed in response to imbalances between elderly care demand and supply, and is, as well, not expected to drive the future evolution of elderly care supply.

Thus, in Portugal, the evolution of the supply of elderly care services will be determined by the direction of the Government policy on two matters: 1) coverage of public funded services; 2) measures to incentive the private sector.

- ▶ Regarding the coverage of public funded elderly care services, the Government may maintain the current coverage or increase it;
- ▶ In what concerns the private sector, the Government may maintain the *status quo* or introduce measures to incentive the private sector to assume a major role in elderly care provision.

The combinations of main directions of the Government policy result in four supply evolution scenarios:

- ▶ The “Continuity” scenario;
- ▶ The “Privatization” scenario;
- ▶ The “Privatization and Expansion” scenario;
- ▶ The “Social Welfare” scenario.

Figure 79. Potential supply evolution scenarios

In the "Continuity" scenario, the *status quo* - in terms of coverage of public funded elderly care services and incentives to the participation of the private sector - is maintained.

In the "Privatization" scenario, the Government gradually privatizes the industry by establishing public private partnerships (PPP) for the development and/or management of elderly services. Moreover, the Government implements other measures to incentive a higher participation by private players. These measures can include: tax benefits to providers or consumers or preferential credit conditions to providers.

In the "Privatization and Expansion" scenario, the Government, besides gradually privatizing elderly care and implementing measures to promote the participation of the private sector, assumes a higher responsibility and increases the coverage of public funded services.

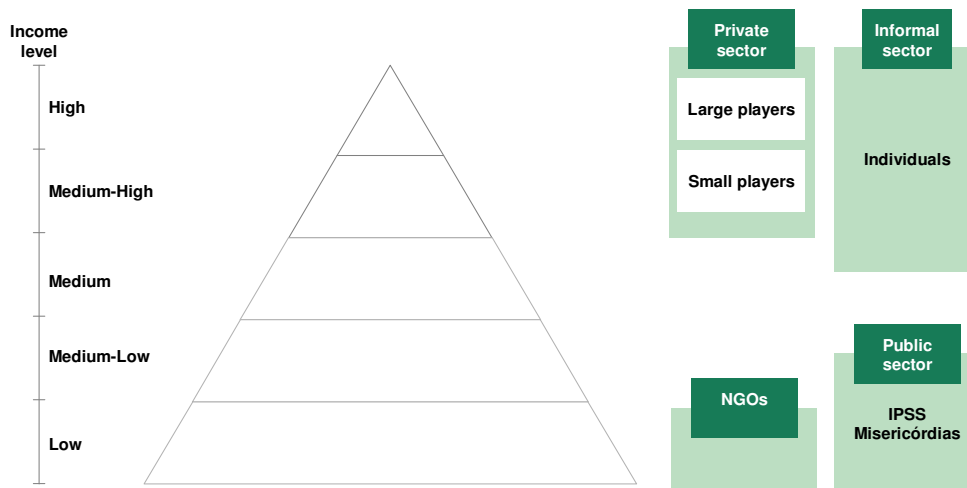
In the "Social Welfare" scenario, the Government assumes a higher responsibility in elderly care and increases the coverage of public funded services. Yet, no new incentives are given to promote the participation of the private sector in elderly care provision.

Role of major actors in the alternative supply evolution scenarios

Major actors - public sector, NGO, private sector and informal sector - will assume different roles in the future depending on the future supply scenario.

In the "Continuity scenario", major actors will maintain their current roles:

- ▶ The public sector will continue to dominate care provision and mainly target low income elderly;
- ▶ NGO will continue to complement the public offer to lower income elderly;
- ▶ The private sector will continue to target mainly higher income elderly;
- ▶ The informal sector will continue to complement the private offer to higher income elderly and be the major provider of medium income elderly.

Figure 80. Target customers of major elderly care providers

Source: BCG analysis.

In the “Privatization” scenario, the private sector (especially large players) will gradually substitute the public sector in the provision of care services to lower income elderly. Thus, the private sector will assume a more important role in detriment of the public sector. In this scenario, private cost-efficient models of elderly care provision are expected to emerge.

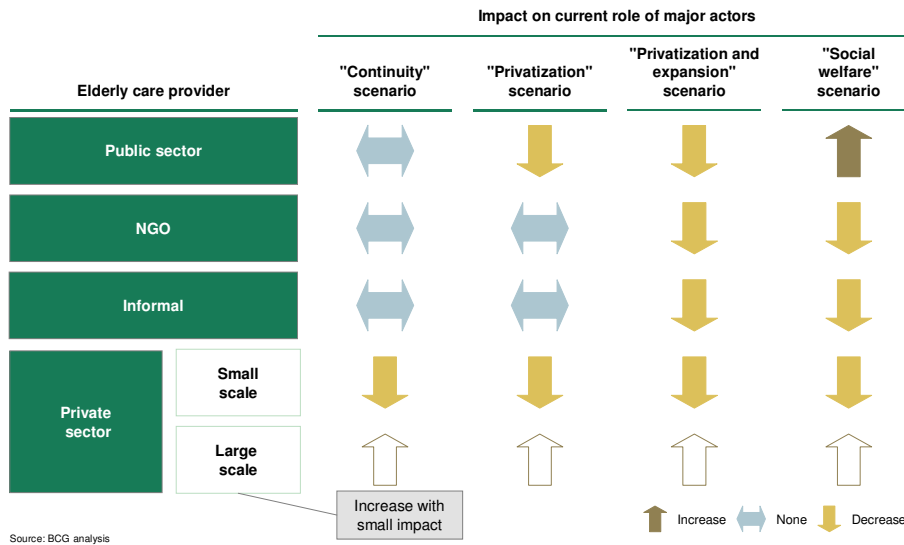
In the “Privatization and Expansion” scenario, the private sector will boom. On one hand, as in the privatization scenario, large private players will substitute the public sector in the provision of low-income elderly. On the other hand, private players will develop services targeted at lower income elderly. In this scenario, the role of the public sector and NGO will decrease. In case the Portuguese Government increases significantly the coverage of elderly care services, the role of the informal sector as a provider of medium income elderly can also be negatively affected.

In the “Social Welfare” scenario, the public sector will further increase its dominance of elderly care provision. In contrast, NGO - who target low-income elderly - will lose weight. In case the Portuguese Government increases significantly the coverage of elderly care services, the role of the informal sector may also be negatively affected.

Additionally, in all scenarios, it is expected that large private players gradually substitute small private players in the provision of services to the medium-high income elderly.

As to the role of families both as providers and as financers, it is only expected to decrease in the scenarios where the Government increases the coverage of public funded services: the “Social Welfare” and the “Privatization and Expansion” scenarios. In these scenarios, families will be able to intervene less in the provision and funding of the care to medium income elderly.

Figure 81. Impact of potential evolution scenarios on the role of major elderly care providers

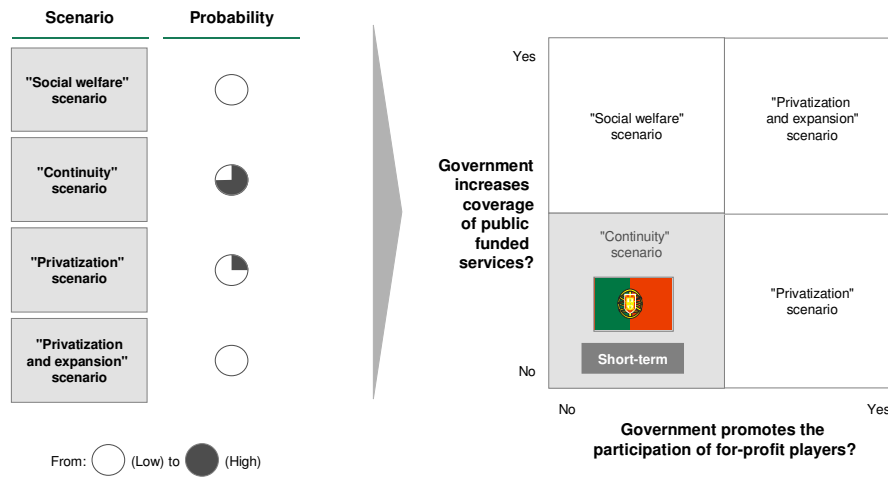


Source: BCG analysis.

Short term evolution of the supply of elderly care services

As the Government is expected neither to increase the coverage of public funded services nor to trigger the privatization of the elderly care industry in the short term, the "Continuity" scenario is the most likely for the near future.

Figure 82. Probability of potential supply evolution scenarios in the short term



The coverage of elderly services is unlikely to increase, in the short term, as:

- ▶ Children care is the priority of the investment in social equipments until 2009;
- ▶ Poverty eradication is the priority of elderly care policies until 2009;
- ▶ Portugal is not the lowest performer in elderly care social equipments coverage;
- ▶ The Government considers that families have a role in elderly care provision and funding.

Until 2009, the public investment in social equipments will focus in childcare. As an illustration, ~70% of the capacity expansion financed by the PARES Programme - the most recent program aimed at financing investments in social equipments - will aim at child care. With PARES, the capacity of childcare equipments will increase by 50% whereas elderly care capacity is only planned to increase by ~10%.

In what concerns elderly, the priority for the next years is the eradication of poverty. Thus, the major social measure targeted at the elderly to be implemented in the next years is the CSI. This measure's purpose is to guarantee a minimum income of 300€ per month to all elders, which will affect ~300,000 people. In the words of Pedro Marques (State Secretary for Social Security): "...governmental measures will guarantee that no elder will be poor in Portugal".

The fact that Portugal is not the lowest performer in EU regarding the coverage of elderly care social equipments will also relieve some of the public pressure to increase the capacity of these equipments. In 2006, that was the case as the coverage of key elderly care services (day centers, residential centers and domiciliary care) was of 11% in Portugal and of ~9% in Spain.

The Government has also been suggesting that families shall not be exempted from their responsibility to provide care (directly or indirectly) to close relatives (especially children to parents). In 2006, during the public presentation of the CSI, the Prime Minister stated that "... this measure, financed by tax revenues, shall not exempt families from their duty to take care of their parents". On top, the Government established that the eligibility to the CSI is determined taking into consideration family solidarity in elders' income.

Thus, the privatization of elderly care in the short term is unlikely once:

- ▶ Non-profit entities continue to be the preferred providers of elderly care services with public funding;
- ▶ The privatization of other care services (namely healthcare) has been advancing slowly;
- ▶ The privatization of public services seems to constitute a higher priority;

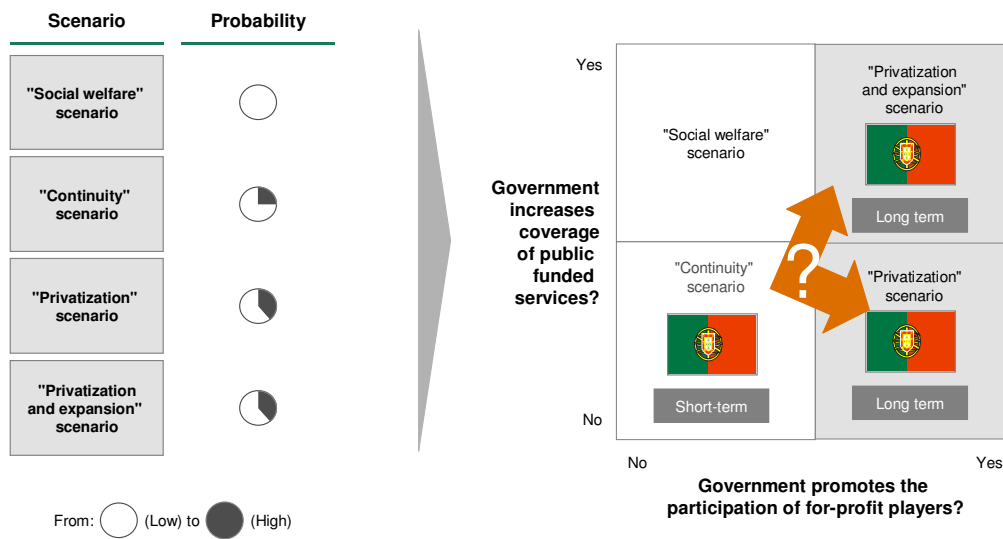
Non-profit entities (namely IPSS) continue to be the preferred providers of elderly care services. As an illustration, in the PARES Programme, less than 5% of the financed capacity expansion is private. This fact has been highlighted by the Prime Minister who stated: "the majority of new places will be created in partnership with IPSS, given the key role that these institutions have had in tackling social problems".

In parallel, the privatization of other care services (namely healthcare) has been advancing slowly. So far, the privatization of healthcare services has only included the private management of Hospital Amadora Sintra and the creation of PPP for the construction of 10 new hospitals. In addition, and although health PPPs were enacted in 2002, the first hospital constructed under a PPP agreement will only open in the beginning of next year. At present, the Government is relying more in the conversion of hospitals in public corporations rather than on privatization to increase the cost efficiency of healthcare services provision. Since the privatization of elderly care will probably be launched after the privatization of healthcare services reaches an advanced stage, it will probably not occur in the near future.

Furthermore, the privatization of public services (like sanitary services) and of companies such as TAP, Inapa and ANA seems to constitute a higher priority of the Government.

Evolution of the supply of elderly care services in the long term

In the long term, Portugal will "migrate" either to the "Privatization" scenario or to the "Privatization and Expansion" scenario.

Figure 83. Probability of potential supply evolution scenarios in the long term

Source: BCG analysis.

In the long term, the increased involvement of private players in elderly care services is likely to occur as:

- ▶ Elderly care have been gradually privatized across European countries;
- ▶ In Portugal, there is increased involvement of private players in some public services (namely health-related services);
- ▶ The Government has recognized the importance of the private sector.

Since the 1990's, countries have been promoting the higher involvement of the private sector in elderly care provision. In several countries, such as UK and Spain, the private sector already controls elderly care provision. Even in "Social Welfare" states, such as Sweden and Finland, Governments have been promoting the participation of the private sector in elderly care provision. As a rule, Government seek higher cost efficiency (e.g. Sweden) or fast expansion (e.g. Spain), when promoting private initiative.

In Portugal, the increased involvement of private players in some public services has also been pursued by the Government. At present, the Government makes use of PPP in several sectors namely in health services, roads and transports to attain higher operational efficiency. Thus, it is expected that privatization of elderly care services will be promoted in the future.

Only recently has the Government publicly recognized the importance of the private sector. In the presentation of the PARES Programme, the Prime-Minister has stated that "the private network is essential".

In what concerns the increase in the coverage of elderly care services, the answer is not that clear. In the long term, the social security budget will be under pressure not only because the size of the retired population segment - the social security recipients - will increase but also because the size of the active population segment - the social security contributors - will decrease. This pressure may compromise the expansion of the coverage of elderly care services. In addition, the direction of social policies in Portugal (as well as in many European countries) has not been towards becoming a "social welfare" state. Indeed, in several sectors such as healthcare and education, the trend has been to increase the responsibility of the civil society in the funding of the services.

Yet, one major factor can encourage the expansion of public funded elderly care services capacity: the increase of the weight of the elderly in the voters group (from 22% in 2005 to ~30% in 2030). This fact together with the possibility to enlarge the coverage of public funded elderly care services with a relatively low investment, can dictate the migration of Portugal to the “Privatization and Expansion” scenario. As an illustration, to increase the coverage of domiciliary care to 10%, an investment of only ~70€ million and annual additional costs of 370€ million in real terms (~0.2%) would be required.

To sum up

The private sector, NGO and the informal sector are not expected to drive the evolution of care supply.

- ▶ The private sector will probably not expand the services targeted at higher income elderly nor develop services for lower income segments due to the high investment and operational costs of the industry;
- ▶ NGO will continue to have a minor role in the elderly care industry as NGOs already operating in Portugal have not announced capacity expansions and the entry of new NGO is not projected;
- ▶ The informal sector has historically developed in response to imbalances between demand and supply.

The evolution of elderly care supply will be determined by the direction of public policy on two aspects:

- ▶ The coverage of public funded services and the promotion of the participation of the private sector;
- ▶ Forming four evolutions scenarios: 1) the “continuity” scenario; 2) the “social welfare” scenario; 3) the “privatization” scenario and 4) the “privatization and expansion” scenario.

In the short term, the “continuity” scenario is the most likely:

- ▶ The increase in the coverage of elderly care services is improbable:
 - Investment in childcare social equipments the is priority for the next years;
 - Poverty eradication is the elderly policy priority for the next years;
 - Current Government considers that the family has an obligation to support elderly care.
- ▶ The privatization of the industry is improbable:
 - The government continues to rely on IPSS to expand its elderly care services capacity;
 - The privatization of other care services (namely healthcare) is advancing slowly;
 - The privatization of other industries (e.g. sanitary services) seems a higher priority.

In the long term, the “privatization” or the “privatization and expansion” scenario are the most likely:

- ▶ Following the European trend of elderly care and the Portuguese trend of in some other public services, the involvement of private players in elderly care services should increase;
- ▶ An increase in the coverage of public elderly care can occur as the weight of elders in voters increase and since it does not imply a too high investment or on going cost (namely if in the form of domiciliary care), yet the social security budget will be under pressure in the upcoming years and, in most recent policies, Portugal has not been moving continuously towards becoming a more “social welfare state” in the traditional Northern European fashion.

3. Summary

- ▶ The articulation of the factors: demographic structure ageing, changes in the family structures, cultural transformations and economic growth, sustain the tendency for the demand for paid care services for the elderly;
- ▶ In qualitative terms and, as the level of education and income of elderly population rises, the demand for elderly care services with higher quality is bound to increase;
- ▶ The private sector, NGOs and the informal sector are not expected to be important drivers of the future evolution of elderly care supply;
- ▶ The informal sector has developed in response to imbalances between demand and supply.

PART II

DRAWING FROM GOOD PRACTICES

MODULE 4

LITERATURE REVIEW OF RELEVANT INTERNATIONAL SUCCESSFUL CASE STUDIES

Developing services for older people: opportunities for commercial and social enterprise

In OECD countries today, there is substantial State intervention in welfare, through legislation, regulation, expenditure on provision and training, through the ownership and management of welfare services' infrastructure and organizations, but most pervasively through public funding. There is also in affluent countries substantial expenditure to improve personal wellbeing from personal income and savings, not just on direct care but also on an expanding range of therapeutic products and services. This module describes the processes of service innovation and development, and particularly the complementary roles of public sector, for-profit companies and non-profit organizations.

This Module concentrates on six types of services for older people that have become widespread in OECD countries only recently and which it may be timely to introduce or expand in Portugal. They include a particular form of health-care delivery, comprehensive geriatric assessment and monitoring in the community, specialized and supportive housing, and innovative approaches to dementia care.

1. Selected service needs and priorities

Each of the following sections will first describe the need for the service, its functions and roles, and then review the ways in which the service is characteristically developed and provided. In particular, the accounts will focus on the processes of needs identification and service innovation. Each section will conclude with broad suggestions about actions that may be appropriate in Portugal today. They are suggestions for local debate and decisions.

1.1. Older people's needs and preferences for assistance with daily living

The needs for care, personal services, support and reassurance

The prevalence of disabling conditions rises exponentially with age after around 70-years-of-age. The combined effect is that, on average, increasing age through old age is associated with reduced personal capacities and functioning. A standard terminology has become established in clinical medicine and nursing for assessing people's loss of functioning or "dependency" on others to carry out basic tasks. Many scales to assess functioning are in routine clinical use (Fillenbaum, 1995).

The Katz index of independence in the *Activities of Daily Living* (ADLs) is the most widely used scale to assess functional status as a measurement of the client's ability to perform activities of daily living independently (Katz *et al.*, 1970; Katz 1983). The index ranks adequacy of performance in the six functions of bathing, dressing, toileting, transferring (getting in and out of bed), continence, and feeding. Clients are scored "yes" (1) or "no" (0) for independence in each of the six functions. A score of "6" indicates full function, "4" indicates moderate impairment, and "2" or less indicates severe functional impairment. Although the Katz index is sensitive to changes in declining health status, it is limited in its ability to measure small increments of change seen in the rehabilitation of older adults. Another well-established tool is the Barthel index, and more sophisticated scales have been developed by Lawton and Brody (1969).

Only a small minority of the general elderly population have limitations in any of the six ADLs, but a large percentage of the residents of nursing homes have scores of “4” or less (Krešević and Mezey 2003). On the other hand, a large proportion of older people, and a majority aged more than 75 years, have limitations in the *Instrumental Activities of Daily Living* (IADLs). These are the everyday activities that enable an individual to live independently within a community. They are: light housework, preparing meals, taking medication, shopping for groceries or clothes, using the telephone, and managing money. There are many different scales for limitations in IADLs. Some incorporate measures of morale or mental states, and some are influenced by cultural specifics, *e.g.* the ability to drive a car. In the United States, for example, occupational therapists have identified 11 activities that are important capacities in contemporary American society (American Occupational Therapy Association, 2002):

- ▶ Care of others (including selecting and supervising care-givers);
- ▶ Care of pets;
- ▶ Child rearing;
- ▶ Communication device use;
- ▶ Community mobility;
- ▶ Financial management;
- ▶ Health management and maintenance;
- ▶ Meal preparation and cleanup;
- ▶ Safety procedures and emergency responses;
- ▶ Shopping.

Not only do a large proportion of people in advanced old age have compromised functioning and need assistance with IADLs, even more are concerned that they will become dependent on others in these ways. This means that apart from their heavy requirements for health care, they also need several types of support and personal services, such as:

- ▶ Aids, home adaptations and assistive technologies;
- ▶ Help at home and with domestic tasks, as with house cleaning, laundry, gardens, preparing meals, and grocery shopping - otherwise known as domiciliary help or services;
- ▶ Assisted living accommodation; that is specialist housing with on-site provision of property and personal services, including building and grounds maintenance, security surveillance, emergency alert and rescues services, and personal care.

Increasingly in North America and Australia, the collective term “Assisted Living” is applied to those products and services that enable people with compromised functions to continue to live independently (and avoid admission to a care home or nursing home), from housing schemes that also provide care to the latest telehealth devices. Further comments are made about “*assistive technologies*” and “*assisted-living housing*”.

Service development: from aids to assistive technologies

The concept of “aids and adaptations” is well established in medicine and social care and covers a great variety of products and systems, from the walking stick to surgical prosthetics, such as artificial hips. The concept has been revolutionized in recent years, with the arrival of many new telehealth systems (that remotely monitor physiological states) and “life style monitoring” devices, such as bed

occupancy and falls sensors. A summary profile of recent changes in the provision of aids, adaptations and assistive technologies (*Table 109*).

Table 109. Service profile: aids, adaptations and assistive technologies

Characteristic innovators	Until recently, much innovation has been firmly located within the professional interests of occupational therapists and medical physics. Early developments concentrated on “prosthetics” such as artificial limbs for the seriously disabled. The information technology revolution of recent years has greatly expanded the range of applications, as with powered wheelchairs, and new systems of their control for the limbless. Today, innovators are as likely to be the information sciences and electronic engineering as in medical specialties.
Observed recent responses	<p>A. Worldwide development of “telecare” emergency alarm systems that provide advice, reassurance and emergency response services to vulnerable people, particularly those living alone with mobility problems;</p> <p>B. Creation of new consumer markets, as for mobility scooters, stair lifts and specialist bathing equipment, <i>e.g.</i> personal hoists;</p> <p>C. Government and health-care provider interest in new assisted living housing using the latest assistive technologies, as for people with chronic, severely disabling conditions including mild dementia, that will provide safe independent living environments, and avoid or delay the need to move into institutionalized housing. New technologies are being promoted by consortia of equipment manufacturers and suppliers, health care providers, specialist housing providers, non-profit advocacy organizations, and public funding.</p>
Long-term solutions	Many new assistive technologies are at an early stage of development and of uncertain reliability and cost effectiveness. The respective contributions of financing from public, philanthropic and private sources is as yet unclear. Some services are however of proven value, such as telecare.

The new technologies are variously described as telecare, telehealth and telemedicine. The meanings are not yet stabilized, but the UK Department of Health’s definitions are reproduced in *Table 110*. The applications extend beyond conventional treatment or health care procedures, however, and “care” itself means different things in general medicine, psychiatry and social work.

Table 110. Definitions of telecare and telemedicine**Telecare:**

Care provided at a distance using ICT. It is the continuous, automatic and remote monitoring of real time emergencies and lifestyle changes over time in order to manage the risks associated with independent living. In simple terms, telecare includes detectors or monitors (for example, motion or fall detectors) attached to community alarm systems that trigger a warning at a control centre that can be responded to within defined timescales. There are likely to be further types of equipment available in the future with increasing availability of mobile and wireless technology. Some people talk about different generations of technology - this includes:

First generation - handsets and pendants;

Second generation - home monitors;

Third generation - mobile and wireless technology.

Telemedicine:

The remote exchange of physiological data between a patient at home and hospital medical staff to assist in diagnosis and monitoring (*e.g.* support for people with lung function problems, diabetes etc). It includes (amongst other things) a home unit to measure and monitor temperature, blood pressure and other vital signs for clinical review at a remote location (for example, a hospital site) using phone lines or wireless technology.

Source: Curry *et al.*, 2003.

Assistive technologies are being actively promoted by many OECD national Governments. It is widely believed that they can simultaneously promote health and wellbeing, retard the increase in healthcare costs, and will have employment and economic stimulation effects. As the Australian Commonwealth (federal) Government's annual welfare review of December 2007 argued, "social and environmental supports can reduce disability and therefore play a critical role in improving quality of life and perceived quality of life. Supports act in two ways: by increasing individual capability or by reducing environmental demands" (Verbrugge and Jette, 1994).

The role of environmental modifications and assistive technology is clear, especially given the numbers of older people in the community who experience mobility and self-care limitations. Well-designed home environments and access to aids and equipment help to reduce environmental demands, in turn reducing a person's reliance on others for assistance. This has obvious benefits for the person with disability, and their families and other providers of assistance (Australia Institute of Health and Welfare, 2007).

The assistive technology service that has been adopted most widely is telecare. The basic system is a device worn as a pendant around the neck with a button for "emergency" use. When the button is pressed, instant telephone contact is made with a communication centre, where trained operators (some with nursing or related qualifications) immediately see on a computer screen the caller's personal details and a summary of their health conditions, and the telephone numbers of their carer(s), closest relative(s) and doctor(s). The call-centre adviser establishes what the problem is, assesses the situation and, as appropriate, gives advice, summons a relative or doctor, or calls an ambulance or another emergency service. Telecare services are widely appreciated by the users and are relatively low cost. Although many calls are not in medical emergencies, but are to seek advice or reassurance, few users grossly abuse the service.

In many countries, telecare services are not available freely to private subscribers, but instead are provided following an assessment by a public-sector health or social-care agency and allocated to clients as part of a package of "care and support". Commonly there are nominal rental charges, but the call centre operation is subsidized. The equipment is provided by for-profit companies, and some suppliers

also operate the call centers through commercial contracts. The supply of telecare services is now big business. The leading UK company, the Tunstall Group, claims 1,5 million customers (actually “end users”) in more than 20 countries, although most of its revenue is obtained through contracts with provider agencies. In March 2008, it was purchased by a group of venture capital investors, Charterhouse, for £514 million, approximately 2.5 the price the owners paid for the business in June 2005 (*The Financial Times*, London, March 8th 2008).

In the United Kingdom, it is estimated that around 1,4 million people have a telecare device (equivalent to approximately one-in-six of the older population, although not all users are old). Central Government is actively promoting the expansion of these services and further developments of the technology. In April 2006, the Department for Health for England (DH) announced the *Preventive Technology Grant Programme* with £80 million to fund the extension of telecare services to an additional 160,000 clients. The DH has established the *Care Services Improvement Partnership* to promote better quality services, and has published advice documents on *Building telecare in England* and these include business models (see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4115303).

In November 2007, the Economic and Social Research Council, together with the Technology Strategy Board (TSB), the Engineering and Physical Sciences Research Council and the National Institute for Health Research (all government agencies) announced their agreement to fund a number of activities in the area of Assisted Living, under the umbrella of the TSB's *Assisted Living Innovation Platform* (ALIP). The purpose of the ALIP is to advance significantly the technology needed to meet the demand for independent living from people suffering from chronic long-term health conditions. Against a backdrop of an ageing population, the Innovation Platform seeks to consider the requirements for improving quality of life, and wellbeing, and also to address the societal challenges raised by health conditions that require a preventative approach (see www.epsrc.ac.uk/CallsForProposals/ATModelling.htm and http://www.technologyprogramme.org.uk/site/IP/ALIP/ALIP_4Page.pdf).

Telecare and Telehealth in Portugal

The technical and service delivery case for telecare in Portugal has been forcefully made by Portuguese researchers (Camarinha-Matos and Afsarmanesh 2004). New telehealth and telecare developments were announced in November 2007. *Aerotel Medical Systems*, one of the world's leading manufacturers of advanced telemedicine and remote monitoring solutions, and T-Care *Conhecimento e Saúde SA*, an emerging telehealth and telecare service provider in Portugal, have signed an agreement to distribute Aerotel's advanced remote monitoring products and related software in Portugal. The agreement with Aerotel enables T-Care to provide its clients with the most advanced range of telemedicine and home care services, including tele-assistance and tele-cardiology. With these innovative solutions, healthcare organizations such as hospitals, private and public healthcare institutions can now offer their patients a simple and efficient means to monitor the state of their health. T-Care has established a modern remote-monitoring call centre in the city of Vila Real, in the North of Portugal with Aerotel's technical assistance (see <http://www.aerotel.com/en/news/press-releases/aerotel-and-t-care-sign-agreement-for-portugal.html>).

This development appears to emphasize applications for patients with serious health conditions. There is considerable scope for broader implementation of telecare systems, with the objectives of extending independent living and reassurance as opposed to the delivery of health care in the strict sense. Many assistive technology systems are promoted by their manufacturers, but as yet the evidence base on efficacy and cost-effectiveness is weak. Health Ministries and major health providers are in great need of independent advice about the merits and potential of different systems.

The Senior Help Line in Ireland

In Italy and Ireland, some of the social, reassurance and wellbeing benefits of telecare systems for vulnerable older people have been achieved at low cost by “help line services”. The *Senior Help Line* in Ireland was established in 1998 by a non-profit organization, the Third Age Foundation in Summerhill, County Meath. It was modelled on an Italian project, *Silver Thread [Filo D’Argento]*. The Irish Government’s North Eastern Health Board provided initial core funding of £10,000 (12,000€), and in addition, £4,000 (5,000€) was contributed each by the Department of Social, Community and Family Affairs and by the Trim Initiative for Development and Enterprise (TIDE).

The initial call centre was staffed by trained volunteers and had three telephone answering stations. The service subsequently developed into a national service, with funding shared among the Regional Health Boards through the Health Boards Executive, including in-kind provision of premises to operate the service. Administration costs have remained low as the service expanded. The national co-ordinator works as a full-time volunteer, and her assistant was until recently employed for only 16 hours per week. The other centers all have voluntary co-ordinators who do not receive any payment for the work that they do co-ordinating various activities. “Today the national service is provided by trained volunteers in 13 centers, providing a day and evening listening service, 365 days a year. Senior Help Line is open each day from 10am-4pm and each evening from 7pm-10pm” (see http://www.seniorhelpline.ie/index.php?option=com_frontpage&Itemid=85).

An evaluation of the service concluded that “The Senior Help Line has made a major contribution to the health and well being of older people in Ireland at relatively low cost. The service is run by older people for older people”, and demonstrates the value of peer-to-peer communication (O’Shea 2006). “The Senior Help Line is a model project in terms of accountability and best practice. It is also a good example of what can be achieved through the vision and leadership of a small number of people”. The project’s website also helpfully sets out the service’s practice principles and the current priorities for further development. These specify more support from State agencies, more inputs from medical professionals, and more training and support for volunteers. Altogether, the information given about the development of the service constitutes a template for its replication in other countries.

It may be that the most efficient way to provide “emergency alert” and an advice, reassurance and social contact service is to combine a formal “social services” supported telecare service with a volunteer, peer-group help line as established in Ireland. This may be feasible in countries where personal social services for older people are not well developed. In these circumstances, there will be few objections from existing staff and agencies, and service planners may welcome collaboration with non-profit agencies to develop a new service. Other suggestions for exploring needs and effective ways of providing telecare services are outlined in *Table 111*.

Recommendations for assistive technologies and help lines

- ▶ An independent review should be commissioned of existing provision of telecare and telehealth services in Portugal and the Department of Health’s development initiatives, especially to evaluate whether they are delivering social and wellbeing benefits for vulnerable older people, particularly those living alone and without informal carers, and also to assess whether investment decisions are unduly influenced by manufacturers and suppliers;
- ▶ Discussions should be held with older people’s organizations to establish their interest in being involved in providing a help line service analogous to that in Ireland;

- ▶ A working group of physicians, social work professionals, representatives of older people's organizations and assistive technology suppliers should be set up to assess whether an integrated telecare and help line service would be feasible and would deliver substantial benefits in Portugal.

1.2. Older people's needs and preferences for accommodation with assistance and personal services

For older people with IADL limitations, the alternative to remaining in their own homes with support from informal carers, paid carers or assistive technology, is to move to more "supportive" accommodation. This is likely to be some form of "congregate" housing, from a small block of four or six apartments to extensive retirement communities with thousands of residents. Such "assisted-living housing" has been very successful in Australia, Canada and the USA. The schemes range from up-market housing that is funded entirely by the occupiers, through non-profit housing managed by religious organizations (such as *United Methodist Homes* in the USA), to "social housing" schemes for disadvantaged and vulnerable groups including older people that is built with substantial public funding of the capital costs (and less frequently continuing public finance support for the revenue account).

Social housing schemes have developed strongly in Northern European countries and in Australia. It is evident that there are substantial and complementary roles for commercial property developers, non-profit organizations and the public sector in the development of assisted-living housing and in assuring quality standards of provision. The range of possible combinations of housing and care is quickly apparent from Internet searches. One site based in California, *Assisted Living On-Line.com* provides a directory of "assisted living and senior communities" across the USA, and offers "user-friendly information about each featured assisted living and senior community". The home page explains that the term senior housing encompasses a vast array of services, lifestyle and living arrangements. It identifies the following main types of assisted housing:

- ▶ **Assisted Living Community:**

Assisted living bridges the gap between living on your own and living in a nursing home. Assistance with daily living activities such as bathing, dressing, eating, housekeeping and transportation is provided. The assistance needed may not require the round-the-clock, skilled health care that a nursing home provides, yet will meet needs that cannot be met in a more independent setting. Choices will vary from single or double rooms to suites and apartments. In some areas of the country, assisted-living residences may be called different names, such as personal care, residential care, or domiciliary care (and) may be part of a retirement community, nursing home or elderly housing facility, or they may stand alone. Whatever the setting, assisted living offers the opportunity for residents to continue living as independently as possible;

- ▶ **Continuing Care Retirement Community (CCRC):**

The CCRC is also known in some regions as a life-care community. Religious organizations, fraternal groups and other non-profit agencies sponsor most CCRC. These communities provide comprehensive residential and health care services. This type of community is different from other housing and care options for older people because it offers a long-term contract that provides for housing, services and nursing care, usually all in one location. The CCRC continues to meet resident's needs in a familiar setting, as they grow older. A CCRC resident can take advantage of a wide variety of activities and services conveniently offered within the community. There are no restrictions on lifestyle;

- ▶ **Independent Senior Living Community:**

Independent Living Communities, often referred to as retirement communities, congregate living or senior apartments, are designed for seniors who are able to live on their own, but desire the security and conveniences of community living. Some Independent Living Communities offer abundant recreational

activities, which may include a swimming pool/spa, exercise facilities, clubhouse/lounge and library/reading lounges. Communities may also provide laundry facilities, linen service, meals or access to meals, local transportation, and planned social activities. Health care is not provided with the normal fees, but many communities will allow residents to pay for a home health aide or nurse to come into their apartment to assist with medicine and personal care;

► Specialized Senior Care Community:

Specialized Care is often related to Alzheimer’s and dementia care and services. For those in early to middle stages of the disease, care can be provided in a residential setting unit, such as an assisted living center or a congregate care community, or may also stand alone. Facilities typically offer personal care assistance and supportive services such as housekeeping and transportation. Centers that specialize in this area are usually purpose-built with Alzheimer and dementia patient in mind.

Other organizations and other countries use different terms and typologies. In all countries, there is immense diversity in the forms of assisted-living housing, from those that provide no more than a porter, concierge, receptionist or warden, who can summon assistance in emergency, to those that provide professional nursing services and even have an on-site clinic capable of minor operations and resuscitation. The main features of provision and the ways in which schemes are instigated and managed are shown in *Table 111*. It will be evident that assisted-living housing schemes target very different groups of older people and that there is no clean break between social/leisure and support/care amenities and services.

At one extreme are schemes oriented towards young, active retirees who are particularly attracted by comfortable and easily maintained housing, social opportunities and leisure facilities - as with many American planned retirement communities and the “spontaneously occurring” retirement settlements on the Portuguese and Spanish coasts. These developments are expressions of the consumer preferences of the latest cohort of older people. Most clients have the benefit of good pensions and reasonable retirement incomes, but are not “rich”. Their “lifestyle choices” create numerous market opportunities in housing development, leisure services and organized travel.

The principal roles of Central and Local Government are to ensure that housing development plans include commensurate investment in essential utilities and services (which reduces the profitability of the schemes and has not always been done assiduously in Spain), and to ensure minimum (but good) standards of construction, maintenance and management.

At the other extreme are assisted-housing schemes for very dependent and very disadvantaged groups of older people, such as group houses for people with dementia (described later in this module). Over the last two decades, many Western European Governments have been increasingly pro-active in expanding the provision of specialized “social housing”. More and more, Governments see no inconsistency between promoting economic growth, the business interest and increasing income inequalities, and at the same time using public funds to improve the living conditions and welfare of the most disadvantaged and needy members of society. It is as though the precept formulated by John Rawls (1971), that increasing inequalities in society are acceptable if they lead to an improvement of the welfare of the most disadvantaged, is now a guiding principle of Social Democratic Government.

Table 111. Service profile: assisted living housing schemes

Specialized Housing For Older People	
Characteristic innovators	<p>A. In the past, religious organizations, socially-responsible employers, professional associations, trades unions, philanthropists and Government agencies;</p> <p>B. Non-profit housing associations (including religious organizations) that build and manage housing for people with special needs, and which draw on long-term investments and philanthropic funds;</p>

Specialized Housing For Older People	
	<p>C. For-profit developers that provide specialist housing and "assisted living" settlements/communities for sale or rent;</p> <p>D. Central Government by providing capital grants for the construction of "social housing" for special needs groups, and Local Government housing agencies that work "on the ground" with social services, health care providers and local charities to identify unmet housing needs, establish priorities and agree development plans.</p>
Observed responses	<p>A. Establishment of special congregate housing schemes with supervision and surveillance, e.g. "almshouses" or retirement housing, as for "deserving" military pensioners and agricultural workers;</p> <p>B. Non-profit housing associations acquire expertise in assessing and responding to local social housing needs, in orchestrating public and charitable funds, in developing appropriate and feasible proposals, in gaining local political support for development proposals, and in managing "housing with care";</p> <p>C. For-profit providers respond to consumer preferences, which locally as in "retirement areas" can be substantial. Attracts many suppliers, leading to the quality, price and range of product advantages of competition. May generate political and philanthropic support, leading to partnership arrangements and public-sector incentives, such as relaxation of planning regulations, part-financing as with low price transfers of public-owned land, and tax concessions;</p> <p>D. Central and Local Government gain expertise in relating development proposals to current and projected local needs. Have an important role in monitoring and imposing ethical business practices and in raising quality standards of both building and service delivery.</p>
Long-term solutions	<p>Development of specialized and assisted housing accepted as a national policy goal, and the respective roles of for-profit, non-profit and State agencies are widely accepted. Most evident in Federal Government systems (e.g. Australia, Canada, Germany, USA) where Local Government and business partnerships determine local priorities and negotiate with Federal Government for State funding support.</p>

The elaboration of Age Care in Australia

A particularly instructive national case study is the development of Age Care services over the last 10 years in Australia. The process began with the *Aged Care Act 1997* and an agreement to develop a *National Strategy for an Ageing Australia*. The 1997 Act provided the main vehicle for structural reforms in residential aged care, while the National Strategy stimulated discussion of the wider context in which aged-care programmes and other services for older people operate. The National Strategy was finalized and published in 2001 (Andrews 2001). There have been many accompanying study reports and commission recommendations (e.g. Costello 2002, 2007). "These initiatives have not only shaped developments in aged care over a decade but have also heralded changes in a wide range of policy areas that are affected by population ageing, and that in turn have shaped the experience of ageing of many older Australians. Some of the major issues or themes that recur in these major policy documents include:

- ▶ Labour force participation and productivity and the need to maintain an adequate labour supply, including for health and aged care;
- ▶ Retirement and the transition to retirement, including ensuring adequate provision for retirement, given longer life spans;
- ▶ Health and care costs, and how to influence the factors that will affect these, such as health and disability status, the supply of informal care, the type and quality of formal care services, and developing sustainable and equitable financing arrangements for such care;
- ▶ Social and community effects, and how to promote positive ageing in terms of health, economic and social participation, as well as access by older people to appropriate services and support including infrastructure, technology and information.

A recently published review of the Programme over the first decade is of considerable interest. "The goal of the Australian aged care service system has been the provision of a cohesive framework of high quality and cost-effective care services for frail older people and their carers". Much of the early progress in implementing the *Aged Care Act 1997* was focused on funding and structural issues in the residential aged-care sector, but during the last two decades there has been increasing emphasis on community-care options that are designed to support people in their own homes for as long as is reasonable. These have been accompanied by the development of respite care and other support services for family carers.

In recent years, there has been a strong and public emphasis on quality of care, the prevention of elder abuse, consumer rights and access to information. The *Office for Aged Care Quality and Compliance* (which replaced the Aged Care Complaints Resolution Scheme in 2006) has established a national centre for the receipt and handling of complaints. Mandatory reporting of incidents of sexual or physical assault has been introduced. Efforts continue to introduce common arrangements for accessing community care programmes and to reduce the system's complexity for clients and providers. The "Securing the Future of Aged Care for Australians" package announced in February 2007 includes six measures to expand and improve the provision of community care, as well as recommendations about financing residential aged care (Australia Institute of Health and Welfare, 2007).

The 2007 review continues, "these developments illustrate the push towards integrating ageing and aged-care issues into broader community concerns, and recognize their connection to policy developments in other areas. For example, the provision of high quality support and care to older people remaining at home poses many challenges." One set of challenges identified by the National Strategy for an Ageing Australia is the role of infrastructure and community support (including housing, transport and communications infrastructure) in enabling older Australians to participate in and remain connected to society. Aged-care service provision continues to be challenged by and to respond to the diversity of consumers needs and preferences. For example, the development of community care options responds to the preferences of older people to remain living in their own homes. However, this does not mean that all older people have been equally well served by the available options. Older people with high and complex needs had limited community care options targeted directly to them until *Extended Aged Care at Home* (EACH) packages were introduced: the creation of EACH Dementia packages in 2006 has now provided a community care option specifically targeted to high care clients with dementia and behavioral and psychological symptoms.

In Australia as elsewhere, the use of "supported accommodation" increases with age. Although in 2003 only around 5% of older people lived in specialized accommodation, about 31 per cent of those aged 85 or more years did so (compared to 1% of those aged 65-74 years, and seven per cent of those aged 75-84 years) (*Table 112*). Accommodation with care mostly consists of, but is not limited to, Australian Government-accredited aged-care homes. On 30 June 2006, 145,175 people aged 65 years or over were permanent residents in these homes, more than half of whom were aged 85 years or older (AIHW, 2007: 85). The total number of recipients of these services is not a high percentage of the Australian older population, but the finely differentiated range of services for those with different levels of need is an appropriate response to the diversity of support needs among older people.

Table 112. Older people living in aged care accommodation, Australia, 2003

Type and Level of Limitations	Age Group (years)			Total	
	65-74	75-84	85+	Number	%
Profound or severe limitation					
Self-care, mobility and communication	8,400	30,200	46,600	85,200	61.5
Self-care and mobility	3,000	11,600	18,700	33,200	24.3
Mobility only	n.º.	n.º.	n.º.	2,400	1.7
Self-care only	n.º.	n.º.	n.º.	4,500	3.2
Communication (with/ without profound/severe self-care/ mobility limitation)	n.º.	n.º.	n.º.	5,200	3.8
<i>Total</i>	12,900	46,100	71,500	130,500	94.2
Moderate/mild core activity limitation	n.º.	n.º.	n.º.	3,900	2.8
No core activity limitation	n.º.	n.º.	n.º.	4,100	3.0
<i>Total</i>	13,600	49,400	75,500	138,500	100.0

Note: n.º. not recorded.

Source: AIHW, 2007. Table 4.3.

Recent developments in the Age Care Programme are summarized in *Table 113*. It is of interest that there have been specific developments to increase the support of frail older people in their own homes (*viz.* community care), to improve dementia care, to improve the effectiveness of rehabilitation after an acute illness, to develop services in rural areas, to extend support to frail older people living in retirement villages or communities, and to support carers through respite care. A notable feature of not only the Age Care Programme but of all major areas of social welfare development in Australia has been the interaction between the Commonwealth (federal) Government and the Governments of the States and Territories. There has been no long tradition of socialist welfare in Australia - indeed the Federal Government was notably unwilling to help the unemployed during the 1930s depression, and its funds were not used to support housing construction until during the Second World War. Nonetheless, for more than two decades it has shown both vigour and creativity in developing welfare services for special needs groups.

In the housing field, the new arrangements began in 1985 with the Supported Accommodation Assistance Programme (SAAP), a single "Sheltered Accommodation Programme" that replaced several disparate federal subsidy programmes. Under this and similar programs, periodic agreements (generally over two to five years) are made between the States and the Commonwealth Governments about the measures and developments that will be supported in part by federal funds. As the SAAP agreements became established, the eligibility criteria for their programmes became increasingly important, for they defined which groups and individuals were entitled to State-subsidized support. The successive revisions and extensions of the Programme are fully documented in the excellent bi-annual *Australian Welfare* reviews produced by the Australian Institute of Health and Welfare (AIHW) and that are available on the web. The periodic negotiation of priorities appears to be an excellent mechanism for identifying service development priorities with inputs from politicians, professionals, provider organizations (business and non-profit) and consumer groups. The record of which services are promoted and funded also provides useful guidance to other countries on service models and perceived needs.

Table 113. Developments in community aged care, Australia 2001-2007

2001	Veterans Home Care began. Commonwealth Carelink Centers established.
2002	Extended Aged Care at Home (EACH) established. A review of community care was announced.
2003	National pilots in community care began: Aged Care Innovative Pool Dementia Pilot, Retirement Villages Care pilot; Innovative Pool Disability Aged Care Pilot.
2004	Release of <i>A New Strategy for Community Care: The Way Forward</i> , an action plan covering five areas to be addressed by Australian Government and State/territory community care officials and cross-jurisdictional working groups. Evaluation of the Innovative Care Rehabilitation Services Pilot was completed (a forerunner to the Transition Care Program). Transition Care Program announced in May 2004 Budget. Transition Care provides goal-oriented, time-limited (up to 12 weeks) and therapy-focused care to help eligible older people complete their recovery after a hospital stay.
2005	Evaluations of the Aged Care Innovative Pool Dementia Pilot and the Retirement Villages Care Pilot were completed (findings published in 2006). Funding of \$320.6 million over five years was allocated to the Dementia Initiative in the 2005 Budget, which included the announcement of an EACH Dementia Program (further information can be found at < http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-dementia >). Transition Care Program began operations.
2006	Announcement of \$30 million of funding for the development of common administrative arrangements and data improvements in HACC. Announcement of a review of subsidies and services in Australian Government-funded community aged care programs. EACH Dementia Program became operational. A national evaluation of the Transition Care Program began. The 2006 Budget included new funding for community care services: \$19.4 million over four years for a supplement to providers of Community Aged Care Package (CACP), EACH and EACH Dementia packages in rural and remote areas, in recognition of the higher costs in these areas for goods and services and the difficulties in attracting and training staff. \$24.2 million over 4 years to improve access to community care for people living in retirement villages. This initiative followed the Retirement Villages Care Pilot which trialed the delivery of community care to people living in retirement villages (AIHW: Hales <i>et al.</i> , 2006b).
2007	More and Better Community Care , part of the Securing the Future of Aged Care for Australians package announced on 11 February 2007, provides for more community care packages (\$298.6 million); support for workforce development (\$32.1 million); improved quality assurance (\$26.8 million); more community respite care (\$26.5 million); support for assistive technology (\$21.4 million); and additional support for Assistance for Care and Housing for the Aged (\$5.7 million).

Notes: Completely new programmes are highlighted in bold. Source: AIHW, 2007, Box 3.3, p. 107.

Government financing of special needs housing

Several countries have established a Government agency to channel public funds into social housing investment. In the United Kingdom, *The Housing Corporation* was established in 1964. It is primarily responsible for managing the Central Government housing budget, and has been most actively engaged with non-profit housing associations. Over four decades, it has presided over a radical change in the nature of British "social housing", from a heavy predominance of "council housing" managed by local authorities, to a more diverse stock with considerable special needs housing managed by housing associations. In Canada, the *Canada Mortgage and Housing Corporation* (CMHC) was established in 1994 and has a wider range of housing policy and regulation functions. Until recently, it has had a modest role in promoting special needs housing for housing people, but in 2005 announced a program of support for the construction of small (garden) dwellings on the plots of large properties. In the USA, the *Department for Housing and Urban Development* (contrary to the country's stereotype) has been more active than the CMHC in supporting the development of specialized housing for older people, particularly in rural areas and for disadvantaged groups.

Periodic appraisals and priority-setting procedures for the allocation of public funds can be established in any country. In 2001 the UK Government announced *Supporting People*, a new consolidated grant to replace the various funding streams of housing-related care and support. The main aim of *Supporting People* is to provide service users with help tailored to their individual needs. It ended the link between support and housing tenure. The previous system was biased towards supported (staffed) housing, hostels and local authority accommodation, but under the new arrangements, more support is being directed towards services to enable people to remain in their own homes, such as visiting support, and a greater proportion of the budget is allocated to the independent housing associations. *Supporting People* has more limited “consensus forming” aims than the welfare contracts between the Commonwealth and State governments in Australia. The periodic negotiations are exclusively between the Central Government Housing Ministry and Local Authorities, which may approve and put forward housing association schemes.

The first year of *Supporting People* bids also demonstrated that priority setting and funding allocations need careful management. By mid-2003, it was apparent that local authorities had responded to the new funding arrangements in unanticipated ways, and that total expenditure would be far greater than first estimated. Independent financial consultants RSM Robson Rhodes reported that the expenditure, at £1.8 billion, was twice what the Government originally estimated, that the price of individual schemes for the same kind of service varied wildly, and despite taking five years to implement the Programme the funds were still not being allocated according to need. It is also paying for care services it was never intended to fund (Sullivan, 2004). In August 2004, the Government announced that the Supporting People Programme budget was to be cut by £80m (down to £1.72 bn) in 2005-06 and that for each of the following two years, the budget would remain at about £1.7 bn.

Three suggestions for appraising the feasibility of increasing the supply of assisted housing schemes in Portugal are outlined in *Table 114*. Two themes run through the suggestions. The first is to promote collaboration between and the complementary contributions of private-sector developers and the State agencies that provide health and social care services to older people. The aim is to combat a phenomenon that is widespread in retirement communities in North America, Australia and Iberia. There is a tendency for the developments to be poorly served by primary care medical facilities and even more by personal social services, especially if the population has a high foreign-born component. As the average age of the residents of a scheme increases, the result will be an increase in unmet care and support needs. That in turn will unnecessarily compel a proportion of the residents to move to a more supported setting. It may also result in some increase of cases of serious distress and illness, and eventually raise the load on the State-funded health and social services, particularly in emergencies.

Recommendations for assisted-housing schemes for older people with special needs

- ▶ A consultation exercise should be mounted to determine which groups of older people have the most severe unmet support and personal care needs. Professional associations, non-profit older people’s advocacy organizations, and care providers should be brought together to develop the case to Central Government for new programmes of specialized housing with support and care for those with the greatest needs and disadvantages;
- ▶ Central and Local Government should review the partnership arrangements between private sector developers of assisted and special housing schemes for older people, and appraise whether the arrangements for providing access to State-supported welfare services are satisfactory. In particular, an evaluation should be commissioned of the accessibility of personal social care services to the residents of planned and spontaneously occurring retirement communities;
- ▶ A system of periodic review and negotiation of housing-related welfare priorities should be established between Central Government and Local Governments, consumers’ associations and non-profit welfare organizations.

1.3. The need of older people with multiple chronic conditions for frequent comprehensive assessment and intensive management of their conditions

So far in this Module, we have considered the support and care needs of the relatively large fraction of people aged in their seventies and above who have some (or mild) limitations in their capacity to undertake the instrumental activities of daily living. We now turn to the more intensive support needs of the much smaller number of people, most of them in advanced old age, who have multiple disabling conditions and more severe limitations in both the instrumental and the physical ADLs. Many diseases and disorders of the heart, circulatory system, lungs, kidneys, bones and joints, digestive system, endocrine system, and the nervous system and of the brain are progressive and seriously disabling. The discomfort, pain and disabling symptoms of many chronic disorders, however, can be relieved by careful management, which very commonly involves medications. The decreased vigour of advanced age and diseases and disorders damage the body's homeostasis (or equilibrium) capacity. The problems are compounded when a patient has multiple conditions because the medicines prescribed for the two (or more) disorders can interact in unexpected and person-specific ways.

The need for comprehensive assessment and the intensive management of conditions

To summaries, a patient with chronic conditions is intrinsically unstable and their conditions and the treatment plan needs frequent reviews and adjustments. In a perfect world, the family doctor (or primary care physician or general practitioner) would undertake this role, but in practice this is rarely achieved. The reasons lie partly with patients and partly with the organization of primary care services. Most patients do not visit their doctors except when their condition has seriously deteriorated. They will put up with "bad days" and with pain and discomfort in the hope that their condition will improve. Family physicians are under great pressure to see many patients, especially perhaps in public health care systems. In the United Kingdom, the average duration of a primary care consultation is around eight minutes, much too short to carry out a comprehensive assessment of a patient with multiple conditions. The key features of the innovative ways in which the needs of this small minority of older people with severe chronic conditions for more intensive monitoring of their conditions are being met are set out in

Table 114.

Table 114. Service profile: the provision of comprehensive assessments and the intensive management of multiple chronic conditions by nurse-led intermediate care schemes

Characteristic innovators	<p>A. Private health-care costs insurers and health care management organizations, concerned both to control the high treatment costs of individual "high risk" patients and to improve their care;</p> <p>B. State-funded health care agencies, particular those responsible for hospital charges, concerned to reduce the frequency and duration of hospital patients among high-risk older patients;</p> <p>C. Nurses and their professional bodies, keen to upgrade the profession's skills and responsibilities in the health care system.</p>
Observed responses	<p>A. Establishment of multi-disciplinary specially trained teams to deliver comprehensive assessments, treatment reviews and plans to a selected group of high risk patients. Most examples to date have been pilots and of fixed duration;</p> <p>B. Positive reports from patients and the practitioners involved, and clear evidence that the teams identify unmet needs and untreated conditions, with the general effect of improving the care of their patients;</p> <p>C. Disappointment on the part of health-care managers and funders that there is not clearer evidence that such schemes reduce hospital admissions. This is partly because of the success of the schemes in "case finding" and in putting patients with untreated conditions in touch with the appropriate clinicians and providers.</p>
Long-term solutions	<p>Further trials are needed to establish more precisely which groups of patients derive most benefit from intermediate care teams, and what configuration of patient inclusion criteria and staffing lead to the greatest returns on expenditure.</p>

Many health care systems employ different kinds of support staff to meet the recurrent care and treatment needs of older patients with chronic conditions. Specialist teams of nurses are trained in specific assessment, rehabilitation and maintenance procedures, such as giving injections, taking blood samples and changing dressings (as for leg ulcers arising from poor circulation). Such nurses may work in the primary care clinic, in specialist clinics as for chiropody, or make home visits. The occupational therapists and speech therapists that work in rehabilitation teams and specialize in helping the patient recover functions after an operation or a stroke attend to work in hospital outpatient departments. These specialist and community teams of nurses and therapists provide enormous health benefits but have limitations for patients with multiple conditions. The staff is knowledgeable about the symptoms and treatments for particular conditions, but do not have the range of diagnostic skills or medical knowledge of a doctor. In extreme cases, the patient receives multiple visits at home and also has numerous clinic appointments each month. The clinics are likely to be in different locations and some may be difficult to reach by public transport. For those patients who are socially isolated and have no one to help them with transport, keeping the appointments can be arduous and impossible without a taxi or ambulance.

Recognizing the limitations of the condition-specific organization of community nursing services, there have been several approaches to providing more appropriately organized and better care. The first protocol for “comprehensive geriatric assessment” (CGA) was developed in the 1930s, since when many have been developed and thoroughly tested. A meta-analysis of the controlled trials performed up to 1993 provided strong confirmation that these programmes improve survival, decrease the use of institutional services, and improve levels of both mental and physical functioning (Stuck *et al.*, 1993; Rubenstein 1995). CGA became the cornerstone of geriatric medicine, and led to its establishment alongside the organ- and condition-based specialties in hospitals in most OECD countries.

One problem, however, is that geriatric medicine departments bring patients with multiple disorders into acute hospitals. Their assessment and rehabilitation is protracted, generating exceptionally long hospital stays. To both health economists, whose evaluations of the benefits of medical procedures are informed by estimates of “Quality Adjusted Life Years” (QUALYS), which are not high for very old patients with multiple disorders that cannot be cured (Loomes and McKenzie, 1989; Joiner, 1999), and to hospital managers, working to targets for the number of patients of treated, geriatric medicine is increasingly thought to be inappropriate in acute hospitals.

Intermediate care schemes

It is in this context that both private-sector health providers (health-care insurers and health management organizations in the USA) and State-managed national health systems have for two decades shown increasing interest in “intermediate care schemes”. These are nurse-led multidisciplinary teams of clinicians and social care staff that focus on “high-risk” patients and on particular objectives (here “risk” refers not only to survival, but also to becoming a long-term hospital patient.) The team members generally include various specialist nurses, therapists and a social worker. In the United Kingdom, medical responsibility usually remains with the patient’s general practitioner. Some intermediate care schemes focus on reducing “delayed discharges” from hospitals following an acute episode. This is most likely for very frail older people who live alone and do not have an informal carer that can provide the frequent personal care and reassurance that they need. Others known as *hospital avoidance schemes* or *rapid response teams* respond to an alert of a serious problem from a high-risk patient. Their objective is to stabilize the patient at home and to prevent a hospital presentation. There have been many evaluations of these schemes (*e.g.* Blue *et al.*, 2001; Hébert *et al.*, 2001; Leveille *et al.*, 1998).

The Evercare model of intermediate care in the UK

A third type of specialized community health service that originated in the USA has the more general objective of improving the management of multiple conditions among very frail older people, and thereby to reduce emergency presentations (Kane *et al.*, 2003). They have been instigated by commercial health-care providers that offer their services to Health Management Organizations backed by the claim that they reduce overall treatment costs. One such scheme, *Evercare*, has been tried in the United Kingdom and thoroughly evaluated. The Evercare model combines elements of nurse-led assessment and intensive case management. Its distinctive features are:

- ▶ An evidence based approach to identifying high-risk patients;
- ▶ Changed staff roles through a new role of Advanced Practice Nurse (APN) with extended generalist skills;
- ▶ The organization of the care around the patient's needs rather than current organizational boundaries, with prompt responses to any deterioration, and the delivery of preventive advice.

An evaluation was carried out by the National Primary Care Research and Development Centre at the University of Manchester between 2003 and 2005 (Boaden *et al.*, 2006). It was strongly supported by *United Health Europe*, the promoters of Evercare. The patient selection (recruitment) process identified some patients who were not in regular contact with primary care or community services but that would benefit from case management. Interviews were carried out with 46 nurses, 10 GPs, 72 patients, 52 carers and 46 managers/others, and Hospital Episode Statistics were analyzed on rates of emergency admission, emergency bed days, and mortality between April 2001 and March 2005. Changes in these outcome measures for 62 Evercare practices (or sites) were compared with the comparable measures for nearly 7,000 non-Evercare primary-care practices.

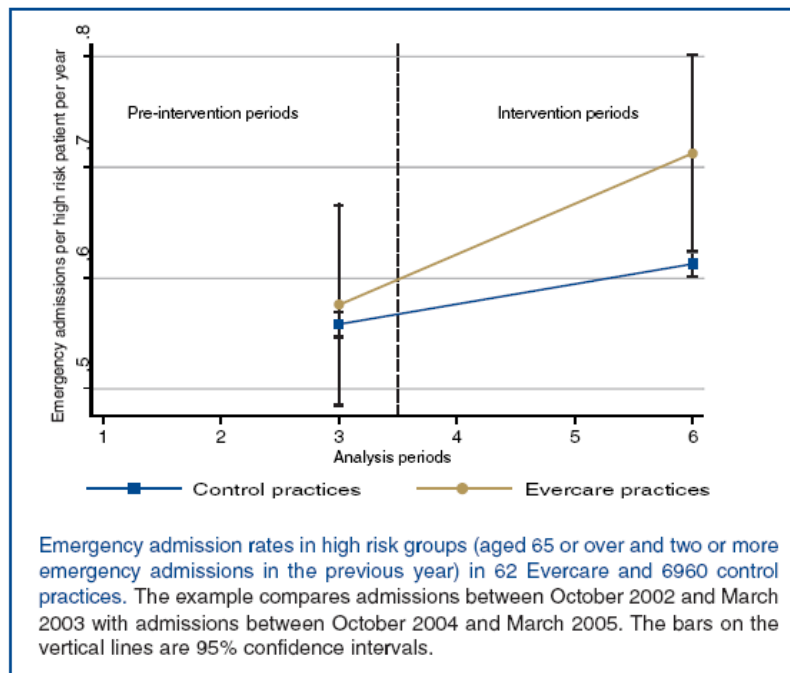
Among the findings, the APN reported many cases in which they had altered medication to avoid adverse reactions, co-ordinated care to reduce fragmentation among services, improved patients' functional status, improved quality of life, and avoided hospital admissions. As the APN' knowledge of locally available services increased over time, they referred their patients to an increasing range of resources for support; and as they became more experienced, GPs spent less time visiting patients and liaising with other services. The nurses were able to provide more patient care themselves. The patients were all very satisfied with the service and mostly said they preferred the changed patterns of service delivery to previous arrangements. Carers were generally even more positive than patients. Patients and carers particularly valued:

- ▶ The psychological support which APNs brought;
- ▶ Their ability to respond rapidly in crises;
- ▶ Their ability to monitor medications and organize prescriptions;
- ▶ Their ability to explain long-term conditions, clinical investigations and treatments;
- ▶ Their advocacy for the patient including the ability to acquire aids and appliances to use at home.

The analysis of hospital admission data showed that there was no significant effect of Evercare on rates of emergency admission, emergency bed days, or mortality. This was so both for a high risk group (aged 65+ years with two or more emergency admissions in the previous year) and for the general 65+ years population. The result was not altered by using different methods of analysis, by adjusting for mortality, or by allowing for differences in length of exposure of individual patients to Evercare (*Figure 84*). The figure shows that admission rates in both Evercare and control groups increased during the study period, but with no significant difference between Evercare and control practices.

There was a contradiction between the findings of the qualitative research in which nurses and patients gave examples of avoided admissions, and the quantitative analysis, which found no overall reduction. This may be partly explained by the additional case finding which resulted from Evercare's intervention. One explanation is that when a very old population is studied, as time passes it is highly likely that the frequency of their hospital admissions increases. Moreover, when very "high risk" patients are compared with general elderly patient populations, it is inevitable that the former have higher admission rates.

Figure 84. The impact of the Evercare intermediate care scheme on hospital admissions



Source: Boaden *et al.*, 2006, unpaginated.

Among the subsidiary findings, the APN had difficulty in being involved when their patients were admitted to hospital, and did not think they did much to influence length of stay. There were also problems with out-of-hours care (when APNs were not available). Primary care out-of-hours services did not appear to keep patients out of hospital. The evaluation team concluded:

- ▶ Evercare provided working examples of a model of case management. United Health Europe's energetic management style along with the high political profile of the pilots helped case management to be introduced rapidly;
- ▶ Access to case management added a frequency of contact, regular monitoring and knowledge of a range of referral options that had not recently been provided by GPs or anyone else;
- ▶ Having GPs as mentors for APN led to the development of effective relationships between GP practices and nurses. However mentoring by consultant geriatricians was even more highly valued by nurses;
- ▶ Case management can be provided in a range of different ways which should be explored in the NHS, including different methods of identifying high-risk patients and different professionals who might act as case managers (e.g. social workers have also been used in this role);

- ▶ The Primary Care Trusts had poor information systems, which meant that they were not able to monitor case managed patients as a group. This made planning and development of the service difficult.

Their overall assessment was that the Evercare pilot projects provided support for a policy of promoting preventive primary care for vulnerable older people at risk of unplanned hospital admissions and other deteriorations in health. The project has provided a stimulus to the development of new models of care and reappraisal of some existing aspects of primary care practice. Because of the modest anticipated impact of case management on hospital admissions, new developments, including the new NHS policy on Supporting People with Long Term Conditions, should recognize that there might be benefits of case management *apart from* reducing admissions.

Relevance to Portugal

In neither the USA, where a high proportion of health care is delivered from hospitals and by specialist physicians operating from scattered clinics, nor the United Kingdom, where primary care and community health services are well developed, has the health care system provided a good quality of treatment and care to older people with multiple chronic conditions. Evidence to date suggests that intermediate care schemes can play a very useful role in meeting this group of patients' needs, although it is still uncertain whether they reduce demands on other elements of the health care system. It may be the case that in Portugal, and in other Southern European countries where community health services are in their infancy, and the average distance from patients to hospitals and clinics is high, that these schemes will be particularly valuable. Further thoughts on this suggestion are set out in **Table 115**.

Many health care innovations are generated within the system, by either clinicians or health care policy makers, but external scientific and technological advances also engender change. The unique organization of care delivery in an intermediate care scheme is increasingly described in the English-speaking world as a "health care technology". Where there is evidence that a new "delivery technology" delivers benefits, forward thinking clinicians and policy makers will be interested in evaluating the case for adopting the innovation. It is accepted that all practice innovations in health care are controversial and resisted, particularly when the perception is that the innovation threatens jobs or professional prestige. These may be the circumstances in which a disinterested, independent outside agency could play a valuable role in encouraging a major innovation in a country's health care provision.

Recommendations for intermediate care for older people with multiple chronic conditions

- ▶ One of the most disadvantaged groups of older people are those with multiple chronic conditions. Their conditions require close monitoring and frequent assessment and their treatments require frequent adjustment. In recent decades, many such people have been admitted to nursing homes, but if health care is organized differently, a proportion could receive better treatment, enjoy a higher quality of life, and be less likely to present in emergencies to family doctor services or hospitals;
- ▶ There have been interesting experiments in recent years with "intermediate care schemes", with generally positive results, particularly with respect to "case finding", identifying unmet needs, and improving the quality of care. Such schemes may be particularly helpful in countries and local settings with relatively undeveloped community health services. Two groups of patients in Portugal are in mind: the relatively affluent residents of retirement communities, and very disadvantaged and socially isolated older people in low-income urban districts;

- ▶ Intermediate care schemes may be particularly valuable in the less affluent and rural regions of Portugal where it is difficult to support primary care practices. Establishing them will however require extended discussions with the health care authorities and professional groups. Supplementary funds to support pilot trials would be of great value.

1.4. The care of older people with dementia: medical and psychosocial models

Personal reactions to disabling conditions in old age

The rapid gains in average life expectancy in the world's developed countries are generally welcomed and seen as a sign of "progress". Every human being is driven by the instinct fundamental to all life forms, to survive, and the question of whether it is advantageous to live much longer than did our predecessors is addressed only by philosophers and ethicists: most people take for granted that it is "a good thing". Governments, particularly their financial ministries, as well as pensions managers and health economists, express great concern about future pensions and health-care costs and frequently employ the terminology of crisis and catastrophe when discussing the implications of an ageing population, but it is likely that most of the population are little troubled by these issues. They principally concern the welfare of future cohorts of older people (and the burdens they entail on Government). Most older people, by contrast, are concerned about themselves and their immediate family, including the prospects for their grandchildren in young adult life. Rarely does an older person worry about the circumstances of their children or grandchildren when they reach advanced old age.

There is, however, one accompaniment of great longevity that deeply concerns older (and younger) people in every society, to the extent that it has taken on some features of a "moral panic". It is the association of advanced old age with degenerative, irreversible and disabling disorders, including the cancers, heart failure, diabetes and other severely disabling and eventually fatal progressive conditions, but most of all cognitive disorders and decline. The association of being "really old" with disability and dependence upon others may be less freely discussed in the mass media than paedophilia or international terrorism, but for many middle-aged and older people, it is a matter of prime concern. Gerontologists and others who interview older people about their well-being and hopes for the future are told time-and-time again: "I most want not to end up" ... "as a burden on my family", "having to go into a nursing home", "having to give up my home", "not being able to look after myself", and more colloquially, "gaga" (meaning demented) or "a cabbage". The central fears are about losing independence and "losing one's mind"; that is, of contracting "senile dementia", which in North America and the United Kingdom is increasingly understood as having Alzheimer's disease (although many other conditions have similar devastating effects).

The concerns are not only egocentric, as described. Individuals with moderate and severe dementia require intensive supervision, support and care, which in many cases imply that an informal carer needs to live with the cared-for person or immediately adjacent. If a parent requires such care, there is a dilemma for those in middle age who love their parents but also have to support a spouse, children and themselves. Expecting women to give up careers and paid work, and even to relegate the nurture and education of their children, in order to become full-time carers of a parent with dementia is, however, not the only way that a country can improve dementia care.

Two models of care

The case has been made that, from the perspective of promoting the quality of life and care of people in advanced old age, one of the greatest challenges that all developed societies face is how best to support and treat people with dementia. Even the richest countries are only just beginning to recognize the problem of raising the quantity and quality of "dementia care" and to address it systematically. This

section discusses the roles of two approaches, in the simplest terms, the *biomedical* and the *psychosocial* models of dementia care. Sometimes they are presented as antagonistic or alternatives, but it is argued here that the two have complementary roles and that both are required. All those who are involved in dementia care should recognize that they have a common objective, to expand and improve treatment, care and support for both the sufferers and their families, and that this requires the expansion and improvement of both medical and social care. It is counter-productive when the protagonists of the two approaches are in opposition. Mutual respect and co-operation will be the best approach to achieving fast improvement in the care and support of people with dementia.

Table 115 summarizes the main features of the medical and the psychosocial models of dementia care. The medical model is dominated by the understanding that dementia results from incurable brain damage and results in *cognitive losses*. The psychosocial model emphasizes that a person with a dementia has remaining cognitive and social *capacities* and *emotional needs*. It follows that the psychosocial model is most appropriate for those with “early-stage” or “mild” dementia, while the medical model is more appropriate for those with severe dementia. The evidence from countries around the world is that when the need for dementia care is recognized, the first developments follow the biomedical approach. This is particularly clear in the rapidly developing economies of South East Asia, possibly because of the great influence of the medical profession and the tendency to denigrate “traditional medicine” (which attends to “the whole person” or in effect psychosocial care).

Table 115. The two principal approaches to the development and delivery of dementia care

	The Medical Model	The Psychosocial Care Model
Models of the disorder and required care	Dominated by the biomedical understanding that the condition is incurable and progressive. Conceptualizes the condition as “terminal” and indicates “end-of-life” care.	Dominated by the understanding that the sufferer retains “personhood”; that is, many cognitive capacities and social and emotional needs.
Attributes of the care	Emphasizes hygiene, protection, reducing risks, restraint and medication that controls the symptoms and may retard the progression of the disorder. Indicates institutional settings, to minimize risk and emergency presentations at acute hospitals, which tends to suppress self-responsibility and self-care, <i>e.g.</i> patients not allowed to prepare drinks or simple meals in kitchens (seen as dangerous) or to bathe themselves (lest they fall). Indicates staff trained to maximize hygiene, good nutrition and medication administration. Professional and trained staff are expensive, so staffing levels are low and insufficient to provide much individualized care.	Indicates highly individualized and intensive social support, with emphasis on identifying effective means of verbal and non-verbal communication and on activating those capacities that remain. Indicates support of family carers, in their own homes or at day centers (giving the carer respite or opportunity to work). Professional domiciliary care is expensive, but the model encourages the contributions of informal carers and volunteers, as at day-centers. The number of helpers can be raised by medical, nurse and social work student placements. Many older people who once cared for a spouse with dementia, who has died, will volunteer to help others.
Outcomes of care	The cared-for are treated as patients and technically well managed but with harm to their self-image and little stimulation. Leads to high rates of distress and depression (which increases anti-social and disturbing behavior). Relatives or informal carers tend to be excluded from the care, and may feel demeaned, criticized and guilty.	Maximizes the continuing independence and self-responsibility of people with mild and moderate dementia, and therefore their sense of self-worth. The cared-for continue to feel valued and to have more rewarding daily lives, so there is less depression and distressed behavior. Relatives and informal carers feel supported and that they are useful in providing continuing support.
Development priorities	Development of high-technology medical dementia-care centers. Pharmaceutical, neurological and genetic research into the aetiology of the condition and its progression <i>to seek a cure</i> .	Development of education, advice and support centers for informal carers. Active efforts to recruit, train and deploy volunteer helpers. Emphasis on inculcating psycho-social care skills. Research into effectiveness of different approaches to care and support, <i>to raise the quality of care and of the sufferers’ lives</i> .

A pervasive problem of the biomedical approach is that it tends to favour long-term care in institutional settings. All over the world, it is recognized that institutional care is accompanied by several problems:

- ▶ Little regard for the autonomy or self-responsibility of the patient/resident;
- ▶ Little regard for the role of relatives and informal carers;
- ▶ Rigid daily routines that facilitate physical care but are not stimulating or boring and that induce hopelessness and depression;
- ▶ High costs because residential care is labour intensive, with the result that staffing levels are low and the priority to provide a well regulated environment becomes the over-riding concern, and little individualized care is provided.

These unfortunate outcomes arise from several attributes of institutional long-term care. Care of the elderly mentally ill is arduous and has low professional prestige. It tends to be low paid, and it is often the case that care-assistants are among the least-well educated in the population. Many care and nursing homes are provided by independent proprietors. In all sectors of care, some managers and staff are incompetent or negligent. Given these “supply conditions” and the vulnerability of the residents or patients, governments establish registration and inspection agencies. Such regulatory systems emphasize minimum standards of physical care (hygiene, nutrition, medication administration, risk minimization). Good standards in such care become the highest priority for the management and the staff, and are onerous to achieve. These priorities leave little capacity for providing the residents with a wide choice of diverting activities, opportunities for social interaction or individual attention. The outcome is exacerbated by low staff numbers and high turnover and sickness rates, particularly at weekends and in the evenings. Another blight is that it is rare for institutional homes to encourage the complementary roles of relatives or informal carers.

Although from a biomedical point of view, the dysfunctional abilities observed in people with dementia are ascribed to neuropathology in the brain, in recent years it has been observed that psychosocial factors also play an important role (Scholl and Sabat, 2008: 103, citing Kitwood, 1987, 1997; Snyder, 1999; Sabat, 2001; Harris, 2002; Keady and Nolan, 2003). “The psychosocial factors include the person’s reaction to the effects of neuropathology, the ways in which others behave toward the person diagnosed, and how persons diagnosed react to how they are treated. More specifically, the treatment accorded to the person with dementia can have a profound effect on his or her (a) subjective experience; (b) ability to display cognitive abilities that remain intact; (c) ability to meet the demands of everyday life; and (d) quality of life and ability to live meaningfully” (Scholl and Sabat, 2008: 104). According to this analysis, not only is long-term institutional care ill-designed to provide psycho-social care, it may actually harm the mental wellbeing of residents and exacerbate their problematic behaviors.

Organizational and service developments in response to dementia

Organized responses to the problems of dementia sufferers and their carers (aside from treatment in mental hospitals and by psychiatric services) became evident during the 1980s. Several forms can be recognized, each with different roles (*Table 116*). The first “community’s” response to the need for improved dementia care in many countries has been the formation of a membership society, to offer advice and mutual support to sufferers and carers, and to advocate for an expansion of services. These have grown very rapidly and are now major advocacy and support organizations (as well as businesses) in several countries.

Table 116. Organizational responses to the need for improved dementia care

Innovation	Activities and Roles
Membership associations - Alzheimer's societies. Examples: - The Alzheimer's Association in the United States of America (http://www.alz.org/index.asp); - The Alzheimer's Society in the United Kingdom (http://www.alzheimers.org.uk/site/); - The Alzheimer's Association in Japan (www2f.biglobe.ne.jp/~boke/dementiaseoul2006.ppt).	Provide advice and support to people with dementia and their carers Advocate for better services and public education. Fund research.
Biomedical research centers. Examples: - National Institute on Aging in the United States of America (http://www.nia.nih.gov/); - Dementia Research Centre at the National Hospital for Neurology and Neurosurgery in the UK (http://dementia.ion.ucl.ac.uk/).	Investigate aetiology, develop treatments and search for cures.
Dementia services development centers. Examples: - National Dementia Care Research and Development Centers in Japan (http://www.bradford.ac.uk/health/dementia/dcm/DCM_Annual_Report_0607.doc).	Develop and test new models of social care and the required staff training. Develop and deliver training materials.
New forms of social care, particularly day care.	To support people with early stage or mild dementia living independently, with and without carers, and to support the carers.
New forms of residential care.	To support and care for people with intermediate/moderate dementia, with skilled medical staff trained to work sensitively with the residents and provide psycho-social care

Responses to population ageing - The case of Japan

Japan's population is one of the oldest among the world's countries, and the average life expectancy is higher than in any other large country. By 2010, it is projected that 25% of the population will be aged 65 or more years. The country also has an exceptionally low birth rate. The total fertility rate is 1.43%, well below the replacement level. Two-thirds of women aged between 20 and 30 years have never married (Davis and Konishi, 2000: 89). It has been estimated that there are 1,7 million elderly people with dementia in Japan (Hozumi, 2007: 89). The Japanese have addressed the problems arising from an ageing society vigorously and with great thoroughness. They have studied service innovations and care programmes in many other countries, adopted what they see as relevant to their own situation and developed innovative models of care.

End-of-life care for the elderly is now recognized as a major problem in Japan (Hirakawa *et al.*, 2004; Suzuki and Iguchi, 2004). Although most deaths are in hospitals, it is generally believed that elderly people wish to die either in a long-term care facility or at home, where they have spent many years (Sauvaget *et al.*, 1996; Tilden *et al.*, 2004). As a result of rising health care costs in Japan, institutional care has been strongly encouraged by the long-term care insurance system. As a result, a gradual shift in the place where people spend their last years is expected, from hospitals to long-term care facilities or group homes (Hirakawa *et al.*, 2006).

The reaction to the increasing number of frail and dependent older people and their need for care has also been influenced by the strong cultural belief in filial piety, the importance of honour and of moral probity, and the great respect shown to the medical profession. Interpreting another country's culture and prevailing attitudes without very close study and verification by country nationals is fraught with difficulty and dangers. A recent synopsis jointly authored by American and Japanese authors is however available (Fiori, Antonucci and Akiyama 2008). It illuminates differences in the understanding of dementia and dementia care between the two countries. The following paragraph is a synopsis:

“Many researchers have compared the prevailing norms of Western and Eastern cultures, and the USA and Japan are frequently used as archetypes of “West” and “East”. The experience of social relations for older people in the USA and Japan may diverge due to differences in cultural factors, historical experiences, life expectancies, health care, and housing. For example, because of its relative isolation as a country, Japan is ethnically and linguistically homogeneous, in contrast to the ethnically- and linguistically-diverse United States. Furthermore, because of the longer life expectancies of both Japanese men and women, older Japanese individuals are more likely to be married than older Americans” (Fiori, Antonucci and Akiyama, 2008). Japanese elders express a stronger preference for living with their children than do American elders (Sugisawa *et al.*, 2002) and the “stem-family-structure” (*i.e.* elders living together with their oldest son, his wife, and their grandchildren) is also upheld in Japan. As a result, social support systems among Japanese older people tend to be centred on the family more than the support systems of American older people (Koyano *et al.*, 1994; Takahashi *et al.*, 2002). The cultural meanings ascribed to social relations may also differ between the USA and Japan, at least partly as a result of contrasting contextual factors. According to Kitayama, Markus and Kurokawa (2000) and Markus and Kitayama (1991), in Japan relationships are considered focal and objective. The major cultural task for the Japanese is to fit in and adjust to relationships while constraining personal desires. In contrast, in the USA, group ties are governed less by group norms. Americans may have to rely instead on trust of unfamiliar others (Rothbaum *et al.*, 2000).

There is no direct translation of these observations into the attitudes of spouses and children towards (a) the choice of caring intensively for a close relative, (b) accepting formal support, or (c) placing a relative in a long-term care residential setting. The presumption, however, is that the strong cultural norms of filial piety and of conforming to social norms incline most Japanese families to accept the duty of care.

Group Homes for people with dementia in Japan

Since the late 1980s, there has been a rapid development of *Group Homes* (GH) for people with dementia in Japan, especially after the introduction of the public long-term care insurance plan in 2000. The number reached 6,645 by the end of April 2005, according to the WAM NET nationwide online database (<http://www.wam.go.jp/>). A GH is a small, home-style facility funded by public insurance. The law stipulates that each GH must provide specialized, in-home care services with mutual support for the elderly person with dementia. Thus, it assumes the roles of both institution and home. Similarly, the number of elderly people choosing to spend their remaining years in GHs has been increasing. GHs should therefore be able to adequately respond to the often demanding needs and complex wishes of individual users (Hirakawa, 2006).

The group home idea was partly based on a Swedish model, and there is much exchange of ideas and experience between the two countries. The rationale for the homes is described very well in a report of the presentations by Swedish advocates at Tohoku Fukushi University in November 1996 (see <http://www.sendai-senior.org/eng/bokememoe.htm>). The features that distinguish group homes from existing nursing homes and care homes are:

- ▶ The homes are small - commonly with six to eight residents;
- ▶ The residents are encouraged to be as self-reliant as possible;
- ▶ The staff is intensively trained in dementia care.

Group homes are an interesting model that draws from both the biomedical and psychosocial approaches. As described by the authors of an evaluation of over 1,600 group homes in Japan, they “provide a particular model of care for elderly patients with intermediate-stage dementia, it is a modified form of “reality orientation”. The method helps stimulate and activate the patients’ functions that are still

alive by focusing on reality and eventually it can guide them to regain a positive attitude as well as strengthening self-esteem. Elderly patients with dementia are often subject to stress. Animals could play an important role as stress relievers because physical contact with them often brings back old and pleasant feelings. Music is also a great tool that gives patients comfort and brings back good memories. The intact functions of the patients could be stimulated using this excellent care method, which could result in less extensive use of diapers, sleeping pills and psychotropic agents. The importance of the education and skill of staff members along with their understanding of the philosophy of care cannot be stressed enough" (Hirakawa *et al.*, 2006).

Hirakawa and colleagues examined the end-of-life care policies and practices of the group homes. The informants were 3,701 managing directors. Data were collected through mailed, anonymous, self-reported questionnaires in 2003. The content of the questionnaires included: (1) general characteristics of the GH, (2) end-of-life care policies and experiences; (3) available end-of-life care services at the GH, (4) staff education concerning end-of-life care; and (5) types of information provided to users and families. The response rate was 45.6%. Many GHs had implemented progressive policies for end-of-life care. GHs with progressive policies for end-of-life care were found to have different backgrounds than those with regressive policies. Only a few GHs provided end-of-life care education for their staff. GHs with progressive policies for end-of-life care tended to have the following characteristics: availability of medical intervention within and outside of the GH, self-contained physical plant and staff education about end-of-life care.

The principal quantitative findings are shown in **Table 116**. It can be seen that the model has been rapidly growing in recent years and has been adopted enthusiastically by non-profit and for-profit organizations and by medical and non-medical institutions. Staffing levels are not particularly high for long-term care facilities, but a high percentage are trained specifically in dementia care. A great diversity of specialist services are provided, and many involve day care. A small number of GHs were affiliated with a hospital or with a geriatric intermediate care facility at which limited medical services were available. Also, many GHs were self-contained buildings. Many companies and organizations are marketing group homes with great energy (see, for example, the webcasts advertising TMed dementia day-care centers which are supported by an unrestricted educational grant from the pharmaceutical company Eisai at <http://webcasts.prous.com/dccjapan/>).

Table 117. General characteristics of 1,689 group homes in Japan, 2003

Attribute	Number	Per cent
Number of patients (average)	13.1	
Year opened		
2003 (up to September)	470	27.8
2002	337	20.0
2001	214	12.7
2000	61	3.6
Before 2000	49	2.9
Number of staff (average)		
Overall	12.1	
Certificated care worker/helper	4.6	
Nurse	0.4	
Physician	0.1	
Organization		
Non-profit organization	976	57.8
Incorporated social welfare institution	498	29.5
Incorporated medical institution	373	22.1
Others	105	6.2
Profit making organization	673	39.8
Others	32	1.9
Affiliated institution/in-home care services		
Nurse's night work	436	25.8
Day service/care	840	49.7
In-home service center	48.9	
Home help	418	24.7
Short stay	414	24.5
Nursing home	344	20.4
Geriatric intermediate care facility	226	13.4
Home-visit nursing care	197	11.7
Hospital	166	9.8
Clinic	147	8.7
Others	207	12.3
Nothing	480	28.4
First-aid manual	1,530	90.6
Admission to hospital available	1,537	91.0
... within 24 hours	1,366	80.9
Medical support from outside available	1,232	72.9
At GH when the user dies	962	57.0

Source: Hirakawa *et al.*, 2006.

The medical interest in group homes in Japan has been focused on how well they deliver end-of-life care (including support for relatives). Although the broader aims of psychosocial care have informed the model, and are emphasized on several promotional websites, the evaluations available suggest that even more staff training is required for the principles to be fully implemented. Hirakawa and colleagues (2006) found that many GHs have implemented progressive policies for end-of-life care, and that "the availability of medical interventions within or outside of GHs, self-contained physical plant, and staff education are associated with progressive policies for end-of-life care at GHs". They also found a relationship between staff education and GH policies, and argued that there is a need to develop effective educational programs for nonmedical professionals, such as GH staff, to promote essential knowledge and information regarding end-of-life care.

Recommendations for dementia care

Marked increases in longevity mean that the most rapidly growing element of the older population are those at the oldest ages, in their eighties and nineties and above. At these ages, the prevalence of

dementia (or organic brain damage) increases exponentially with each year of age. All societies face a rapidly growing demand for dementia care. Some of the recommendations for addressing this issue are:

- ▶ Both biomedical and psychosocial forms of care need to be developed in every country. A particularly pressing need is for public education in dementia and staff training in dementia care. Portugal has a well established Alzheimer's disease "members association". This organization will have well informed views about current development priorities;
- ▶ There are many service and staff development opportunities in dementia care. It is likely that the following innovations would give high returns in improving the quality of life of people with dementia and their carers:
 - An expanded network of day centre services;
 - A specialist training and service development centre;
 - New training materials for Portuguese nurses, community health and social services staff;
 - A demonstration or prototype group home in the Swedish/Japanese model.

2. Summary

The limitations of the experience of other countries for guiding the development of a nation's welfare services must be recognized. Health and welfare services are particular to a country's social customs, values and inheritance. Nevertheless, when one compares countries of equivalent levels of economic development and rates of change through the second half of the twentieth century, several important similarities in development paths can be seen. Stronger economies enable more welfare provision. As the level of affluence rises, so previously neglected welfare tasks and needs can be addressed. At an early stage, Governments decide that absolute poverty, indigence and living in unsanitary or damp housing in old age is no longer tolerable, and introduce minimum income support and special housing provision. At a later stage, it is decided that all older people should have ready access to the medications prescribed to them by their doctors, so even in the USA arrangements are made whereby even the lowest income groups have assistance with medication costs.

In the early 20th century, the (largely) unmet needs of older people that are receiving increasing attention in most affluent countries include how to maintain the social participation and sense of personal security of the growing number of older people who live alone and have mobility difficulties, the care of people with dementia, and the care of very frail people with multiple chronic conditions. There are ample opportunities for all sectors of society and the economy - private companies, voluntary organizations and State agencies - to make enterprising, innovative and valuable contributions in the strengthening of welfare services for older people.

MODULE 5

DESCRIPTION OF INTERNATIONAL POLICIES AND LEGISLATION FOR THE ELDERLY

Setting Priorities for Older People's Formal Support: Guidelines for Service Development

This Module provides a synoptic review of the responsibilities of the Central Governments of developed countries in guiding and stimulating effective response to population ageing and to meet the rising expectations and aspirations of older people as to their level of living, health-care and welfare. Their task is not just to ensure the provision of services for the treatment, care and support for today's older people, but also to develop strategies for the progressive improvement of the wellbeing of future cohorts.

This Module draws from the experience of countries that have developed extensive programmes and services for older people. It reviews the principal Government roles in promoting the wellbeing of older people and in improving the quality and effectiveness of service delivery, and also notes the important initiatives and enterprise contributions of non-profit organizations and private sector companies. The underlying aim is to provide an understanding for policy makers and professional innovators in Portugal about the kinds of services that have been successfully developed in other countries, some many decades ago when they were at levels of economic development (or *per capita* GDP) comparable to Portugal's today. No single "service provision model" is advocated; rather, the emphasis is upon identifying unmet health and social care needs.

This Module therefore reviews older people's most prevalent needs for treatment, care and support, the main types of services that are provided in response, and the service development paths available to all countries. It summarizes the UNO templates for the goals and components of service development, and comments on how they might be helpful to Portugal. It concludes with a number of recommendations for the way ahead. These will not prescribe the services that should be developed or expanded, but rather point to appropriate processes by which to develop a strategy and specific objectives that take into account older people's unmet needs, the population's aspirations and expectations, and political and financial realities; in other words, that are appropriate to Portugal today.

1. The development of services for older people: the long view

In all European countries for many centuries, there have been formal arrangements for the care and support of a minority of frail, sick and socially isolated older people. Until the modern period, beginning in the later decades of the 19th century, the institutional arrangements provided no more than a thin "safety net" to alleviate the worst poverty and to prevent avoidable cases of starvation. Even in the exceptionally affluent northwest European countries with the most fully developed systems of public welfare, many of today's services for older people began only within the last 40 years. It is informative to examine the development sequences followed in various countries, because this reveals both how new "needs" are identified and translate into development priorities. Some of the driving factors have been specific to a country or a time, and some have been widely shared. The influences range from developments in scientific medicine and therapeutic technologies, such as the invention of the artificial hip or the perfecting of heart replacement surgery, to political pressures from older people themselves (not least as voters) and from the NGO that represent them. A very recent instance is the pressure from organizations representing those who suffer from Alzheimer's disease and their carers for drugs to be licensed and paid for by the State even though their efficacy is uncertain or not proven.

Comparative historical accounts also reveal that the same perversities and mistakes in the development of older people's services have been made in several countries. During the 1960s, for example, many northwest European countries rapidly expanded low-intensity personal social services (such as home-help services and home-delivered meals). This was done without a reliable procedure for assessing needs, so that there was great expenditure on supporting people that hardly needed the services. This reduced the budgets available to support those with seriously disabling functional limitations. For the last 20 years, across northwest Europe, more rigorous assessment and "care planning and packages" have been introduced, and social services budgets now support fewer clients more intensively. Some of the "wrong turns" may never be repeated, because the initiating conditions have passed - an example is the misguided development during the late-nineteenth and early-twentieth centuries of large "institutions" or asylums for not only the mentally ill but for all categories of very frail older people; but others are very likely to recur - for example, the excessive, counter-productive and expensive over-reliance on pharmaceuticals in older people's health care, not least because physicians find it difficult to resist their patients' expectations and demands for medication.

The next section examines the development of health and social-care services for older people in the United Kingdom and in Japan. As throughout this review, there are references to the elaboration of State old-age income support, or social security, and to broader pensions arrangements, but the focus is on what in North America are called "human services": hospital, community and primary (or family) health-care services, personal social services, mental-health services and specialized and supported specialist housing. Pensions policies are closely tied with labour-force and macro-economic management, and are a highly technical topic that requires specialist appraisal. The political task of minimizing poverty in old age is obviously an important element of raising the health and wellbeing of older people, and in most countries, including Portugal, has been addressed relatively early. The more complex, also expensive but less widely recognized prominent task facing many European countries today is to improve support services for older people, not least because the population aged from 60 to more than 100 years is immensely diverse and includes people with very different needs. This report focuses on this "human services development agenda". By referring to the UK, Japan and other countries, it will draw out general principles and lessons, which will inform the recommendations for Portugal at the end of the report.

2. The development of services and welfare programmes for older people in the United Kingdom

Key Innovations and dates in the development of UK programmes and services are set out chronologically in *Table 118*.

Table 118. Innovations in policy and services for older people in the UK after 1945

Date	Legislation or new service	Source
	NHS - universal access to health care without fees.	GR
1948	National Assistance Act - local authorities to provide residential accommodation for persons who by reasons of age are in need of care and attention. Created powers to provide domiciliary, day centre, adaptations and aids, laundry and assisted holiday services.	M&S
c1949	Specialized local authority housing for older people.	JGE
1962	Prototype local authority sheltered housing scheme.	KS
1961	Charnley's hip replacement.	AT
1962	Help the Aged (an advocacy organization) established.	JC
1963	Kidney transplantation.	PC
1964	Prevention of strokes. Professor of Geriatric Medicine.	JLF
1967	First heart transplant.	JLF/JCB
1968	Health Service and Public Health Act. Mandatory duty on all local authorities to provide home-help service.	JLF
1970	Local Authority Social Services Act (unified social services departments).	AT
1976	Sheltered housing for sale.	AT
1978	<i>A Happier Old Age</i> first policy document exclusively on older people's welfare.	W&L
1979	Coronary angioplasty.	AT
1981	<i>Growing Older</i> first Government White Paper on older people's welfare.	JLF
1984	Registered Homes Act and Home Life: A Code of Practice.	AT
1986	Cumberledge Report on community nursing. Community psychiatric teams.	CPA
1987	Thrombolysis (clot busting) for heart attacks.	GR/P&B
1988	<i>Community Care: An Agenda for Action</i> (Griffiths report on social services).	JLF
1989	NHS recognition of old age psychiatry as a specialty.	L&G
1990	NHS and Community Care Act - new GP contract and GP fund-holding.	P&B
1993	Community care provisions of 1990 NHS Act implemented.	GR
1999	Royal Commission on the Funding of Long Term Care.	L&G
2000	Care Standards Act and National Care Standards Commission.	RC
2001	National Service Framework for Older People.	KF
2001	Care Homes for Older People: National Minimum Standards ¹ .	DH
2003	Nurse-led intermediate care schemes to reduce hospital admissions.	KF
		JR

Notes: c: circa. 1. Now the Commission for Social Care Inspection (CSCI).

Sources: CPA Centre for Policy on Ageing (1984); JCB Brocklehurst, Tallis and Fillit (1992); JC Charnley (1979); PC Coleman (1975); RC Royal Commission on the Funding of Long Term Care (1999); JLF Le Fanu (1999); KF Froggatt (2007); L&G Lewis and Glennerster 1996; DH Department of Health 2001a; P&B Philpot and Banerjee (1997); GR Rivett (1998); JR Reed *et al.*, (2006); KS Slack (1960); AT Tinker (1992); W&L Wames and Law (1985).

Progress in developing health and social care services during the first half of the twentieth century was slow and mainly associated with the enterprise of local authorities in hospital management and residential care (at that time mainly for orphans and mentally-ill and handicapped people). It was the foundation of the NHS in 1947-1948 that greatly increased the access of older people to primary and acute health care and established an organizational and funding framework in which geriatric medicine could grow; and the National Assistance Act 1948 not only established a social security fund but also laid the foundations for the expansion of local authority personal social services for older people.

These had hardly existed before 1940, and for more than a decade after the NHS began, "local [community] health and welfare services were a low priority [and] a favoured target for cuts in each expenditure round. Even implementation of small policy advances, such as a chiropody service, or permitting local authorities to provide a meals-on-wheels service, were held back for years" (Webster 1998, 54). Through that period there was a lack of imagination about alternative forms of support and the developing social services formed a muddled mosaic. The complementary roles of informal, voluntary organization and statutory service care have been in flux ever since.

Following the Seebohm Report of 1968, "unified" local authority social services departments with an enhanced role in providing domiciliary and day-centre services for older people were created. One result of Seebohm and the NHS, however, "was to separate into two statutory camps the social workers and the medical and related professions, like nursing. ... For those dependent on both, like the [frail] elderly, the mentally ill and the handicapped, the results were not to be good" (Glennerster, 1995: 128-31).

There have been many subsequent developments, such as key reforms in the NHS (the internal market, the removal of long-term care from acute hospitals, the reorganization of primary care into professionally-managed NHS “Trusts”, and the “modernization” agenda of the current Government), and in the social services (the promotion of private-sector residential and nursing home care, the 1993 “community care” arrangements). It can be seen from *Table 119* that attention to the needs of older people in policy, training and specialized services has never been greater. The current rate of change and the prospects for real gains are unprecedented. In this situation, there is a need for rigorous analysis of needs and effectiveness, for fresh thinking, and for prioritization.

It is pertinent to emphasize that in the United Kingdom the beginnings of home-delivered health and social care services were *not* accompanied by a debate about the respective care roles of the State and the family, or any agonizing that introducing formal services implies a cultural or moral demise. The plain fact was that in cities disorganized by wartime bombing, some older people were unable to continue to live independently. Their power and water supplies were disconnected, local shops had been destroyed or were inaccessible, and for many their children (particularly sons) were away in the armed services or engaged in war materials production. In any society, there is a minority of older people who have never married or who have never had children. Among very old people, there are many whose spouses have died, and whose children have pre-deceased them. To assert that the family can provide care to all older people who need it can never be true.

During the 1960s, the mistake was made to develop home-support services for older people “as a right” and without sufficient attention to relative needs. “Care Management” has now been introduced. Although by no means a perfect system, for it is plagued by inflexibility and slow responsiveness to changing needs, it provides a framework by which the available resources are targeted towards those in greatest need. It also makes explicit which needs will be met in whole or part by publicly-funded services, which provides a “care map” through which professionals, advocacy organizations and politicians can identify unmet needs and campaign for new or expanded services.

3. The development of older people's services in Japan

Japan has been transformed from a quasi-feudal, paternalistic monarchy in the early 20th century into one of the world's major economies (despite its recent low rate of growth). Since 1945, it has developed a modern if distinctive welfare State. Japan also has very high average life expectancy at birth and very low fertility. Its population is falling through negative “natural population change” (the balance of births and deaths). In no other country is “demographic ageing” so advanced. A chronology of the major steps in the development of Japan's State-instigated or State-managed programmes and services for older people is set out in *Table 119*. The document from which the table is drawn emphasizes legislative change.

Until 1989, the Japanese Government actions concentrated on developing the social security system and promoting older people's access to medical services, primarily in hospitals. These emphases were consistent with a strong cultural belief that the family should support its own, including frail older people (Goodman and Peng, 1996; Peng, 2000), and the very strong influence of the medical profession in determining priorities for the development of the country's health and welfare services. By 1989, the rapidity of the country's demographic change and the profound social changes that followed its industrial and commercial success, not least the entry of women into the labour force and the very low birth rate, made it apparent that a more comprehensive programme of service development was required. After intensive study of the elderly care systems of European and North American nations, the Government approved a “Golden Plan” for the development of new domiciliary and local services that would be managed by municipalities. Among other things, it was recognized that the very low birth rate implied

that an increasing proportion of older people would have no children or grandchildren who could provide care.

An evaluation in 2000 of the impact of the Golden Plan in 5 cities and 38 towns in Kagawa Prefecture showed that the outcomes were extremely variable. The rate of provision of home helps, of short-stay or respite care and of day-centre services in relation to the number of older people was more than five times higher in some municipalities than in others. This variation by local area was much greater than that in health-services expenditure per older person. Correlation analysis revealed many negative and significant correlations between the provision of services for older people at home and financial resourcefulness - in other words, the municipalities that provided few services were not making use of government (and other) funding programmes. There were positive correlations between day-centre services and the provision of respite care and the rate of admission of older people requiring special care to institutional care (Masaki *et al.*, 2000). In other words, where services were being developed, a complementary pattern was evident by which unmet needs were identified, and older people were being referred to more appropriate forms of care. In passing, the last observation illustrates the general rule that the provision of a new service commonly results in increased referrals from that service to existing services.

Table 119. Innovations in policy and services for older people in Japan

Date	Legislation or new service
1946	Public Assistance Law (former).
1947	Health Centers Law.
1950	Public Assistance Law (new).
1957	Preparation of a programme for universal medical insurance.
1958	National Health Insurance Law (universal coverage).
1961	Implementation of universal medical insurance and pension programmes.
1963	Welfare Law for the Elderly.
1966	Revision of National Health Insurance Law (payment of 70% of health care costs).
1969	Home-help services for older people (for families with a bed-ridden person).
1973	Revision of the Welfare Law for the Elderly (medical services free for older people).
1973	Revision of the pension system (pensions increased and indexed to inflation).
1982	Health and Medical Service Law for the Elderly (introduction of partial cost sharing; removal of the limit on the income of home helpers).
1985	Revision of pension system (introduction of basic pension and establishment of the pensions rights of women).
1987	Revision of Health and Medical Service Law for the Elderly (new regulations on certificated social workers and certificated care workers).
1989	The Golden Plan - 10-year strategy to promote health-care and welfare of older people Prototype local authority sheltered housing scheme.
1990	Revision of the Welfare Law for the Elderly (promotion of in-home care services, and integration of welfare and local authority services).
1991	Revision of Health and Medical Service Law for the Elderly (new system for home-nursing services).
1994	Formulation of new Golden Plan. Revision to pension regulations (raising eligibility age).
1997	Long-term Care Insurance Law (the fifth form of social insurance).

Source: Japan, Ministry of Health, Labour and Welfare (MHLW) 1999. *Annual Report on Health and Welfare 1998-1999*. MHLW, Tokyo, Chapter 1 "Social Security and National Life". Available online.

4. Lessons from Japan, the UK and other countries

Several generalizations can be made from the experience of not only the United Kingdom and Japan but also many others. There is a characteristic sequence in the elaboration of social welfare and human services. In almost all countries, a government's first intervention in the human services is in to regulate and inspect the orphanages and children's homes run by religious and philanthropic organizations. Other early initiatives are: to regulate medical training and practice (commonly by partially devolving or licensing the responsibility to medical societies); to regulate or take over the running of hospitals and asylums for the mentally ill; and to develop maternity and peri-natal services.

With particular reference to older people, the first intervention is invariably to provide a limited and means-tested income benefit or pension, with the objective of reducing indigence or destitution among the very old, particularly widowed women. In many European countries, rudimentary forms of social protection were in place before the First World War. State-funded or subsidized old-age benefits or pensions generally followed soon after the introduction of compulsory State-funded education. Adverse economic conditions from 1914 until the beginning of the Second World War prevented much improvement of State-sponsored health care or social welfare. It was the exceptional circumstances of the civil population during and in the immediate aftermath of the conflict that stimulated the development of home-delivered personal care and community health services. The return of peace and of economic growth after 1945 was followed by the sustained development of public welfare services for older people.

Table 118 and **Table 119** show that in both Japan and the UK, the first “post-industrial” welfare measures, passed during the 1940s and 1950s, were to establish the basics of social protection and more universal access to health care based on need. It is also apparent that acute hospital services tend to attract the earliest investment, followed by the establishment of a comprehensive network of primary care health centers (including rural clinics). After these services have been well established, attention turned to the development of community-health services that are delivered to the homes of older people with mobility limitations.

Table 120 extends such generalizations about the sequence of programme and service development objectives with reference to income support (social security), medical care, residential or long-stay care, personal social services, specialist and supportive housing, and psychosocial or person-centred care. In the table, the time dimension applies to both the order in which the different types of programme are initiated (beginning with income-support and proceeding with the still-to-come widespread provision of psychosocial care for people with cognitive disorders), and to the numbered objectives for each type of care. The table identifies several drivers of change and the new objectives. The most powerful drivers are rising affluence, growing expectations and a growing awareness of unmet needs. Over time, an increasing proportion of the population believes it is entitled to medical treatments that previously only the affluent received. And as the succeeding cohorts of the population receive more education and work in more responsible, creative, demanding and satisfying work, so their expectations for their quality of life in retirement also grow.

Table 120. Characteristic sequences in the development of services for older people

Form of support	Characteristic Developmental Sequence
Income support	<ol style="list-style-type: none"> 1. To prevent starvation and end destitution (absolute poverty); 2. To enforce a minimum acceptable level of living (eliminate relative poverty); 3. To reduce income inequalities in old age.
Medical services	<ol style="list-style-type: none"> 1. To treat acute, life-threatening conditions, especially those that can be followed by rehabilitation and restored functioning, <i>e.g.</i> stroke; 2. To provide universal access to primary care services to manage chronic disorders, such as hypertension (high blood pressure), atherosclerosis (obstruction of the arteries) and diabetes, to increase survival, raise the patient’s quality of life, and reduce emergency hospital presentations; 3. To combat the disorders and functional restrictions of old age through prosthetic surgery, <i>e.g.</i> hip and knee replacements, corrective heart surgery; 4. To provide community-health services to patients with chronic disorders, mobility limitations and nursing-care needs (<i>e.g.</i> surgical dressings), partly to improve the care and quality of life of the patients, and partly to reduce expenditure on hospital out-patient clinics and emergency presentations; 5. To correct visible signs of old age, as through cosmetic surgery. The boundary between interventions that are indicated by medical need, and which therefore are legitimately (part) funded by the State, and those that satisfy vanity and which are not is highly contentious.
Residential or institutional care	<ol style="list-style-type: none"> 1. To remove from society the mentally-ill, those with particular diseases, <i>e.g.</i> leprosy, and those deemed social outcasts; 2. To provide medical care to people who are chronically ill or disabled; 3. To provide an acceptable level of technically proficient care for those with high care needs, <i>i.e.</i> to

Form of support	Characteristic Developmental Sequence
	<p>reduce the number of cases of abandonment and neglect;</p> <p>4. To provide respite care to relieve informal or family carers who are providing intensive support to a person with high care needs;</p> <p>5. To provide specialist “end of life” care for patients with terminal conditions (especially cancers) and their close relatives - described in the UK and USA as hospice care.</p>
Personal social services	<p>1. To offer support to socially-isolated older people who cannot manage the instrumental (practical daily) activities of daily living.</p>
Specialist and supported housing	<p>1. To provide, by funding local authority provision, minimally acceptable housing standards for the poorest and most isolated older people - as particularly in countries where the general level of affluence has improved but low quality housing persists, particularly among older people. Particularly associated with The Netherlands, the Nordic countries and the UK during 1945-1965;</p> <p>2. To encourage non-profit housing providers to provide specialist housing with enhanced access to surveillance and/or care, in part to reduce instances of neglect and emergency presentations for medical care.</p>
Psycho-social care	<p>1. To supplement the biomedical model of the care of people with cognitive disorders (what emphasizes hygiene, nutrition, behavior management (through restraint or medication) and is risk averse, with more intensive interactions between carers and patients, or true “person-centred care”, which aims to recognize and sustain the remaining “personhood” of the patient. Still in its infancy, even in Sweden and the USA.</p>

Many countries have created a concentration of “medical excellence” in their major cities. In London, despite successive rationalizations, there is still a surfeit of teaching and research hospitals within 10 kilometers of the centre. These provide specialist, elective procedures for patients from the whole of the United Kingdom but particularly Southern England, yet the provision *per* head of hospital episodes for the city’s older population is below the national average (Warnes, 1997, 2005). The hospitals provide excellent specialist services, but below average routine services for common conditions. Moreover, the quality of primary-care (or family medical services) and community-health services for older people in London has been significantly below the national average. It is still proving very difficult to decentralize acute services to the London’s suburbs and the rest of South East England. Partly because of the high property and labour costs, the provision of residential care and nursing homes services is also far below the national average (Warnes and Strider, 2005). A similar distortion of a country’s medical services is known to apply in New York, Paris and Tokyo, and could well apply to Lisbon.

A similar development sequence has been followed in the Republic of South Korea. From being one of the poorest countries in the world at the end of the Korean War, the country rapidly became a South East Asian economic “tiger” (Oh and Warnes, 2001). The country has experienced exceptionally rapid demographic, economic and social transformations. As recently as 2000, most care services were accessed mainly by the rich and, perhaps surprisingly, the very poor (through State provision). South Korea first introduced State old-age income support and free medical care only for the very poor and has been reluctant to introduce universal “socialist” provision. The dominant policy influences have been industrial corporations and in human services, western-medicine physicians.

There is a deeply ingrained conflict between traditional and western medicine in Korea, which partly explains the low current priority for “care services” as opposed to “western” medical “cure services”. The distortion extends to a slight interest in the management of chronic conditions and rehabilitation - a critical gap in promoting the longevity, functioning and quality of life of older people. Neither long-term care services nor personal social services are well developed. There is a marked disparity between the acute services, which are predominantly provided by private sector organizations in a highly competitive market and generally achieve high standards, and the rudimentary public primary care and residential services. The latter are weakly regulated and there are many instances of low standards of care.

The problem of the low status of older people's care

The history of the development of human services is particular to each country, but apart from the described sequences of new priorities for different types of services, there are other shared experiences. One apparent in the UK, the USA, Canada, France and Australia is the intractable problem of preventing low standards of care, neglect and abuse in residential and long-term care. There have been at least three attempts to impose minimum standards by legislation that establishes strengthened systems of registration and inspection (in 1927, 1984 and 2000/01). There is the suggestion of a recurring cycle of strong and weak regulation. Particularly scandalous cases of neglect and abuse, and widespread evidence of poor management, prompt a government to strengthen inspection and provide increased funding. For a few years, the system is implemented diligently. Then it is realized that a great deal of the inspection effort is unproductive, for well-run facilities are inspected as thoroughly as those that are performing less well. Budgets are then not increased in line with inflation, or are cut, and the rigour of the inspection regime decreases.

In the UK, following the Registered Homes Act 1984, which created both local authority and NHS registration and inspection units, the NHS inspection regime was opaque, and the local authority inspection units were quickly neutralized. Their orders that independent proprietors should close homes that failed to meet the required standards were challenged in the courts on the grounds of unreasonable "restraint of trade". Some decisions went against local authorities and resulted in very high compensation payments. Not surprisingly, the local authorities relaxed their vigilance and diverted a proportion of the inspection budget to other purposes. The result was that poor standards of care and neglect went unchecked, and that by the 1990s the Government accepted that a new set of "Care Standards" and a new inspection regime was required (UK Department of Health, 2001b).

The new inspection regime was implemented by the Commission for Social Care Inspection (2005). It involved two inspections a year of every registered care home, one announced in advance, and the other unannounced. In 2007, the regime was revised, with the previous grading "good", "satisfactory" or "problematic", designated by green, amber and red colour codes, determining the future frequency of inspections, which could be three years apart. In similar fashion, a supplementary (if small) budget for training the care assistants that work in care homes introduced in 2002 has not been continued at the same level.

Very similar difficulties have been perennially associated with low standards of nursing and personal care in hospitals, particularly the long-stay older people's (geriatric) wards. The UK Department of Health has produced a series of "National Service Frameworks" (NSF) - (National Services Framework Law), or good practice guidelines, for the following conditions:

Children	Long term conditions	Mental health
Cancer	Renal services	Coronary heart disease
Diabetes	Paediatric intensive care	
Older people	Chronic obstructive pulmonary disease (COPD)	

The *National Service Framework for Older People* was published in March 2001, and set new national standards and service models of care across health and social services for all older people whether they live at home, in residential care or are being cared for in hospital (UK Department of Health 2001a). It included specific guidelines on stroke, falls and mental health, "which were more or less contentious. However, there were also aspirational system-wide standards on avoiding age-based discrimination, promoting dignity and person-centred care, a Single Assessment Process, and rehabilitation

in the form of intermediate care. This came without tightly defined operation targets, or additional funding. Professional ownership was uncertain; the policy was for older people in the health service everywhere, not just geriatric medicine or old age psychiatry” (Harwood, 2007: 483).

An evaluation of the NSF for Older People (NSFOP) has recently been commissioned by the Healthcare Commission (Manthorpe *et al.*, 2007). “Some 1,839 people participated in public listening events, 1,639 took part in nominal groups and 120 were interviewed individually. The existence of the NSFOP was not widely known”, but positive changes in primary care services were offset by reports of increasing difficulties in accessing general practice and a sense that services were becoming impersonal. The quality of social care at home varied from sensitive and personal to fragmentary, hurried and impersonal. Hospital treatment was perceived as improved in speed and quality in most places, but hospitals were also seen as risky and insufficiently caring, with discharge sometimes being unprepared, over-zealous and disorganized. Overall, the evaluation found that older people perceived improvements in health care but not as the result of the NSFOP.

The perennial difficulties of maintaining good standards of care in residential settings and in hospital wards reflects a pervasive weakness of health and social care services for older people: they have low prestige and tend to attract minimal funding, and are often the first target for cuts. The least popular career option among medical students is geriatric medicine (surgery is the most prestigious); the least desired work placement for trainee nurses is a nursing home for older people (the most popular is an intensive-care paediatric team); and most professional social workers are interested in child protection or in working with people with learning disabilities. The problem is acknowledged worldwide. It can only be combated by changes in medical, nursing and social work education and training. Any nation that seeks a radical improvement in its elderly care services must introduce prior and parallel changes in professional education and raise the financial and prestige incentives to work with frail older people.

One final lesson is learnt from the experience of other countries. It is that no single interest group should be permitted to determine priorities in the development of elderly care services. Geriatricians and psychogeriatricians have been the most energetic and knowledgeable proponents of improved medical care for chronically ill elderly people, but most are strongly biased in favour of hospital-based care. Social workers and personal social services staff have been among the most ardent proponents of more and improved domiciliary services for older people, but have shown very little imagination in developing complementarity between their own and informal carers’ roles. Among clinicians, nurses have the most expertise and insight into the problems of delivering good quality care in residential settings, but they have shown little enthusiasm for raising the skills of non-professional care assistants (again for reasons associated with pay and prestige differentials). As in many aspects of the human services, which are by definition labour intensive and therefore increasingly expensive as the GDP of a country grows, a pervasive problem is the “producer interest”. Whenever a service becomes “mainstream” and is provided on a large scale, those who deliver the service become protective of their jobs and of familiar ways of working. The reform and modernization of any human service is many times more problematic than the launch of a new service.

5. State roles in promoting human services for older people

This selective review of the experience of various countries in developing health and social care services for older people has made evident the various ways in which governments can influence service planning, development and delivery. The most limited intervention is to regulate a form or component of human service delivery, which generally translates into setting and enforcing minimum standards in training, knowledge, professional practice or service delivery (*Table 121*). Beyond regulation, a point comes in the elaboration of hospital and other health-care services at which Governments seek to raise the quality of treatment and care, which is first done by increased public spending on medical, nursing and

allied-health professionals' education and training. That is followed by direct funding of service delivery. With the exception of the timeless role of the midwife, there are few examples of personal social services or community health services being developed without State funding.

Table 121. Government interventions in human services development and provision

Types and Processes of Intervention	Objectives
Regulation, empowered by legislation, and implemented (a) directly by a government department, (b) by creating specialist agencies, or (c) by devolving the power to other organizations (e.g. universities) or professional societies.	Ensure minimum standards of competence, practice and delivery.
Subsidies or wholly finance education and training.	Raise average standard of competence. Brings the power to regulate entry into care professions and to manage the development of the care labour force. To incentivise professional re-training and job mobility. The power of established professions may partly account for the enormous disparities in the cost of training different grades of care staff.
Subsidies service delivery, through capital grants (as for specialized and supported housing), and through revenue budgets (as with support for for-profit and non-profit organizations that provide residential care and day centers for frail older people). In the UK, capital grants are distributed through central government agencies, but most service contracts are through local authorities.	To raise the volume and quality of service delivery, as particularly in under-served localities, e.g. remote rural areas and deprived inner-city districts.
Set budgets and priorities for all aspects of the delivery of a service except the micro-management of individual facilities. Characterized primary health care in the UK from 1948 to the late 1990s, when most general practitioners were independent self-employed professionals and their surgeries/clinics were small businesses.	To be able to dictate the pattern of service delivery, e.g. services are available to the entire population in all parts of a country. To strengthen powers of regulation and influence on service priorities and development.
Own facilities and employ staff, as with the US Veterans Administration medical service and the UK NHS. The extent of out-sourcing (privatization) of both the principal and ancillary services varies greatly.	As above, with augmented power over professionals and suppliers to determine priorities in service delivery and change. Meets socialist ideological objectives.

The most comprehensive intervention is when the State takes over every aspect of a service, including the ownership of buildings and land, being the employer of the staff, and performing all management and development functions. The UK National Health Service approximates this model, at least to the extent that the British Government controls every aspect of the service through the Department of Health. In pluralist, democratic States, monolithic State monopolies are widely regarded as prone to distorted producer-led priorities, inflexibility and inefficiency.

Before the State takes on a responsibility for funding and managing welfare services, and in low-income societies generally, children and other family members are key providers of accommodation, income and instrumental support to older people of reduced capacities. By contrast, in contemporary countries with the highest standards of living and extensive State welfare, an older person's housing and income are largely independent of their family's help, but the closest same-generation and descendent relatives are predominant providers of emotional and affirmational support to the majority, and of personal and intimate care to older people with functional limitations (although not of nursing and medical care). The result in the richest countries is that the boundaries and complementary roles of informal and formal carers become a contentious and fiscally-important public policy arena. Policy debates can become charged with opposing ideologies of the normative role of the family in caring for its frail members. Proposals to improve the welfare of older people through new personal social services should include new ways of supporting informal carers.

6. An international framework for the development of older people's programmes and policies: the Madrid International Plan of Action on Ageing (MIPAA)

The UN has actively promoted constructive national policy approaches to population ageing that seek to raise the health and welfare of older people. The First World Assembly on Ageing took place in 1982 in Vienna, Austria, and produced the *Vienna International Plan of Action on Ageing*. The Second World Assembly on Ageing took place in Madrid almost exactly 20 years later and produced the Madrid International Plan of Action on Ageing (MIPAA). It sets out a typology of the range of older people's needs and relates these to the kinds of programmes and services that address those needs. This section draws on a report from two participants in the Madrid Assembly, and compares the Vienna and Madrid plans (Sidorenko and Walker, 2004).

Prior to the Madrid assembly, a consultation exercise had revealed that governments around the world believed that the Vienna International Plan of Action on Ageing had been useful in helping them address the issues arising from population ageing, but there was also widespread agreement that it needed updating to take into account demographic, economic and technological developments since 1982 and to increase its relevance for low income countries. Issues such as protection from violence, neglect and abuse, and the welfare of older people in rural areas had been neglected in the Vienna document. Some countries argued that it was important to establish well-defined and time-bound objectives in the new plan.

Although the Vienna plan is 20 years old, many of its recommendations continue to be relevant, particularly for developing countries that are now addressing issues arising from population ageing for the first time. It is of interest that the representatives of governments at the Second World Assembly reaffirmed in the Political Declaration the principles and recommendations of the Vienna International Plan of Action on Ageing, endorsing both its legacy and relevance.

The central concept of MIPAA is "A Society for All Ages", which was formulated for the 1999 International Year of Older Persons (see <http://www.un.org/esa/socdev/iyop/iyopcf0.htm>). The UN Secretary-General (1999) defined "A Society for All Ages" as one that: "adjusts its structures and functioning, as well as its policies and plans, to the needs and capabilities of all, thereby releasing the potential of all, for the benefit of all". It would additionally enable the generations to invest in one another and share in the fruits of that investment, guided by the twin principles of reciprocity and equity. "A Society for All Ages" is interpreted in the Plan through foundation themes that run throughout the document: these include human rights; a secure old age (including the eradication of poverty); the empowerment of older people; individual development, self-fulfillment and well-being throughout life; gender equality among older people; inter-generational inter-dependence, solidarity and reciprocity; health care, support and social protection for older people; partnership between all major stakeholders in the implementation process; scientific research and expertise; and the situation of elderly indigenous people and migrants.

The foundation themes are organized into three priority areas: older persons and development; advancing health and well-being into old age; and ensuring enabling and supportive environments. The most important differences between the two plans of action are that MIPAA addresses ageing from a developmental perspective, while the Vienna Plan was primarily concerned with the "humanitarian" needs of older people. This change of emphasis reflects the altered construction of demographic ageing in policy circles and, more generally, the replacement of "compassionate ageism", which regards older people as a "deserving group", with the acceptance of their rights to equal treatment and self-determination. The highlighted issues in the two plans also differ: the Vienna Plan had 62 recommendations in seven areas of concern to older people, while the Madrid Plan proposed 239 policy actions to address 18 priority issues.

Table 122. Main contrasts between the two international plans of action on ageing

Attribute	Vienna Plan of Action on Ageing 1982	Madrid Plan of Action on Ageing, 2002
Focus	Older persons in advanced' countries.	Population and individual ageing in developing countries and economies in transition.
Overall priority	"Humanitarian "issues	"Developmental" issues.
Significance	Identified ageing as an internationally significant issue.	Called for inclusion of ageing into international development agenda.
Scope	62 recommendations in seven areas of concern to older individuals.	239 recommendations concerning 18 priority issues.

MIPAA has then a clear social and economic *development* focus. It emphasizes the need to integrate the evolving process of global ageing with larger processes of social and economic change. A necessary first step for the successful implementation of the Plan is seen to be the integration of the concerns of older people with national development frameworks and poverty-eradication strategies. The Madrid Plan includes 3 priority directions, 18 priority issues, 35 objectives and 239 recommendations for action. The detailed recommendations are set out on **Table 123**.

Table 123. The Madrid International Plan of Action on Ageing

Policy goals/outcomes				
A. From Poverty to income security	B. From social exclusion to integration and participation	C. From lack of social support to supportive social network (family, kin, community)	D. From lack of well-being to social, mental and physical well-being	E. From non-supportive to supportive social and physical environment
1. Critical Policy Domain: The life course (life-long individual development)				
1A National targets for poverty reduction in all age groups [A6-1(a,b)]	1B Education/ awareness raising among young people about ageing [A5-1(a); C4-1(c),(d)]	1C Recognition of support provided by older people [C2-2]	1D Access to health and social services [A3-1(h); A8-1; A7-1(e); B2-1; B2-2(a); C1-1(d); C2-1(b)]	1E Right of access to clean water and nutrition [B1-3]
Life-long learning [A1-1(c); A2-1(c); A3-1(d)]	Continuing employment [A2-1(b), (k), (l)]	Development of basic supportive services [B2-2(b); C1-1(f) C2-1; C3-2]	Risk factors of disease and disability [B1-1(d), (e), (f); B1-2 (g)]	"Ageing in place" [C1-1(e-j); C1-2(d); C2-1(b)]
Dignity at all stages of life [A1-1(h); C4-1(a)]	Flexible retirement [A2-1 (c), (h), (j)]	Access to services in emergencies [A8-1(e)]	Maximizing healthy lifestyles [B1-2(d); B1-2(j)]	Access to non-damaging habitation [B1-1(d), (g)]
Ageing farmers [A3-1; A3-2]		Older persons as leaders for conflict resolution [A8-2(b)]	Health promotion across life course [B1; more specifically [B1-1(g); B1-2(a);(b)]	Independence in rural and remote areas [A3-2(a)]
Training and re-training [A2-1(c); A3-1(d); A4-1(c)]			Food and nutrition [B1-3; A8-1]	Disability prevention and rehabilitation [B6]
Self-reliance for independent living [C2-1(i)]			Continuum of health and social care services [B2-3; B5-1(f), (g), (i); C2-1]	Right not to be abused by anyone at any age [C3]
2. Critical Policy Domain: Societal development and ageing				
2A Opportunities for older people to participate in development [A1-1; A6-1(f); B3-3; C4-1(f)]	2B Recognition of informal(unpaid) work [A1-1(f)]	2C Strengthening support networks [A3-2(b), (e); A3-3(a); A6-1(g); A8-1(f); B1-2(e); B2-2(b); B5-1(d); C1-1(b),(c); C2-1(a),(h),(j); C2-2(a)]	2D Development of primary health care services with training to recognize special needs of older people [B2-2; B2-3(f)]	2E Right to a non-polluting environment and environmental protection [B1-1(d), (g)]
Debt relief [A6-1(h)]	Access to technology [A3-1(a), (e); A2-1(c); A4; B2-1(g)]	Family and care [A2-1(i); B1-1(b); C2-1(a), (h), (j)]	Access to primary health care w/ o discrimination [B2-1 (e), (f); B2-2(a)]	Limiting negative impacts of development and urbanization [C1-2(a)]

Empowerment [A1-1(j); A6-1(f); B1-2(f)]	Volunteering [A-1(e); A4-2(e); B1-2(e)]	Community empowerment [B1-2(e); B2-2(a); B2-3(b), (c); B5-1(f); B6-1(d); C1-1; C2-1(a),(b),(j); C3-1(e)]	Equal access to health resources and care [B2-1; B2-2(a) A8-1; C2-1(b)]	
Equal access to employment and income-generating opportunities [A2-1(g); A6-1(c); A3-1(b)]	Decision-making [A1-2; B2-4(b)]		Training of health and social care professionals [B1-2(d); B1-3(h); B2-2(d); B2-3(d); B3-2(b); B4; B5-1(a),(j);C2-1(c);C3-2(d)]	
Social protection [A3-1(g);A7-1;A7-2(b),(e)] Credit [A2-1(e); A3-1(c); A6-1(c)]	Potential and expertise of older persons [A4-2]		Involvement of older persons in care services [B2-4]	
Access to credit [A2-1(e); A3-1(c); A6-1(c)]	Contribution to development [A1-1; B3-3; C3-3; C4-1]			
Emergencies and development [A8-1(l)]				
Poverty and health [B1-1(a);B2-1]				
3. Critical Policy Domain: Cultural and ethnic diversity				
3A Cultural barriers [A3-2(g)]	3B Participation in cultural life [A1-1(b), (f), (j)]	3C Care systems in different cultures [C2-1(e)]	3D Access to health and other services	3E Right to freedom from violence [C3-1(d)]
Cultural contribution [A1-1(c), (f), (j); A4-2(f); B1-2(f)]	Integration of migrants and refugees [A3-3; A8-1(f)]	Social networks for older migrants [A3-3(a)]	Traditional medicine [B2-2(c)]	
Cultural needs [C1-1(i)]				
4. Critical Policy Domain: Gender				
4A Including older women in poverty eradication strategies [A6-1(d), (e), (f)] politics [A2-1 (c), (d), (e); B2-1]	4B Removing barriers/ discrimination e. g. labour market, health services, [C2-2(b); C5-1(d)]	4C Reducing the burden of care falling on women [A2-1(i); C2-1(h), (j);	4D Reduce stress and burden borne by women [B6-1(b); C3-1(b); B1-1(c); B1-3(c)]	4E Women's disproportionate share of chronic conditions [A7-2(b); B1-3(c); C2-1(i)]
50% improvement in level of adult literacy for women by 2015 [A4-1(a)]	Empowerment [A3-2(d); C4-1(h)]	Gender equality in social protection/ social security systems [A3-2(c); A7-1(b); A7-2(b)]	Access to health care without discrimination [B2-1; C2-1(e), (f)]	Abuse, neglect, violence [C3-1(b), (f), (g)]
Gender-specific targets for health status [B1-1(c)]	Decision making at all levels [A1-2(c)]		Gender-specific prevention [B1-2 (c)]	Protection in emergencies [A8-1(g); C3-1(f)]
Inheritance rights for women [C3-1(b)]	Older women rural or remote areas [A3-1(f)]			
Access to credit and economic resources [A2-1(e);A3-1(f);A3-2(d)]				
5. Critical Policy Domain: Multi-generational cohesion				

5A	5B	5C	5D	5E
Policies to develop basic income security based on generational transfers which maintain social cohesion [A7-2(a); A4-2(b); A5-1(b)a]	Multi-generational approaches to social development [A5-1(f); B3-3]	Family as the basis for care(inter and intra generational) [A2-1(i); A4-2(d); C2-1(a), (h), (j)]	Measures/ facilities to enable older people to involved [A8-1(e); B2-4]	Design for all generations [A4-1(f);C1-1(c),(g);C1-3(c)]
Role of pensions in distributing wealth [A7-1(f,g); A7-2(a),(d)]	Programmes which integrate older and younger people [A1-1(d)]	Support for caregivers (for older people and older people as carers) [C2-1(f); C2-2]	Multi-generational basis of traditional health care [B3-3(b)]	Age-integrated housing [A3-3(d), (e); A5-1(g); C1-2(c)]
Minimum income [A7-2]	Mutual assistance [A4-2(d); B1-2(e)]	Reconciling work and care-giving [A2-1(l); C2-1(j)]		Minimizing barriers to all generations [B6-1(f); C1-2(a); C1-2(d)]
	Age-integrated communities [C1-1(a),(b),(c)]	Post-traumatic stress [A8-1(h)]	Avoiding age segregation	
	Grandparenting [C2-2(c); B3-3(b)]	Older caregivers and HIV AIDS [B3-3]		
		Community-based care [A3-2(b); C2-1(b), (j)]		

Notes: The central themes or foundations on which the MIPAA are based are: human rights and fundamental freedoms; secure ageing, participation; individual development and self-fulfillment; gender equality; inter-generational interdependence, solidarity and reciprocity; health care, support and social protection; societal partnership in action on ageing; and research and expertise. The letter/ number references in square brackets refer sequentially to [priority direction -issue - objective - (action)], e.g. [A1-1(a)]is expanded to priority direction 1, issue 1, objective 1, action (a).

Source: Sidorenko and Walker 2004, Table 2, compiled from the The Madrid International Plan of Action on Ageing. See <http://www.un.org/esa/socdev/ageing/ageraa.htm>

The last section of the Madrid Plan proposes actions for its implementation and follow-up in a country. The Plan specifies that governments have the primary responsibility for implementing its recommendations at the national level, while underscoring the need for effective partnership between governments, all parts of civil society and the private sector. Several crucial elements of the national implementation are identified in the Plan, including:

- ▶ Promotion of institutional follow-up, including the establishment of agencies on ageing and national committees;
- ▶ Effective organizations of older people;
- ▶ Educational, training and research activities on ageing;
- ▶ National data collection and analysis, such as the compilation of gender and age-specific information for policy planning, monitoring and evaluation;
- ▶ Independent and impartial monitoring of progress in implementation that can be conducted by autonomous institutions;
- ▶ Mobilization of resources by organizations representing and supporting older people.

International co-operation is incorporated into the Plan as a measure to enhance and enable its implementation in both developing and “economies in transition” countries. MIPAA also identifies several priorities for international co-operation:

- ▶ Promotion of training and capacity building on ageing in developing countries;
- ▶ Exchange of experiences and best practice, researchers, research findings and data collection initiatives to support policy and programmes;

- ▶ Establishment of income-generating projects;
- ▶ Better dissemination of information.

In designing measures for the implementation of MIPAA, it is necessary to be clear what is the principal content of the implementation effort: this is defined in the Plan as “adjustment to an ageing world”. Such adjustments have to be evident at all levels of a society from macro social and economic change to the micro level of an individual progressing through the lifecourse into old age. Policy actions should support the adjustments at the societal (macro), organizational (meso) and individual (micro) levels. Two types of policy action are necessary: “ageing-mainstreaming” and “ageing-specific”. The first comprises measures that aim to integrate or mainstream ageing issues into all major national policy domains, *e.g.* development planning, finance, employment, education and health. MIPAA emphasizes that the first necessary step in its successful implementation is to incorporate ageing and the concerns of older persons into national development frameworks and poverty-eradication strategies. The second type of action includes policies and programmes that specifically address the needs of older people, *e.g.* old-age pensions, long-term care and health-care services. An important component of both types of policy action is capacity building, or training more and more-skilled social and health-care staff.

The aims of MIPAA are to ensure that people everywhere are able to age with security and dignity and to continue to participate in their societies as citizens with full rights. As Sidorenko and Walker argue, its successful implementation will be measured in terms of social development, the improvement in older people’s quality of life, and the sustainability of various formal and informal systems that underpin the quality of well-being throughout the lifecourse (MIPAA, paragraph 14). Thus the ultimate goal is to improve the quality of life of older people on the basis of security, dignity and participation, while at the same time promoting measures to reconcile ageing and development, and sustaining supportive formal (*e.g.* health care and social security) and informal (family, neighborhood and community) systems of individual well-being.

7. Summary

Politicians and some academic analysts emphasize the differences among the “welfare States” of the most developed countries, as with Esping-Andersen’s (1996) much cited distinctions between neo-Liberal (or Anglo-Saxon), Social Democratic and Corporatist welfare regimes. The first is said to emphasize self-reliance and private-sector contributions (as in health care), and the last to emphasize the contributions of the family and the church. Taking a long, comparative view, however, the similarities in the welfare States of countries with very different political cultures are as striking as the differences. *Contra* Esping-Andersen, it can be argued that the principal influences on the level of development of social security and human services are the gross domestic product of a country and the historical period. Both are broadly related to average life expectancy at birth and the percentage of the population in the older age groups, or to the progress of demographic ageing; and both are associated with the levels of education and income of the population which in turn are related to the participation of women in paid work and the incompatibility between being an earner and providing intensive care to a very dependent relative.

In this light, the emphasis of the UN Madrid Plan on seeing the development of services for older people as an aspect a country’s economic and social development makes great sense. When a country grows economically, just as it develops its school and road systems, at the same time it has a greater capacity to develop “human services”. The implication is that, when a government plans an elaboration or reform of the country’s personal care services, it should avoid, as many have done, using or inciting social ideologies to make the case. More specifically, it should avoid constructing formal and informal care as alternatives or substitutes, but present the two as complementary and as both having vital roles not only in improving the health and quality of life of sick and frail older people, but also in raising

the quality of life of their children and relatives. Concern for frail parents, or filial piety and family care, are strong in all countries, but have constantly changing forms. It is emotive and misdirected to see the development of improved services for frail and dependent older people as “weakening the family”. People’s responses to increased longevity, reduced fertility, rising affluence and more education are not easily summarized and there is no strong evidence from any country that they lead to decreased concern for frail older relatives. As societies become more affluent and female emancipation spreads, there may be a decreased willingness to be a full-time, hands-on carer, but that has always characterized the privileged in society. Because a family directly purchases nursing and personal care for a frail relative, or votes for this to be provided partly by the State, does not mean that they are uncaring or callous about their kin.

Portugal like the other countries of Southern Europe has recently experienced very rapid modernization and economic growth. Considerable efforts have successfully been made to develop and improve access to hospital and primary care medical services. By comparison with other Western European countries, the achieved pattern of human services provision reveals strong urban-rural disparities and little provision of home-delivered personal care and community health services. This may have something to do with the long-established strong role of the Catholic Church in providing residential services for disadvantaged groups (*e.g.* orphans, abandoned mothers, the mentally ill and frail older people). It may have something to do with the high social prestige and political influence of the medical profession (as compared with nurses, therapists and social care professionals), It is not in itself a sign of a superior moral order or culture.

Portugal’s population has aged very quickly in recent decades and it now faces many “unmet needs” and service development issues that are shared with the countries of Northwest Europe, but without the advantage of a strong tradition of community care and domiciliary service provision. There is however an advantage that the Northern countries do not have. It can develop innovative community services appropriate to today’s needs without threatening an established constituency of social care and community health agencies, managers and staff. It certainly does not have to proceed through the same stages of development as seen in the UK, The Netherlands or the Nordic countries. It can proceed directly to develop services that meet the needs of the most needful group, very old people with multiple, chronic disabling conditions including the dementias. An astute mix of home-support, day care and residential facilities is indicated. One thing it should avoid is to encourage a debate in cultural rather than technical, needs-led terms. This error has been made in several of the rapidly modernized Southeast Asian countries. It leads to a strong focus on the development of hospital and long-term care facilities, and little attention to maximizing the functioning and quality of life of older people who can continue to live independently or with the support of their families. It is in a sense an anti-family policy.

The more that the debate about improving older people’s programmes and services is based on identifying unmet needs, service gaps and spatial and socio-economic inequalities in service provision, and is informed by the general populations’ preferences and complaints about existing services, the more appropriate will be the service development plan and priorities. Quantitative evidence should be collected from the operational statistics of a wide range of existing services and through community surveys. It is important to survey the health, functional abilities and wellbeing of older people in city, suburban, urban and rural locations, and to ensure that a wide range of age groups are well represented. This will require “over-sampling” the oldest age groups, but at the same time it should not be forgotten that in all countries there are strong health inequalities in old age. Although in general people aged in the sixties are healthier and have lower support needs than those aged in the eighties, in large cities it is not uncommon for their to be greater unmet needs among young elderly people in low-income or deprived districts than among people in advanced old age in high status districts, as demonstrated clearly in Belfast, Glasgow and London (Levin and Leyland, 2006; Macintyre and Soomans, 1995; Warnes 1997; Warnes, Armstrong and Peters 1997).

A wide ranging consultation exercise should also be conducted, not just of senior managers and leaders in the various caring professions, but also of junior staff (such as care assistants in residential and nursing homes) and of the general public. Public meetings and focus groups will be informative, but so also will be a carefully designed and rigorously representative social survey (which does not have to be exceptionally large but aim for 500 respondents). In developing the recommendations from the consultation exercise, an iterative exercise is strongly recommended that tests professionals' proposals among the general public, and vice versa.

Care professionals tend to recommend more resources for existing services, and tend to give little weight to preventive and health education initiatives. A consensus has formed in many countries, however, that health promotion measures, particularly to encourage better nutrition, regular exercise, stopping smoking, controlled alcohol consumption, regular immunization and eye and dental check-ups, make a substantial contribution to improving the health of older people. Delivering effective health promotion is not however straightforward, and itself requires substantial prior training or capacity building efforts.

PART III

THE INTERNATIONAL MARKET

MODULE 6

MARKET ANALYSIS OF THE ELDERLY IN SELECTED COUNTRIES

An Analysis of the United Kingdom and German Markets

From the perspective of addressing the needs of senior people in Portugal, there are three main reasons for selecting residents from the United Kingdom and Germany as case studies in a market analysis: they form a substantial proportion of the senior population in the country, they are an important source of mass tourism, an essential precondition for international retirement migration to the Mediterranean, and finally existing research underlines the importance of understanding more about the differences between and within these two national groups with reference to their residential patterns, needs and preferences while living abroad.

Despite the poor quality and availability of official data concerning the *size of the senior population* with British and German backgrounds living in Portugal, there is no doubt that both groups represent significant and rising shares of the elderly foreign population in the country. They are concentrated in the coastal districts. Following the results of both market analyses, Portugal is clearly on the way to becoming a “hot spot” of retirement migration. Additionally, as existing surveys indicate, the future demand for real estate in Southern Europe from other European countries will be substantial, and Portugal will benefit from this demand.

The second argument for selecting Britain and Germany is the importance of both countries as *sources of mass tourism and of international retirement flows*. In Europe, retirement migration used to be largely confined within national boundaries. Only in the last few decades have an increasing number of elderly migrants crossed national borders, most often heading towards Mediterranean countries. Most come from Northern and central Europe and are aged in their fifties or sixties when they take up residence in the “sunshine” locations. The importance of this destination area for Britons and Germans can be associated with both its positive image in the media and knowledge acquired through holiday visits. Tourism has also improved accessibility, through the greater availability of frequent and cheap flights, and has encouraged the development of infrastructure for foreign visitors and residents. Through the liberalization of the EU labour market and the rising demand for personal and social services in later life, many foreign professionals and entrepreneurs now live in the region and work in personal service and health sectors.

Finally, the inclusion of both countries in the market study underlines the necessity to *understand more about the diversity* of national groups with reference to their residential pattern, needs and desires while living abroad. The path breaking research on German and British senior foreigners has been replicated for other nationalities living in the region, and reveals that they cannot be seen as a homogeneous phenomenon. As official statistics are fragmentary, their circumstances and motivations for selecting residential location, their socioeconomic background, living arrangements, networks and problems are not easily understood or known from such sources, which means that special surveys are necessary to provide such information and enlarge our knowledge of this important topic.

1. The United Kingdom and retirement to Portugal

1.1. Introduction

The UK has one of the largest diasporas of its older people of any developed country. Although some of this derives from the colonial legacy and a strongly internationalized economy, there has also been significant later life migration (in which are included both retired and early-retired individuals) to Southern Europe in recent years. Portugal, although less important as a destination for older British migrants than

France or Spain, has attracted relatively large numbers, and experienced rapid growth in retirement immigration from the UK (especially in relation to its size). This report will address a number of key questions relating to this migration:

- ▶ What is the likely rate of elderly migration to Portugal?
- ▶ What are the primary motivations of the migrants?
- ▶ What are their social, economic and demographic characteristics?
- ▶ What knowledge do they have of the realities of living in Portugal (winter climate, costs of living, taxation, registration requirements)?
- ▶ Will they retain homes and/or close contacts in the country of origin?
- ▶ Will they be full-time or seasonal residents in Portugal?
- ▶ Where will they live in Portugal?
- ▶ What are their long-term residential plans as they become older and frailer?

Research on these questions is constrained by data limitations. We therefore draw on a variety of sources including: a) Portuguese official sources, such as the census and the *Serviço de Estrangeiros e Fronteiras* (SEF); b) UK sources, including the International Passenger Survey and the Department of Work and Pensions; c) in-depth case studies of older British residents in Southern Europe. In terms of the latter, we draw on two main sources. First, the comparative research undertaken by a group of more than 20 European researchers as part of a European Science Foundation scientific network on "Older migrants in Europe". Secondly an in-depth study of later life British residents living in the Algarve in the late 1990s. This was part of a four country study by King *et al.* (2002), which in the Algarve carried out 219 semi-structured and 50 in-depth interviews with British retirees as well as interviews with local professionals and government officers.

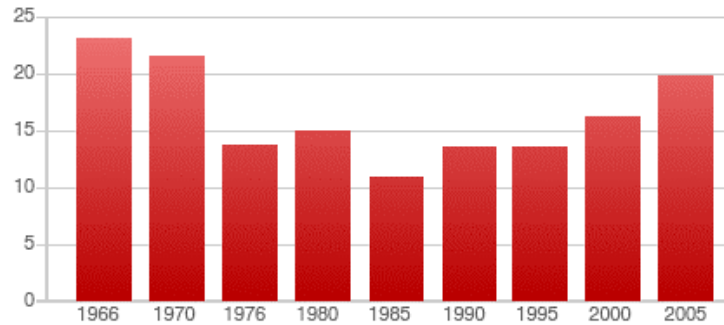
1.2. The UK context

International migration from the UK

The UK is characterized by strong immigration and emigration, reflecting both its colonial legacy and internationalized economy. For example, although France has a broadly similar population to the UK, a far smaller proportion lives abroad. Estimates made in 2006 suggest that almost one-in-ten British citizens lived outside the UK that is some 5.5 million. This figure rises to 6 million if those who live or work part-time abroad are included (IPPR, 2006).

Data on emigration is provided mainly by the International Passenger Survey (IPS) although there are some alternative means of providing estimates, such as de-registrations from doctors. The IPS, based on surveys at points of departure from the UK, is a problematic source, not least because there was a change in 1991 in the way in which migration statistics are compiled, making it difficult to analyse trends in detail. Nevertheless, it is possible to identify the main features of these trends (*Figure 85*).

Figure 85. Emigration from the UK of british citizens, 1966-2005, (N.)



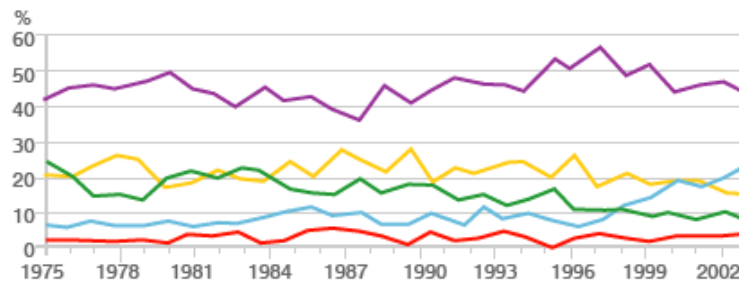
Note: Data does not take into account returning British citizens in same year
 Source: Office of National Statistics.

There was a peak in emigration in the mid 1960s, then lower emigration rates during the 1970s and 1980s, followed by increases in the 1990s. Numbers have continued to increase in the 2000s, with 198,000 emigrants in 2005 and 196,000 in the year to mid-2006. It should also be noted that in the year to mid 2006 there were also 189,000 long-term migrants who left the UK. Given the recent growth in Portuguese migration to the UK, this may have significance for future flows of returned migrants to Portugal.

Age profile of British emigrants

Most migrants are relatively young, with 40-50% being aged between 25 and 44 years (*Figure 86*). This is because most emigration from the UK is related to employment. However, there has been a notable increase in the proportion of older migrants, in particular of those aged 45-65 years and including the early or recently retired. In the late 1990s, some 10 per cent of emigrants were aged between 45 and 65 years, but by the mid 2000s, this had risen to about one-quarter of the total.

Figure 86. Age distribution of british emigrants, 1975-2004 (%)



Source: UK International Passenger Survey.

Destinations of British emigrants

The most popular destinations for British migrants are both English-language speaking countries and European countries. They reflect both economic and life style migration, including later life migration. An Institute for Public Policy Research (IPPR)-(2006) study has sought to provide estimates which incorporate not only census data in the countries of destination (that notoriously are underestimates) but also estimates by key informants of the numbers of unregistered British people living in particular countries. The methodology is relatively crude, but does provide an overview of the distribution of British migrants, globally.

Table 124. Estimates of British born people living abroad, top 20 ranked destinations, 2006 (N.)

Country	Number
Australia	1,300,000
Spain	761,000
USA	678,000
Canada	603,000
Ireland	291,000
New Zealand	215,000
South Africa	212,000
France	200,000
Germany	115,000
Cyprus	59,000
UAE	55,000
Pakistan	47,000
Singapore	45,000
Switzerland	45,000
Netherlands	44,000
Israel	44,000
Thailand	41,000
Portugal	38,000
China	36,000
Turkey	34,000

Source: IPPR (2006).

Portugal features at number 18 in this league table, a relatively high position given its total population. In general, some of the most rapid growth rates appear to have been in East Asia and in Southern Europe. The same report estimates that there are a further 11,000 British people living in Portugal for more than three months a year but less than full time - but any such figure is problematic as discussed later in the report. It should also be noted that more British nationals are also emigrating to Eastern Europe, with an estimated 10,000 living in Bulgaria - a feature that has significance for consideration of future trends, later in this report.

Reasons for emigrating from the UK

A survey undertaken by ICM for the BBC in 2006 asked people who were considering emigrating the reasons for this. Although studies of intentions are problematic because intentions do not easily translate into actual migration behavior, the responses indicate that the prime reasons were to seek a better quality of life and better weather and, as will be seen in the next section, these were particularly important for later life migrants.

Table 125. Reasons for considering emigration from the UK, 2006 (%)

Reasons	%
Better quality of life	37
Better weather	24
New job/relocation of job	13
A new experience/adventure	13
Do not like Britain/what Britain has become	12
Start a new life	9
Have family/friends there	9
Too much government interference	5
Government legislation/taxation	5
Crime	3
Cheaper/money will go further	3
Better quality of people	2
Less populated	2

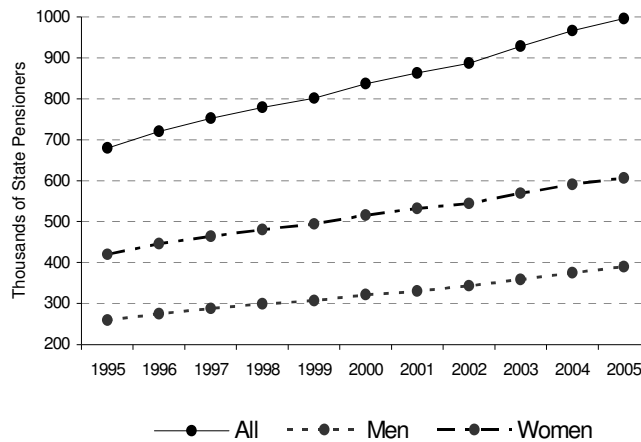
Source BBC (2006); sample size 528.

Later life migration from the UK

Scale

There has been growing later life migration from the UK, as evidenced by the IPS data (*Figure 87*). Probably the most reliable data on this comes from the Department of Work and Pensions (DWP) that collates statistics on UK State pensions paid outside of the UK. Whereas there were a quarter of a million pensions paid outside the UK in 1981, this had increased to 847,000 by 1999, while a further 16,100 received widows benefits (*Table 126*). Further rapid growth took the figure to circa 1 million by 2005 (*Figure 87*). Care is required in interpreting these statistics as they: a) include returned migrants, entitled to pensions, who are non citizens and non-nationals; b) exclude those who live part of the year abroad, but continue to have their pensions paid to a UK address.

Figure 87. UK State pensions paid overseas, 1995-2005 (N.)



Source: DWP, UK; figure prepared by Prof Tony Warnes of Sheffield University.

Table 126. UK State pensions paid overseas, 1981-1999

	1981	1986	1991	1996	1999	81-99
Number (thousands)	252	372	594	763	847	
Average annual growth (%)		8.1	9.8	5.1	3.5	6.9

Notes: The figures give the number of customers of the Pensions and Overseas Directorate of the UK DWP (formerly Department of Social Security). These special tabulations were prepared by Prof. Tony Warnes of Sheffield University.

Distribution

The distribution of British pensions paid abroad is changing over time, and the most rapid growth during 1995-2005 was to Nordic countries, followed by Southern Europe (127%). This is indicative of the increasing significance of later life migration to these countries. However, the absolute numbers also confirm the continuing importance of English-language speaking destinations such as Canada and the USA: these figures include economic migrants who have stayed on and retired in these countries, family reunification migration (e.g. parents moving to be near their children) and later life amenity-seeking migrants.

Table 127 lists the top 20 ranked destinations by numbers of pensions paid in 2006, and *Table 128* show the growth rates for 1995-2005. In terms of absolute numbers, English-speaking countries dominate, accounting for 6 of the 7 top-ranked countries in 2006. With the exception of Jamaica most of the other top ranked countries are European. Amongst the Southern European destinations, Spain, Italy and France (classified as Southern European for convenience in this report). Portugal is ranked at number 14, with 6,257 pensioners. Given that migration to Portugal has been relatively recent, the younger profile of later life migrants may mean that there are relatively more early-retired people rather than those aged 65 or more years, compared to say Spain. Therefore, the pension data may understate Portugal's position in relation to say those aged over 50 years.

Table 127. UK State pensions paid abroad: top 20 ranked countries, 2006 (N.)

Country	Number
Australia	245,311
Canada	157,435
USA	132,083
Ireland	104,650
Spain	74,636
New Zealand	46,560
South Africa	38,825
Italy	33,989
France	33,869
Germany	33,034
Jamaica	23,275
Cyprus	11,742
Netherlands	7,811
Portugal	6,257
Pakistan	5,771
Switzerland	5,449
India	5,115
Barbados	4,993
Belgium	4,660
Israel	3,995

Source: Department of Work and Pensions.

Table 128. UK pensions paid abroad: % change 1995-2005, for top 20 destinations, 1995/1996 (%)

Country	1995-2005 (% change, annual average)
France	9.8
Spain	9.8
Cyprus	8.1
Barbados	7.7
Portugal	7.4
Switzerland	6.3
Italy	6.0
Germany	4.9
New Zealand	3.8
USA	3.8
Netherlands	3.6
Australia	3.3
Ireland	3.2
Austria	2.4
Canada	2.0
India	1.8
Jamaica	1.8
South Africa	1.8
Belgium	0.5
Pakistan	-2.1

Source: Department of Work and Pensions.

The percentage change data show a rather different picture with 5 of the first 7 ranked positions being Southern European countries. These data emphasize the growing importance of amenity led migration amongst later life migrants. Portugal is in 5th rank with an annual growth rate of 7.4% over the last decade.

The drivers of UK retirement migration

Later life migration from the UK has a number of determinants (Williams *et al.*, 1997):

- ▶ The overall UK population profile is ageing as a result of both reductions in birth rates and increased life expectancy. In common with most other developed countries this has meant an increase not only in the proportions and numbers in middle and later life, but also of those who are frail elderly (usually in their late 70s or older). Further details are provided in the discussion of future trends;
- ▶ Incomes. Real incomes have increased sharply in the UK. Although the gains have been polarized, it has meant that there is an increasing number of individuals with income from State, occupational and private pensions, and from savings, to allow them to move abroad, and especially to own a house in more than one country. House price increases, well above international averages, have also created a wealth base that facilitates international retirement. The strength of the British pound has also been a general factor, although this does not apply to the Euro, with which it maintained broad parity during the 2000s;
- ▶ The UK has relatively high costs of living, including housing costs. Price differentials have made Southern Europe an attractive retirement option, although the introduction of the Euro and wage/price convergence within the EU are reducing the significance of this factor;
- ▶ Innovations in transportation and communications and airline deregulation have reduced the costs of traveling between the UK and other countries, particularly in Europe, and the barriers to

communicating with family and friends in the UK. In terms of transport, the growth initially of charter flights, and more recently of “no frills” airlines, has been particularly important. Low cost airlines, which accounted for approximately one-half of all growth in European air travel 1995-2004, are particularly significant: they provide more direct regional connectivity, which has a major impact on reducing total travel time (Dobruzkas 2006). Web-based communication (the internet, web cams, internet based telephone calls, etc) have made it easier and cheaper to remain in regular contact across international borders;

- ▶ There is growing familiarity with visiting, and with working in other countries. The UK is the second largest source of international tourists within Europe, and in many years the largest source for Portugal. This has: a) increased levels of confidence about living abroad, especially where individuals have previously owned second homes abroad; b) given individuals at least a superficial knowledge of life in other countries, which has consequently shaped their “search spaces” when considering retirement destinations. This has been particularly important for the growth of amenity-seeking retirement migration from the UK, and other Northern European countries, to Southern Europe. The numbers of British nationals working abroad (some in Southern Europe) has also increased the potential numbers who have the confidence, networks, and general knowledge or country-specific knowledge that facilitates living abroad in later life;
- ▶ There are also specific reasons why migrants have been attracted to Southern Europe for retirement. These include the climate, cultural attractions (particularly strong in the case of Italy) and the pull of largely romanticized rural and traditional ways of life.

Turning to individual motivations, there have been a number of surveys of attitudes, experiences, and decision making amongst international retirement migrants to Southern Europe. Many of these follow a similar model to that developed in the largest such study to date (King *et al.*, 2000). The main findings of this study in relation to the decision to retire in particular regions in Italy, Malta, Portugal and Spain are summarized in **Table 128**. Considering first their main reason, 41% emphasized “the climate”, which was as much about an outdoor life style, as about meteorological conditions. Another 16% emphasized “the pace of life” or because they “felt healthier” in the country. The third ranked reason was “childhood or family links”, which included some cases of parents moving to be nearer their children. No other main reasons were cited by more than 10% of the respondents. A similar pattern emerges for second ranked reasons, but when lower ranked reasons are considered, then lower costs of living, and admiration of the country are also cited by more than 10%.

Table 129. Expressed reasons for residence in four Mediterranean regions (%)

Reasons	Main reason (%)	Second (%)	3rd-8th (%)	All (%)
Climate, other natural environmental	40.4	29.6	15.5	27.6
Pace of life, feel healthier	15.7	17.8	17.0	16.8
Lower living housing costs or taxes	6.7	17.4	17.9	14.1
Social advantages	2.7	7.7	16.1	9.4
Admiration of country	6.3	8.7	11.5	9.0
Childhood or family links	11.8	5.7	5.2	7.5
Antipathy to UK	7.6	5.3	5.7	6.2
Practical advantages	2.1	6.1	9.4	6.1
Work or business	6.8	1.6	1.5	3.3
Number of reasons (\neq 100%)	925	768	1,109	2,802

Note: 32 respondents (3,3%) gave no reasons.

Source: King *et al.* (2000).

1.3. British retirement in Portugal

Historical context

Madeira, Lisbon, Oporto and the Algarve have historically been home to the largest numbers of British resident in Portugal, reflecting historical trade links and more recent tourism/second home/retirement preferences, especially in the case of the Algarve.

Small resident British communities have existed since at least the 1930s in the Algarve, but international retirement migration (IRM) to the Algarve is essentially a recent phenomenon; for example, 34.7% of those surveyed in the Algarve in the late 1990s by King *et al.* (2000) had arrived since 1990, and 71.2% had arrived since 1984, which was far higher than in Malta, Tuscany and even the Costa del Sol.

In the 1920s and 1930s small seasonal, British residential “colonies” were established in the Algarve (Williams and Patterson, 1998). They were mostly retired people, who had often worked in the British colonies, and were attracted by the climate. Prices were low and pension incomes had far greater purchasing power than in the UK. In the 1960s, international tourism came to Portugal, especially to the Algarve, and to a lesser extent to Madeira and Lisbon. The development of the Algarve as a destination for foreign settlement lagged behind that of tourism, but by 1970s several commentators noted increasing numbers of permanent British residents.

Thereafter, both international tourism and international retirement increased rapidly, especially to the Algarve. The British were the largest source of tourists during the final decades of the 20th century, and many purchased second homes for a variety of purposes: for investment and letting to tourists, as second homes, or as planned retirement homes. The importance of second home purchases remains significant down to the present, with one survey placing Portugal in fourth position for British second home ownership in continental Europe.

Table 130. Distribution of british owned second homes, in 2003-2005 (%)

Country	% of all British second homes
Spain	34
France	23
USA	6
Portugal	2
Italy	2
Other European countries	16
Other non-European countries	17

Source: DCLG (2006) quoted in IPPR (2006).

Different routes to retiring in Portugal

There are two main routeways to British retirement in Portugal:

- a) In common with other areas in Southern Europe (King *et al.*, 1998), many of the retired British in the Algarve have previously lived or worked abroad. Almost one-half (47.9%) had previously lived abroad for at least three months, and 37.7% had lived abroad either exclusively or for part of the time during the five years prior to moving to Portugal. This underlines the complexity of international retirement -- it is not simply a case of direct movement from the UK to the Algarve at the end of formal employment. It also emphasizes the importance of having worked abroad in providing the confidence and knowledge to facilitate retiring abroad. Also important in this context, is the retirement *in situ* of British people who have been working in Portugal - this is increasingly significant in both higher order professional jobs (mainly in the larger cities) and in a range of consumer services in tourism destinations such as the Algarve;

b) In the Algarve, as in other areas in Southern Europe, tourism (88.9%) has been by far the most important channel for acquiring prior knowledge of the country; work connections accounted for only 3.7% and family connections for 4.1% of responses to the survey in the Algarve in the late 1990s by King *et al.* (2000). It is also notable that 28% of those surveyed in the Algarve were currently living in houses that they had first acquired as second homes (Williams *et al.*, 2004). This is likely to be less significant in other areas of the country.

The British in Portugal - numbers

It is difficult to obtain accurate estimates of the numbers of British resident in Portugal, due to under-enumeration in the census and to non-registration with the authorities. The latter is compounded by the variable that seasonal residents spend in Portugal, which may blur their residential status.

According to the most authoritative Portuguese source, the *SEF*, there were 19,592 British residents in Portugal in 2005. The IPPR survey, based on a subjective assessment of the numbers of non-registered migrants, suggests a figure of 38,000 full time residents in Portugal, with a further 11,000 living there for more than 3 months of the year, but less than full time. This yields an estimate of some 49,000 in total, which is about 2.5 times larger the official estimates. In the parallel German case study, experts have estimated that the ratio between registered and non-registered is of the order of 3.6. If the same figure applied in Portugal, then the figure of 49,000 may be an under-estimate.

It is clear that the retired British community spend varying amounts of time in Portugal. The only reliable source that we have on this is the late 1990s study by King *et al.* (2000). The study only surveyed those who had spent at least 3 months in the country, and the figures show that in the Algarve:

- ▶ 54.4% can be considered to be full time resident or almost so (>40 weeks);
- ▶ 19.6% had their main home in Portugal, but did not live there full time (27-39 weeks), and;
- ▶ 13.0% were seasonal residents (13-26 weeks).

Age profile of the British in Portugal

The most recent data on the age profile of the British in Portugal is provided by the *SEF (Table 131)*. Assuming that there is no age bias in those who are registered v non-registered, this provides a good indication of the age structure of the population and how it has been changing in recent years.

The overall age profile of the British in Portugal is relatively elderly. In 2005, 46.9% were aged 50 and over, and 25.5% were aged 60 or over. Compared to 2001, this demonstrates a marked ageing of the profile, with 36.9% being aged over 50 and 15.9% aged over 60 at this earlier date. This is probably due to an ageing of the population *in situ* combined with continuing immigration of later-life migrants from the UK.

In 2005 there were 3,836 British men aged over 65 and women aged over 60 in Portugal, according to the Portuguese data, that is over the official retirement ages for receiving State pensions. This compares to the DWP figure of there being 6,257 UK State pensions paid in Portugal. Allowing for some of the British not being eligible for pensions, through having lived abroad extensively etc, this suggests a ratio of registered to non-registered of approximately two to one amongst the later life migrants - which is not inconsistent with the IPPR estimate.

Table 131. Age profile of the british in Portugal 2001-2005 (%)

Age (years)	2001 (%)	2005 (%)
0-4	566 (3.8)	729 (3.8)
5-9	645 (4.4)	825 (4.3)
10-14	630 (4.3)	789 (4.2)
15-19	547 (3.7)	666 (3.5)
20-24	506 (3.5)	668 (3.5)
25-29	639 (4.4)	828 (4.4)
30-34	943 (6.5)	1220 (6.4)
35-39	1173 (8.0)	1522 (8.0)
40-44	1075 (7.4)	1388 (7.3)
45-49	1130 (7.8)	1428 (7.5)
50-54	1550 (10.6)	1994 (10.5)
55-59	1513 (10.4)	2075 (10.9)
60-64	1319 (9.0)	1737 (9.2)
65+	1004 (6.9)	3097 (16.3)
Total	14953	18966

Source: *SEF*.

The late 1990s study by King *et al.* (2000) commented that the age profile of the later life British community in Algarve was younger than the equivalent communities in Malta, Costa del Sol and Tuscany, due to the later onset of substantial immigration flows. The evidence of the mid 2000s suggests that this demographic profile is now ageing, with important implications for health and welfare provision.

Geographical distribution within Portugal

The most reliable guide to the regional distribution of the British within Portugal is the *SEF* that provides data at the level of the District (**Table 132**).

In 2001, Faro (or the Algarve) was the most important location for British residents, with just over one-half (52.3%) living in this District. The second most important location was Lisbon accounting for 28.8%. Oporto was third ranked at 6.2% and Madeira was fourth ranked at 2.9%. There is therefore a very high level of concentration in the tourism/retirement zone of the Algarve (although many of the migrants may be involved in providing services for their compatriots) as well as in the two main cities of Portugal, where employment and business is the main attraction.

By 2005, the proportion living in Faro had increased to 54.6% and the proportion in Madeira to 3.2% suggesting the strengthening of the retirement/tourism attraction of Portugal. In contrast, the proportion living in Lisbon had declined to 26.5%, and that in Oporto to 5.4%. In absolute terms, there were increases in virtually all Districts.

Table 132. The british in Portugal at district level, 2001-2005 (Nr)

District	2001	2005
Aveiro	115	134
Beja	151	181
Braga	111	121
Bragança	7	13
Castelo Branco	25	28
Coimbra	327	451
Évora	19	23
Faro	7,822	9,790
Guarda	5	8
Leiria	158	192
Lisboa	4,300	4,767
Portalegre	53	78
Oporto	900	979
Santarém	65	84
Setúbal	320	360
Viana do Castelo	80	99
Vila Real	11	12
Viseu	27	28
Açores	26	40
Madeira	431	589
Total	14,953	17,977

Source: SEF.

Motivations for retiring in Portugal

The only reliable source on the motivations for British later life migrants settling in Portugal comes from the survey undertaken in the Algarve by King *et al.* (2000), and it is shown here alongside the comparative findings for the three other European study areas.

The most important reasons for having retired in the Algarve were the climate and other environmental factors (44.2%), followed by health reasons and a slower pace of life (15.2%). These reasons are broadly in line with those for other British retirement destinations in Southern Europe (e.g. Casado-Diaz *et al.*, 2002). An antipathy to Britain, and work or business connections, are more important than in some destinations, while admiration of the country and family connections are of lesser importance. Portugal is clearly seen as a good place to retire for amenity reasons, and for quality of life.

Table 133. Most important reason for moving to chosen destination (late 1990s) (%)

Most important reason	Tuscany	Malta	Costa del Sol	Algarve	Total
Lower cost of living (including tax reasons)	2.9	8.6	6.2	6.9	6.7
Climate (including other environmental factors)	15.4	37.5	48.1	44.2	40.4
Health, slower pace of life	10.6	14.6	18.4	15.2	15.7
Antipathy to UK	14.4	3.0	6.8	11.1	7.6
Admiration of destination country	11.5	7.9	5.0	3.7	6.3
Work or business connections	18.3	6.0	2.7	8.8	6.8
Family connections	19.2	15.0	8.9	8.8	11.8
Other	7.7	7.5	3.9	1.4	4.8
No. of respondents	104	267	337	217	925

Source: King *et al.* (2000).

Socio-economic features of British later life residents

The study of the Algarve is again the only source of data that we have on the particular socio-economic features of British residents in Portugal, other than the census that excludes most of them

and only covers a limited range of social features. Here we note their social-economic status, residential shifts within the Algarve, and housing circumstances.

Socio-economic status

Inevitably, the later life British residents in the Algarve are drawn from a wide income band and from many educational and occupational backgrounds. Only those with the lowest incomes were not well represented in the survey. Almost three-quarters (72%) of the sample were classified as belonging to Social Class I or II, which can be understood mainly as higher and intermediate level professional and managerial posts. This is broadly comparable with the social class composition of the British populations in the Costa del Sol and Tuscany (King *et al.*, 2000) and is higher than the overall profile of the UK population as a whole.

Residential shifts

Over time, the British residents in the Algarve have been relocating away from their initial concentrated settlements along the coast, in reaction to the growing congestion and rising costs associated with increasingly high levels of tourism and residential development. The first cohort were overwhelmingly (64.3%) located in the coastal urban areas and *urbanizações* (**Table 134**). By 1991/96 - when tourism had transformed the nature of these coastal places - they attracted only 36.1%. Instead, there was a shift by the second cohort towards the coastal rural areas, and by subsequent cohorts to the interior and the far west. Whereas, the earliest migrants mostly settled along the coast, later cohorts have been more likely to move to coastal rural and remoter western or interior Algarve locations. There has also been consistent, if modest, growth in the numbers of British retirees living in the interior and non-metropolitan areas of Portugal as a whole between 2001 and 2005 (**Table 134**). In-depth interviews in the same study also provided evidence that some of the earlier arrivals had also moved away from the coast of the Algarve over time.

Table 134. Residential shifts in the Algarve, 1998 (%)

Date of arrival	% living in settlement type:			
	Coastal urbanization	Coastal rural	Interior & west coast	Total
1961-75	64.3	17.9	17.9	28
1976-85	47.6	33.3	19.0	42
1986-90	46.8	29.9	23.4	77
1991-96	36.1	32.8	31.2	61
Total	46.2	29.8	24.0	208

Note: Coastal rural is the zone adjoining the dense strip of coastal settlements.

Source: Williams and Patterson (1998).

Housing

Most of the British living in the Algarve own their homes, and very few rent them. There are no significant differences in terms of age groups (King *et al.*, 2000). The preferred accommodation type in the Algarve is a house, echoing UK residential preferences. However, age differences are important, as increasing frailty or the loss of a partner is associated with moves to different types of dwelling as individuals adapt to changing needs and circumstances. In the Algarve, this is evident in terms of dwelling type, for while circa 90% of those aged 50-80 live in houses, only 69% of the 80+ group do so, with a further 31% living in apartments.

There is evidence then that the oldest age groups are adjusting to their changing needs by moving into apartments. The ready availability of apartments to buy means that there is no shortage of such

housing in the Algarve. However, there is little provision of various forms of sheltered or retirement housing and, although this picture is changing, it is likely to be one of the greatest challenges for the future (Warnes *et al.*, 2000).

There is a relatively high level of second (or retained) home ownership in the UK although this is still characteristic of only a minority. Just over 30% of each of the first three cohorts that had arrived before 1990 had maintained homes initially in the UK, but this proportion increased to 47.6% for the cohort who had arrived 1991/96 (*Table 135*). The reasons are not clear; while being related to the difficulties of selling houses in the depths of the 1990s housing depression in Britain, there may also be increased propensity to dual residential patterns, perhaps reflecting the greater resources available to the most recent cohort of migrants. The data on whether second homes were still maintained in the UK in 1996 show relatively low levels for the first two cohorts (pre 1980) but just over a quarter of the latter two cohorts (1986-1996). Therefore, there is a small group who maintain a residential base in the UK even within the longest resident cohort.

Table 135. Maintenance of second homes in the UK, survey in the Algarve, late 1990s

Date of arrival	Maintenance of home in UK		
	Initially	Still maintained	No of respondents
1961-75	31.0	13.8	29
1976-85	31.8	9.1	44
1986-90	32.5	26.9	83
1991-96	47.6	27.0	63
Total	36.5	17.8	219

Source: Williams *et al.* (2004).

1.4. Quality of life of the later life British residents

Integration

The only direct evidence on the social integration of the British comes from the study by King *et al.* (2000) in the Algarve. The findings indicate that in the late 1990s:

- ▶ British residents were generally more strongly integrated with each other than with the Portuguese residents in the Algarve - evident in their memberships of associations, patterns of friendships, and the media, which they read or watched. This tendency was greater in the coastal urbanizations than in the interior;
- ▶ There were considerable differences in language ability, with only 27% considering that they spoke Portuguese very or quite fluently, while 19% answered that they spoke no more than a few words of Portuguese. In one sense, such self-evaluations are inexact but they do tell us about the level of self-confidence in the use of Portuguese. However, language does seem to be a real influence on some areas of everyday life. For example, the same survey found that only 43% read a Portuguese newspaper at least occasionally. Additionally, only 40% considered that they could deal with official forms with few language difficulties. Not surprisingly, language difficulties were quoted as one of the major problems encountered in living in Portugal;
- ▶ There were important variations by date of arrival. The earlier immigrants, as would be expected, were more able to speak Portuguese, although it is notable that only 59% of those who had arrived before 1975 - i.e. more than 20 years earlier than the survey date - considered that they were very or quite fluent;
- ▶ For many of the British residents, there is relatively little need to speak more than a few words of Portuguese when shopping. The rest of the time they can watch English-language television,

read English-language newspapers, and meet friends in associations where - if not mainly British in memberships - English is frequently used as a common language. However, the same does not apply to the British who have settled outside of the Algarve but we have no data on their social integration and language skills.

General well being

King *et al.* (2000) undertook a systematic comparison of the general well being of the British in the Algarve, Costa del Sol, Malta and Tuscany in the late 1990s. The results show that the highest general level of well being (a composite index based on objective characteristics and self-evaluations) was in the Costa del Sol, with Malta and Tuscany being close to the overall mean, and the Algarve being surprisingly low. The comparison between the Costa del Sol and the Algarve is notable:

- ▶ The high level of well being in Southern Spain was associated with the climate, an active lifestyle, high ratings for hospital services, recreational and social facilities, excellent airline connections to the UK, and relatively few complaints about local services;
- ▶ In contrast, the low Algarve score was associated with a high frequency of problems and disappointments (both minor and major): 12% were dismayed by the roads and driving standards (3% in the other three areas), and 14% by the difficulty of getting work done in their homes (4% in the other case studies). Other disappointments which were at least 2.5 times more common in the Algarve than in the other three survey areas included dirt, litter or pollution, the gas, water and electricity utilities, the rising cost of living, and the high cost of air travel.

It is difficult to know exactly why self-evaluations of well being were so much lower in the Algarve than in the other areas. It may be that the British in the Algarve were relatively recent arrivals, compared to other destination areas, and were still adjusting to life in Portugal. Or it may be that the Algarve was developing more rapidly as a tourist and retirement residential area than the other case studies, so that there was greater disruption and more environmental changes which were sources of irritation in everyday life.

Although the British residents did register dissatisfaction with several areas of life in the Algarve, this was also the destination area where the largest proportion (90%) considered the life style to be a major advantage. Although many of their concerns were irritants rather than major causes of dissatisfaction, health was one matter that caused substantial concern.

Health

The study by King *et al.* was undertaken in the late 1990s, and we do not have any information on British residents' use/experience of health-care services at the current time, after a period of substantial reforms in the health care system in Portugal, especially the 2002 reforms. The main concerns in the late 1990s were:

- ▶ Perceptions of limits in local health care services and the need to travel to Lisbon, or even to the UK for some specialized health care;
- ▶ Perceptions of inconsistency in the type and quality of general practitioners, or family doctors;
- ▶ Perhaps in response to these perceptions, the British in the Algarve were far more likely to have private health insurance than the British in the other three case study areas (*Table 136*). This applied to hospital care in Portugal and the UK, and for nursing home fees in both countries.

Table 136. Possession of private health insurance, late 1990s (%)

Type	Algarve	Average in 4 countries
Hospital care costs, Portugal	60.6	48.7
Hospital care costs, UK	56.6	37.0
Travel costs to UK for care	24.9	15.2
Nursing home fees, Portugal	31.2	27.3
Nursing home fees, UK	30.8	19.4
No health insurance	30.3	40.5

Source: King *et al.* (2000).

UK health services do not have to provide free care and treatment for British citizens who have been living outside the country, although the ownership of second homes in the UK, or the existence of relatives in the UK, means that in practice rights are blurred. Interviews in the late 1990s also suggested that many British residents maintained their registrations with the British National Health Service, in case of the need for specific treatments. In any case, 70% of the later life British in Portugal had private health care insurance.

If they are registered with the (taxation) authorities, work in Portugal (and are contributing to the social security system) or are of State pensionable age, then the British residents are entitled to access public health care in Portugal, on the same basis as the Portuguese. Those who are of State pensionable age have to complete forms E121 to register. If they are retired but below pensionable age, then they can qualify for up to two years, free health care cover by obtaining form E106.

The groups of most concern are: those who have no private health insurance, retired early and below pensionable age; and those of all ages who live most of the year in Portugal but not registered with the Portuguese authorities. The 30% recorded in the late 1990s with no private health insurance was lower than in other case studies in Southern Europe, is strikingly high, but may have changed since. For example, a study of British residents aged over 45 years living in Spain's Costa Blanca found that 67% were covered by UK or Spanish health services, 17% by both, 12% by private insurance only and only 3% had no cover at all (La Parra and Mateo, 2008).

Whatever the exact size of those not formally covered by rights of access to public and private health services, this is potentially a problematic group. This is the group that in a study of the British in Spain, Rosenmoller and Lluch (2006: 67) term "the floating population". The "floating population" or "false tourists" are residents who stay in Spain for more than three months of the year, but without regularizing their situation. They travel back-and-forth between their home country and Spain. Because of their transience, their numbers are difficult to assess. Many European homeowners do not register with the authorities because they use their Spanish home as their second residence, spending only part of their time in Spain. They often do not consider registering with the local authorities. As tourists, they cover any necessary health care with the E111 (now with the newly introduced European Health Insurance Card (EHIC)). Some also have travel and/or private health insurance. Such individuals raise concerns for the Portuguese authorities that find it difficult to know the true catchment populations for local health services. Not all the later life British residents in Portugal will have completed forms E121 transferring their rights (and funds) to the local health service in Portugal. There are also obvious concerns for the health and well being of these individuals, particularly where they need non-emergency health care, for which their "temporary visitor" provisions are inadequate. But we have no firm data on the scale of this potential problem. The main issue is that while they will have access to emergency care, in situ, they are excluded from preventative health care, and may face difficulties in the case of prolonged hospital stays.

1.5. Moving to Portugal

Whereas moving from Britain to Portugal in the 1920s or even the 1960s was something of an adventure, it has now become highly commercialized and organized. Here we consider the role of private-sector property agencies and the information available to individuals.

Private-sector agencies: property acquisition

There is now a substantial industry selling property in Portugal to Northern Europeans. These include both paper sources (especially large numbers of guides providing advice on living in Portugal) and web sites. There are also numerous high street property agencies in the UK and Portugal, web sites, and property fairs. One indication of the importance of Portugal for British prospective buyers comes from a survey undertaken by IPPR (2006) of the numbers of foreign properties, by country, listed on three major international property web sites. It should be noted that not all these properties are destined for residence - they may also be bought for holiday lettings, or as speculative investments.

Table 137. Top 10 most advertised overseas property destinations on three major web sites (No.)

Country	Number of properties listed for sale
Spain	23,834
Bulgaria	7,456
Cyprus	5,261
France	3,356
Turkey	2,608
Italy	1,925
Portugal	1,858
USA	1,194
Greece	389

Source: Total listings on three websites.

(www.worldofproperty.co.uk, www.homesoverseas.co.uk and www.property-abroad.com) (13/10/2006).

Portugal appears at number 7 in this list, ahead of Greece and the USA but a long way behind Spain (even in proportional terms, taking into account differences in the populations of the two countries). It is also notable that it is behind Turkey and Bulgaria, indicative of the widening property searches of prospective British buyers.

Within Portugal, most of the property advertised for sale is in the Algarve: for example, on November 15th 2007 the www.worldofproperty.co.uk website listed 516 properties for sale in the Algarve, followed by the Costa de Lisboa with only 12, and only 11 in the rest of Portugal. However, other sales sites do indicate growing interest in property outside of the Algarve.

Adequacy of information and knowledge

A review of the information on many of the property and “moving abroad” web sites indicates that many provide only minimal information about property law and local taxes. There are concerns about how prepared British residents are, not only for the realities of living full time in Portugal, but also about their changing needs as they grow more frail in later life. Most of those interviewed or surveyed in the study by King *et al.* (2000) in the Algarve in the late 1990s were generally content with their life in Portugal, and most had considerable private financial and other resources to draw on in the face of future needs - including the possibilities of returning to the UK. However, there are individual stories of need and hardship, and it is likely that these may increase, as the British residents in Portugal grow older.

A 2006 BBC report (<http://news.bbc.co.uk/1/hi/uk/6165955.stm>) emphasized this issue, in the context of Spain's Costa del Sol, although similar experiences would also apply to Portugal:

- ▶ Bruce McIntyre, British Consul in Malaga, said his staff were often dealing with the cases of people who had started their retirement 15 years previously - but found themselves in desperate situations as they got older;
- ▶ Sometimes a partner has died and the other is too old or infirm to go out and buy food, said Mr. McIntyre;
- ▶ Sometimes people have made bad property investments or have not budgeted their pensions sufficiently and are living in extreme poverty;
- ▶ British retirees need to realize that not many European countries have welfare provisions like the UK - there are often no old people's homes, no district nursing, community care or meals-on-wheels.

The difficulties are compounded by differential rights to social security benefits, even though there is a reciprocal agreement on social security between Portugal and the UK, those who have moved to work in Portugal may find that they are disadvantaged when they reach retirement age because of the fragmentation of their working lives between different countries - there are still many difficulties in transferring lifetime rights across international borders in the EU. There are also difficulties faced by people who move between European Union member States late in their working life or upon retirement (Ackers and Dwyer, 2002; Dwyer, 2000).

1.6. Future trajectories

This section of the report considers the likely future trajectory of the numbers of British living in Portugal. First we consider future emigration from the UK, followed by a discussion of the important issue of staying v returning in later life.

Potential emigration from the UK

It is difficult to predict future emigration trends from the UK, on the basis of opinion surveys, because intentions are not automatically translated into actual emigration. A survey (based on a random sample of c 1,000 adults in the UK in July 2006) found that 54% had or would consider emigrating from the UK. More significant is the finding that 13% had *actively* considered emigrating, a proportion that was double the level observed in a similar survey in 2003. The total sample size is small, and the notion of "active consideration" is difficult to assess through such surveys. Nevertheless, the findings suggest a strong and perhaps growing interest in living abroad in all age groups. This is consistent with growing emigration from the UK in the 2000s.

The study by IPPR (2006) also estimated that, taking into account the ageing profile of the population and the rising trend in emigration, there could be about 3,3 million UK pensions being paid abroad by 2050. Such long terms predictions are notoriously unreliable, but do at least indicate potential for growth in the numbers of later life British people living outside the UK.

The preferred destinations according to a Bank of Scotland survey in August 2004 were the English speaking countries, especially New Zealand, Australia and Canada, followed by "Southern European" destinations such as France and Spain.

Table 138. Where british pensioners would most like to live overseas (%)

Country Rank	Preferred Country To Live Overseas
1.	New Zealand (11%)
2.	Australia (7%)
3=.	Canada (6%)
3=.	France (6%)
5.	Spain (5%)

Source: <http://www.hbosplc.com/media/pressreleases/articles/bos/2007-08-13-WhereBriti.asp?section=bos>

Determinants of future emigration

Although all such estimates are problematic, an examination of the factors which are likely to influence later life emigration confirm that there are strong reasons to expect to see continued strong growth. There are also reasons to expect that Portugal will continue to be an important destination, although it faces considerable competition from other destinations.

Incomes and purchasing power

UK real incomes, in terms of purchasing power abroad, have generally increased rapidly in recent years (although the fallout from the 2007/08 “credit crunch” has halted the improvement). Although State pensions are low by Northern European standards, there is still considerable access to relatively well funded occupational and private pension scheme. These have come under pressure from, respectively, a shift from final salary to defined benefit schemes, and from increasing stock market volatility. Incomes and pension incomes are also highly polarized. However, there remains a substantial proportion of the population with access to substantial incomes and also wealth (especially from house prices, with the UK having exceptionally high house prices), as well as a relatively strong foreign exchange rate. However, price convergence and membership of the Euro mean that Portugal will probably continue to become a relatively more expensive destination for British migrants.

Ageing population profile

The UK population is growing relatively rapidly, driven by high rates of immigration and is predicted to increase from c 60 million at present to c 70 million by 2031 (*Figure 88*).

In common with most European countries, but less so than some, *e.g.* Italy, the UK population is also ageing. The proportion aged 65+ is predicted to increase from 16% in 2003 to 22% by 2031. This reflects both the life cycle effect of the ageing “baby boom” cohorts born after World War Two, and increasing life expectancy (see *Figure 89*).

Figure 88. Actual and projected UK population, 1991-2031 (N.)

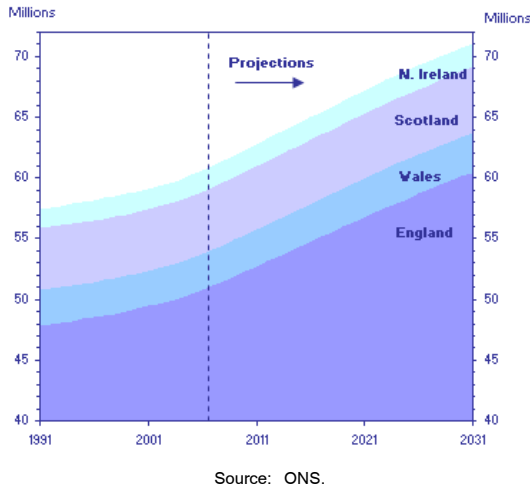
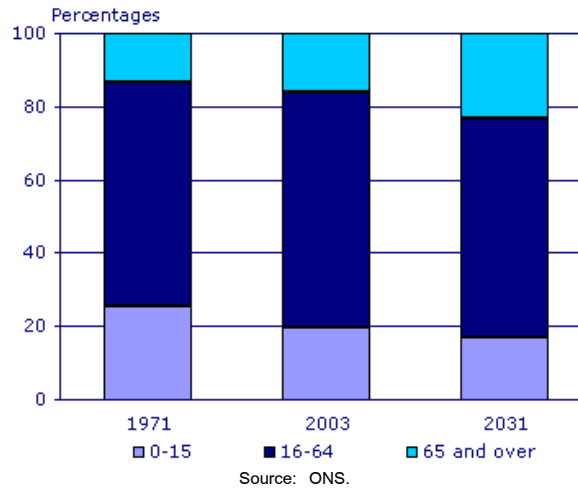


Figure 89. Actual and projected UK population structure, 1971-2031 (%)



Changes in working lives

There are two significant changes in working lives that have contradictory implications for international retirement migration.

The growth in the number of people working abroad increases the knowledge, confidence, social networks and (sometimes) the motivations for retiring outside the UK. The study by King *et al.* (2000) confirms the relatively large numbers of British retiring abroad who had lived abroad for at least 3 months prior to retirement (49%).

In the UK, as in most other European countries, there has been an increase in the “official” retirement age with women’s qualification age for the State pension being gradually increased to 65 to match men, and both being raised to 67 over the coming decades. There is also evidence that the average real age of retirement is now increasing in the UK after several decades characterized by high levels of early retirement. This may dampen the demand for living abroad, although the experiences of retirement and early retirement are likely to remain highly polarized.

Property ownership

Many of the British living abroad owned foreign properties in those countries - perhaps as second homes - before migrating “permanently”. Foreign property ownership is therefore a powerful predictor of future migration.

A survey by ICM Research on behalf of Barclays Bank plc provides insights into foreign property ownership intentions in the UK. Their survey estimated that 5% of the UK population, that is some 2,2 million, already own a home abroad (this is a surprisingly high figure, and needs corroboration in more surveys), and a further 5% - another 2,2 million - stated that they are “definitely” intending to do so. Intentions are not necessarily converted into purchases, and purchases may not always be followed by permanent or even long-term seasonal residence. However, these data are indicative of buoyant potential demand. The survey also identified the top ten potential destinations for British people intending to buy abroad. Portugal is ranked seventh in this league table, accounting for some 5% of the total.

Table 139. Intentions to buy properties abroad: destination countries (%)

Destination Countries	(%)
Spain	30
USA	15
France	14
Italy	10
South Africa	6
Dubai	5
Portugal	5
Bulgaria	3
Croatia	2
Morocco	1

Source: sample of 1001 adults, October 2005, undertaken by ICM Research. (<http://www.icmresearch.co.uk>)

These data include holiday homes and investment properties, perhaps as evinced by the presence of Dubai on the list. However, while indicating the continuing attraction of Portugal, they also emphasize the importance of competing destinations such as Croatia and Bulgaria.

More precise data on international retirement is provided by a survey undertaken by Saga, one of the major UK providers of leisure and insurance services to older consumers. They report that the vast majority of Britons buying retirement homes abroad still prefer Spain and France, but that Italy and Portugal are in the second rank of preferences (www.saga.co.uk). However, they also report growing interest in newer locations such as Croatia and Bulgaria, as well as in Central Europe. Florida is popular for holiday home property purchases, but immigration rules make it difficult to retire there full time. South Africa is also an increasingly popular destination, as - in smaller numbers - are several Asian countries.

Competition linked to prices and tourism

Portugal seems likely to continue to be an important retirement destination for British people as one of the customary "Southern European" destinations. However, as noted above, there are growing numbers buying properties or retiring to other countries outside of the traditional English speaking countries and traditional Southern Europe destinations. Turkey, Bulgaria and Croatia provide particularly strong competition, especially given their lower costs of living and property prices.

Chain migration - the importance of connections

Portugal can be expected to be one of the largest beneficiaries of future retirement migration from the UK, because of the accumulated connections between the countries. First, Portugal has long been a popular holiday destination for UK tourists, and secondly there is already a substantial international cohort of retired British people living Portugal, especially in the Algarve. The presence of this community, the specialized services which have grown up to meet their consumption needs, and the evolution of associations and clubs which cater for their day to day interests, will facilitate further retirement migration to Portugal in future. Not least, many British people now know someone who lives in or has a home in Portugal and this is an important connection leading to decisions to move to a country (Williams *et al.*, 2000; 2004).

Transport and communications

Relocation to Portugal is also facilitated by changes in transport and communications:

- ▶ There has been rapid expansion of air links between Portugal and the UK, especially through the growth of low cost airline flights to regional airports. These considerably reduce the financial and time costs of traveling between the two countries. Faro airport has been a particular beneficiary of this trend (*Table 140*);
- ▶ ITC developments (such as the internet, web cameras, and mobile phones with cameras) have made it much easier to stay in contact with family and friends after migrating.

Table 140. Direct flights from Faro to UK airports, November 2007

Birmingham	Belfast	Blackpool	Bournemouth
Bristol	Cardiff	Coventry	Doncaster
Exeter	Gatwick	Heathrow	Leeds
Luton	Manchester	Newcastle	Norwich
Nottingham	Southampton	Stanstead	

NB - some of these flights are only available in summer months. They also have varying frequencies, ranging from daily to weekly.

Summary of future migration

It is difficult to make confident predictions beyond the short term. However, surveys of British intentions to emigrate and to buy property abroad suggest that there is likely to be sustained strong growth for living abroad in later life. A review of the main determinants of such demand confirm that this is likely to be the case, especially due to the ageing population, real incomes and purchasing power, and improvements to transport and communications. There are some negative features to note including later retirement, and uncertainties about pensions, but these are probably outweighed by the positive factors.

Portugal stands to benefit from these trends because of existing and intended property purchases, greatly enhanced air travel connections to UK regional airports, and the existence of chain migration to the already substantial British communities in the Algarve in particular. However, rising prices and costs in Portugal in context of a strong Euro, and growing competition from South East Europe in particular, do pose questions about the medium to long-term attraction of Portugal.

The ageing British communities in Portugal

The other big question about future trajectories concerns the existing British residents in Portugal. Will they stay in Portugal as they grow older - and frailer - or will they return to the UK?

To stay or return?

It is always difficult to assess return migration intentions. Opinions stated when individuals are active and in the early stages of later life, are not necessarily a reliable guide to the decisions they (or their family on their behalf) make when they become frailer, or face crises such as the death of a partner, or debilitating illness.

The IPPR (2006) study - based on a necessarily unrepresentative web based questionnaire - found that only a minority of Britons currently living abroad would want to return to the UK to live permanently. There are two main reasons for returning while still relatively young and active: missing family and friends (grandchildren in particular), and - for the less affluent - finding that costs of living were significantly greater than they had anticipated. IPPR focus groups found some concerns about whether they would be able to manage such moves, given the very high levels of house price increases in the UK in recent years.

In the specific case of the Algarve, the study by King *et al.* (2000) in the late 1990s, provided useful insights into future intentions at that time. The 220+ respondents in the study, all aged over 50, were

asked about their future residential decisions in response to a number of different hypothetical situations. In general, there was a very high level of commitment to staying in Portugal for the longer term (*Table 141*). Most of those surveyed stated that they would return to the UK if faced with a major crisis that threatened how they lived, but substantial proportions would stay even if faced with being unable to do their own food shopping (35%), their spouse's or their health worsened (31%), their spouse died (42%), or they had to give up running a home (14%).

Table 141. Staying on: conditional responses of the British in the Algarve in the late 1990s (%)

Date of arrival	If could not do own food shopping	If own or spouse's health worsened*	If spouse died	If had to give up running a home
1961-75	48.0	59.1	53.3	30.4
1976-85	37.2	39.5	33.3	18.4
1986-90	38.0	23.4	42.6	12.0
1991-96	23.3	24.6	42.3	6.7
Total	34.8	30.9	41.6	13.8

Source: Williams and Patterson (1998).

However, it is useful to observe how these proportions vary across migration cohorts in terms of date of arrival. The proportions of those who would stay are near or over 50% in all these hypothetical situations for those who had arrived before 1975. Although the evidence is less clear for the other cohorts, this does indicate that over time migrants may become more attached to Portugal, whilst their connections with the UK weaken. Of course, we do not know if these intentions will be followed, or if they will decide to return to the UK when actually faced by such crises.

Issues relating to the frail elderly British in Portugal

As British residents age in Portugal, and given evidence that about one-third would not return to the UK even in the face of serious health and personal crises, a number of issues will need to be faced by them and by the Portuguese authorities. These challenges are emerging later in Portugal than in some other Southern European destinations because of the relatively recent growth of British immigration compared to say Italy, Malta or Spain.

One of the major challenges will be in relation to housing. Most of the British own their own homes and live in relatively large dwellings, often in peripheral urbanizations. Increasing numbers are also living in more rural areas. In future there will be a need for particular types of housing - small apartments with good access to services, and then later sheltered housing (with some warden services).

As the population becomes frailer, they will also make more demands on hospitals for treatment of a range of conditions. There will also be a need for different levels of personal and nursing care, either at home or in care or nursing homes. Some of these residents will only have limited Portuguese language competence, which will also pose additional problems for them and for those providing care.

The resources available to this frail elderly population are diverse. Many have good pensions and large savings to pay for such care, but many do not. Even those with good pensions may find that the values of these have declined over time. There are also major issues about the levels and types of support that they will be able to rely on from their families, from friends and neighbors in Portugal, and from the British community and voluntary organizations. In any case, it is almost inevitable that there will be increasing needs for state provided social and health care. This poses questions for service provision in Portugal, both nationally and locally, for health insurance companies, and for private providers of specialist care and housing.

Summary

Portugal is an important destination for international British retirement. This has been based on both the increase in British emigration in general and retirement migration in particular, and the specific attractions of Portugal. Within Portugal, the British have concentrated in the Algarve, although there are also significant numbers in Lisbon, Oporto and Madeira.

Although data limitations make it difficult to be precise about numbers, the available information suggest not only that there are substantial numbers of older British migrants in Portugal, but also that their numbers are increasing rapidly, and this is especially true of those who are of pensionable age.

The experiences of British later life migrants in Portugal are generally positive, although interestingly their self-evaluations of their experiences suggests that in the late 1990s they were less positive about their general social well being than the British in some other Southern European locations. Health care services were one of the major concerns at that time, but so too were Portuguese language competence, and the difficulties of dealing with the Portuguese local administrations. We have noted that there are particular issues relating to the health care entitlement of those who are neither registered with the authorities nor have adequate private health care insurance.

Looking into the future it is likely that later life migration from the UK to Portugal will continue to be strong and may increase further, given favorable conditions in the UK. However, there is also increasing competition from other countries, and some other sources of uncertainty in the medium and long term. The sharp slow down in house-price growth in the UK during 2008 is likely to cause a least a temporary slow-down in the rate of property purchases in other countries.

Later life migration to the Algarve has a shorter history than say to Italy or Spain, so the British residents tended to be relatively young and active when they were studied in a major survey in the late 1990s. The population is now ageing, and increasing numbers are entering the frail elderly stage of the life cycle. A minority, but a significant proportion (about one-third), seemed committed to remaining in Portugal even in the face of increasing personal adversity. This poses major questions for the provision of specialized housing, care and nursing homes, and geriatric health care services in future - both for those with considerable personal resources, and those who are relatively impoverished.

2. Market analysis of the german elderly in Portugal

2.1. Introduction

In a study that analyzes the needs of senior citizens in Portugal, a market analysis of German older people who may be interested in residing abroad might at first appear to be a marginal concern. During the last two decades, however, there has been a significant growth of interest among German retirees in moving to Portugal. Although the country is not yet a "hot spot" for retirement migration, the German presence is increasing. Unfortunately, however, there is a substantial lack of evidence about the circumstances of their living arrangements, networks, motivations, desires and problems.

Almost no surveys focus on this segment of the population and their socioeconomic characteristics. Even their exact number is unknown. Official statistics about migration or residential status are fragmentary as they only register residents who change their legal residence and/or apply for work permits. However, the large number of non-registered foreigners or those living seasonal in Portugal does not appear in the official statistics.

Because of the lack of data on the German settlement, this account combines primary and secondary sources. It will draw directly on the expertise of scholars working in this field. This will include background knowledge from the Scientific Network on "International Migration in Europe: welfare policy and practice implications for older people" supported by the European Science Foundation (ESF). This, in

combination with expertise gained from two surveys carried out in Spain, will allow conclusions to be drawn by analogy.

2.2. Portugal within the European migration regime

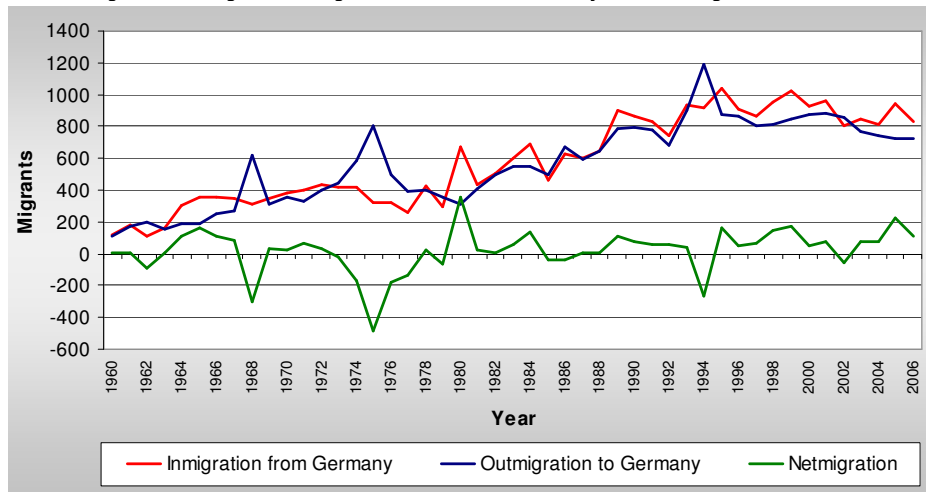
For many decades after World War II the international migration pattern between Portugal and other European countries was characterized by strong emigration flows of labour migrants to Northern European cities. Germany was one of such destination country (Freund, 2003). Meanwhile Portugal is member of the EU and the migration regime has changed completely. Since the early 1990s, the number of foreigners entering the country has exceeded the outflow of Portuguese nationals. A transition from a country of emigration to a country of immigration has taken place (Fonseca *et. al.*, 2005, p.1).

Migration of German population between Germany and Portugal

Part of this transition is the involvement of German nationals in the migrations to Portugal. Considering the migration in- and outflows between both countries from 1960 to 2006, (*Figure 90*) provides us with two key points:

- ▶ During the period under review, a constant rise in the number of migrants can be observed. Since the early 1990s there has been an acceleration in the number of both in and out migrations;
- ▶ Substantial net-migration gains can be observed since 1990. The ratio for this entire period is 27,603 German immigrants to 26,656 return-migrants.

Figure 90. Migration of Germans between Germany and Portugal, 1960-2006



Source: Datafile Statistisches Bundesamt, Wiesbaden (2007).

Portugal as a destination of international retirement migrations

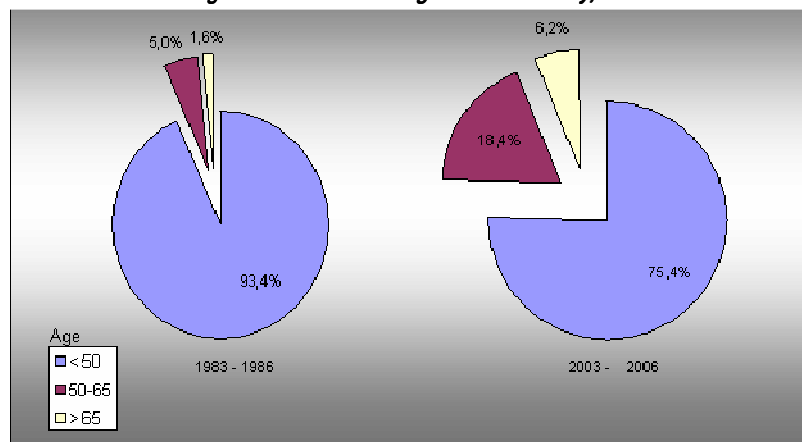
In Europe, *retirement* migration used to be largely confined within national boundaries. It is only in the last few decades that an increasing number of elderly migrants have crossed national borders, most often heading towards Mediterranean countries. Most come from Northern and Central Europe and are aged in their fifties or sixties when they take up residence in the “sunshine” locations, using their retirement home either seasonally or permanently. The importance of this area as a destination for Germans can be associated with both its positive image in the German media and knowledge acquired through mass tourism. Tourism has also improved accessibility, through frequent and cheap flights, and

has encouraged the development of the infrastructure for German visitors and residents. Due to the liberalization of the EU labour market and the rising demand for personal and social services, many German professionals and entrepreneurs now live and work in personal service and health sectors.

Research on international retirement migration (IRM) supports the thesis that this type of amenity-led migration is the result of individual strategies to improve one's quality of life. In the search for better environments, retirement migrants prefer climate benefits and attractive landscapes enabling them to pursue a variety of outdoor leisure activities (Wames & Williams, 2000). These areas most often coincide with tourist destinations (Williams *et al.*, 2000; Rodríguez, 2001). Spain is undoubtedly the country in the Mediterranean that has attracted the most international retirement migrants from Germany (Breuer, 2003; Friedrich, Kaiser and Buck, 2004). The number of them has shifted steadily from the late 1960s onwards with rising annual growth rates, so far culminating in the boom years at the end of the 1990s.

However, challenging the Spanish dominance, Portugal is increasingly becoming a preferred destination-country for German international retirement migrants. The longitudinal analysis of international migration in- and outflows of German seniors (50+) between Germany and Portugal shows clear similarities but also differences to the general migration pattern discussed above. Comparable is the almost balanced relationship between in- and return migrants as well as the low amount of in- and out-migration during the 1960s and 1970s. However, significant increases have occurred since the mid-1980s. Whereas the migration volume for the period 1983-86 shows a yearly mean of 77, this increased to 393 during 2003-06. During this time the proportion of seniors in all German migrants shifted from 6.6% to 24.6% (*Figure 91*).

Figure 91. German senior migrants between Portugal and Germany, 1983-1986 and 2003-2006 (%)



Source: Wanderungsdatei Statistisches Bundesamt, 2007.

2.3. The German Community in Portugal - counting the uncountable

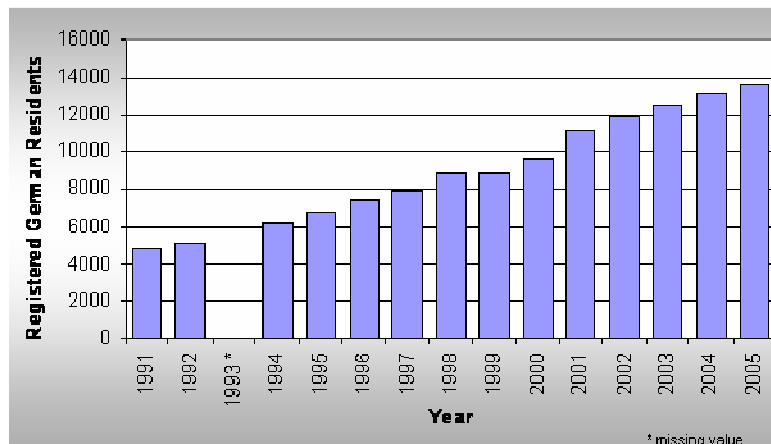
A crucial aim of this survey is to develop a better understanding of the number of German people living in Portugal and the proportion in the elderly age group. This is also true for all other Mediterranean countries whose citizens are not obliged to register as residents. There are many reasons why migrants do not register in their county of destination, such as to maintain their eligibility to social security and other benefits, to avoid income and property taxes, and to maintain the freedom to return to their country of origin. From previous studies of the situation of Germans in Spain, we know that the majority keep another home in Germany and do not register as residents. The Spanish geographer Salva Tomas (2002, p. 91) has estimated that only about one-third of the Germans living on the Balearic Islands are legally registered. As mentioned above, this undermines the reliability of the official data.

Registered and estimated number of German residents

According to OECD statistics (2007, p. 338; based on Portuguese census data), in 2001 about 24,300 Germans lived in Portugal, the second most numerous of all European foreign citizens. According to Eurostat and SEF, however, the number of resident Germans in 2005 was 13,571, only half the previous estimate. As can be seen in **Figure 92**, the number rose steadily between 1991 and 2005, to nearly triple the number in 1991.

The enormous discrepancy in the official estimates requires the use of other approaches. To obtain a more realistic insight into the likely number of German people living in Portugal and the proportion of the elderly within this group, 12 international experts were contacted by e-Mail. They were asked to evaluate the data pertaining to the registered population groups and assess which factors should be used to obtain a realistic figure with respect to the number of Germans currently living in Portugal and in order to predict future numbers (duration of yearly stay 3 months and over). The methodology of modified Delphi analysis was successful, as seven experts with a high reputation in international retirement migration (3), international migration (2) and the situation in Portugal (2) answered within a few days.

Figure 92. Registered german residents in Portugal, 1991-2005 (N.)



Source: Eurostat, 1991-2000; SEF, 2007.

Two main results can be drawn from **Table 142**:

- ▶ Following the expert assessment, the number of German people was multiplied by the mean factor 3,64. As a result, the estimated realistic size of the German population in Portugal in 2005 was as much as 49,398;
- ▶ As the future number of German foreigners migrating during the next decade is expected to be slightly lower than before, the forecast for 2015 predicts a figure of up to 68,139.

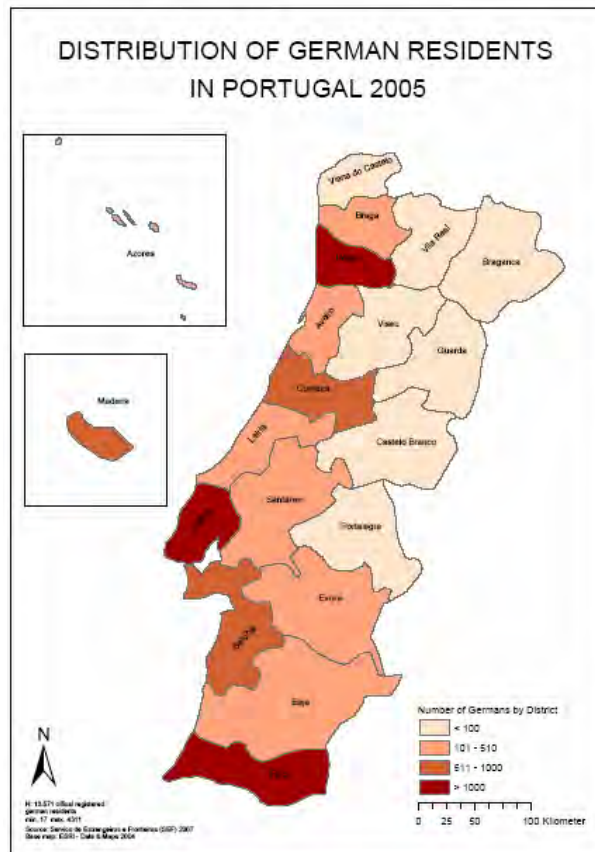
Table 142. Assessment of the realistic german population in Portugal

Registered	residents in 2005 mean yearly shift period 1991-2005 in %	13,571 623 12.9
Expert based assessment	multiplication factor for realistic estimation (min. 2,5; max. 5) mean yearly shift period 2005-2015 (min. -10; max. 18)	3,64 517 10.7
	estimated number of Germans in 2005 in 2015	49,398 68,139

Spatial distribution in Portugal

The distribution of the German population shows features comparable to those of other international retirement destinations in Southern Europe. There is a clear preference for coastal locations with their positive image as well known tourist destinations. Faro (Algarve), Lisboa and Oporto have the highest concentration of Germans (up to 4311) and together account for 70% of the population. On the other hand, rural and peripheral districts like those at the eastern borderline count less than 100 Germans (Bragança 17).

Figure 93. Spatial distribution of the registered german residents in Portugal, 2005 (N.)



Source: SEF, 2007.

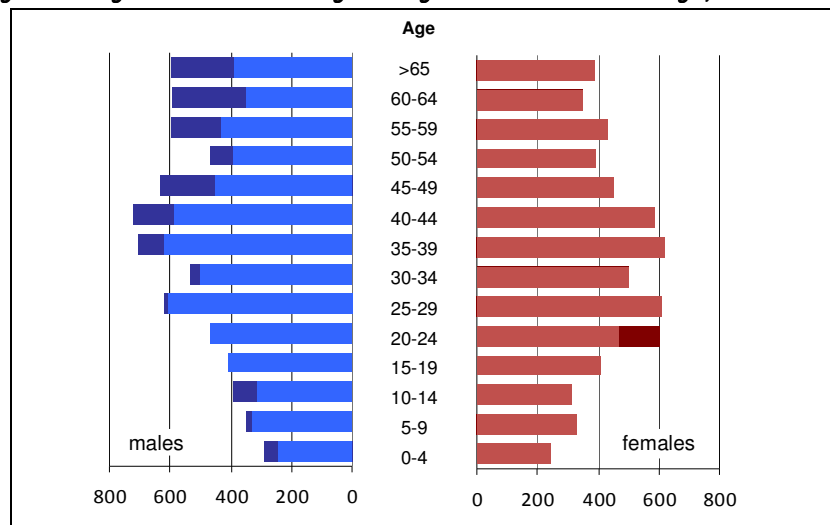
German older people in Portugal

According to the official residential statistics, German seniors aged 55+ years numbered 2,946 were 21.7% of the total. If we consider the experiences from other surveys in Southern Europe, they are obviously significantly under-represented. There, the older foreigners from the North make up a significantly higher proportion of their national community. According to the estimates of Salva Tomas (2002), those aged 55+ years represent 42.6% of the total German population on Mallorca. If we compare the following age structure (*Figure 94*) with that on Mallorca (*Figure 95*) it obviously mirrors the registration behavior of the elderly but not their real representation in Portugal. In addition to the aforementioned reasons, it is possible that in comparison to younger adults, retirees are less obliged to register for career and family reasons (including education for children).

The experts were also asked to make two statements concerning the current and future proportion of seniors (55 and older) within this total German population in Portugal. Their evaluation (*Table 143*) can be summarized as follows:

- ▶ The actual proportion of German seniors in the official data is, according to the experts, much too low. They suggest that the percentage of the 55 years and older Germans will increase within the next 10 years to 35%;
- ▶ As a result, the actual number of German seniors in the population in 2005 is placed at 16,350 and this will be expected to increase during the next decade to 23,985.

Figure 94. Age structure of the registered german residents in Portugal, 1991-2005 (N.)



Source: SEF, 2007.

Table 143. Assessment of the realistic german senior (55+) population in Portugal

Registered	seniors in 2005	2,946
	in % of Germans	21.7
	mean yearly shift period 2001-2005	202
Expert based assessment	current share of seniors in % (min. 21,7; max. 40)	33.1
	future share of seniors in % period 2005-2015 (min. 21,7; max. 40)	35.2
	estimated number of seniors	16,350 23,985

One of the experts - experienced in international retirement migration to Portugal - justifies the conclusion that there will be an increase in the number of seniors in the future, by pointing to the ageing and of the population and its increasing wealth.

2.4. Older Germans abroad: profile, attitudes and needs - learning from Mallorca

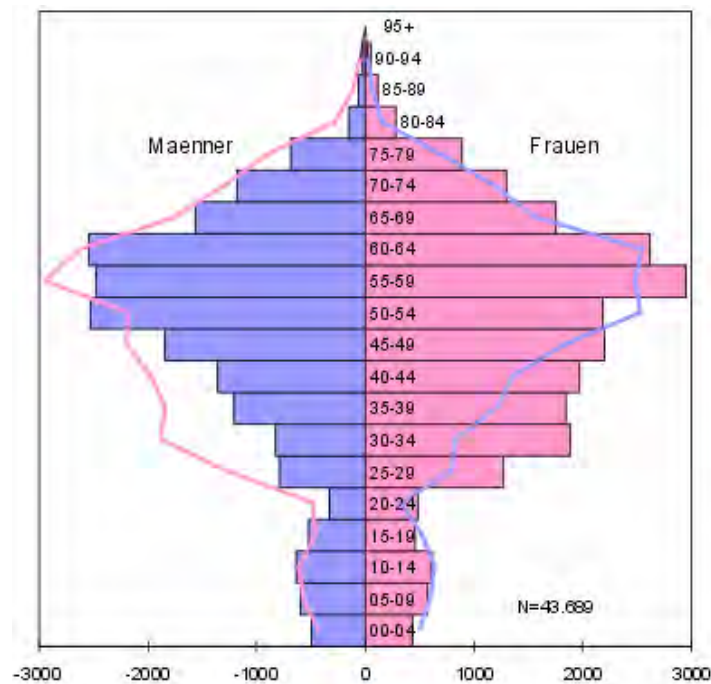
In this section the characteristics, motivations and adjustment conditions of the retired residents in Portugal will be addressed. However, as already mentioned, standard statistical sources offer little reliable information about this migration pattern. Because of this, our own experiences from two surveys about German migrants aged 55+ carried out in Spain will be used to draw conclusions by analogy. The Mallorca study (Friedrich and Kaiser, 2001) consists on 360 and the Costa Blanca survey (Buck, 2004) on 104 face-to-face interviews. These results are seen as being transferable to the situation of Germans in Portugal, because they also reflect and link into the results of other studies on later-life migration to Southern Europe (Rodríguez *et al.*, (Eds.) 2005; Casado-Díaz *et al.*, 2004).

Socioeconomic and demographic characteristics

When the first elderly Germans settled on Mallorca during the late 1960s, property prices and the cost of living were significantly lower than in Germany. Since then, price levels have risen substantially following Spain's integration into the EU and the island's unique economic upturn induced by international mass tourism. Nevertheless, the majority of elderly Germans settled during the 1990s. As a consequence of the steady rise in costs and prices, the socio-economic diversity of the German residents has increased.

It is important to note that only 70% of the migrants currently present decided to move to Mallorca when they were aged between 50 and 69 years - 23% were younger and 7% older. Supporting this assertion **Figure 95** emphasizes that the migrants represent a relatively young older population, the average age being 66 years.

Figure 95. Age structure of estimated german residents on Mallorca, 2001 (N.)



Source: Written message by Salva Tomas, 2001.

About 90% of the migrants had had abundant experiences as tourists on Mallorca before deciding to live there for an extended period. Such experiences influence the migrants' choice of the specific location for their new homes and determine their perceptions and opinions of "Majorcan" culture and society as well as their expectations as to their everyday lives as Germans on the island. Moving to Mallorca was generally associated with positive connotations and seen as a departure into an active and healthy phase of life.

Before their arrival to Mallorca they lived almost exclusively in West Germany and were largely retired from full-time employment. A disproportionately large number were formerly self-employed as well as among the more highly educated. Nonetheless, older Germans than might be expected lived in fairly modest circumstances. Two-thirds (66%) of the residents lived as couples on Mallorca and nearly 30% in single households.

Housing environments and living arrangements

The preference for locations near the coast is in accordance with the Germans' tourism experiences and orientation. Nevertheless, after years of depopulation, the rural and central areas of Mallorca have experienced a property boom, attracting second home owners and elderly migrants. Their homes are located in three distinctive settlement types: coastal tourism resorts (55%), planned urbanizations on the coast or its hinterland (30%), and rural areas (15%).

Table 144. Settlement types of Germans living on Mallorca and occupier characteristics

TYPE 1 - Coastal Towns	TYPE 2 - Urbanizations	TYPE 3 - Rural settlements
Since 1960s steady growth.	Since 1970s; boom in 1990s.	Since 1970s; boom in 1990s.
Apartments, owner-occupied flats, smaller houses.	Homogenous planning; apartments, houses or villas; with leisure infrastructure and general services.	Individual purchase; restoration of old fincas or new villas.
Highest Age; Highest proportion of singles and lower status groups.	Highest Proportion of self-employed.	Highest Proportion of self-employed and lowest proportion of retired.
Owner (81%); Apartment (66%).	Owner (94%); Apartment (42%).	Owner (88%); Apartment (14%).
Mixed Neighborhoods; 40% mostly Germans.	Neighbors mostly Germans (53%) and foreigners (25%).	More Spanish/Mallorquin neighbors; only 22% mostly Germans.
Average stay: 8.7 months; Ordinary language skills.	Average stay: 7.9 months; worst language skills.	Average stay: 9.5 months; best language skills and local interests.
80% would like to stay forever on Mallorca.	68% would like to stay forever on Mallorca.	94% would like to stay forever on Mallorca.

Source: Own survey, design by Claudia Kaiser.

Three-in-four Germans still live in their first Mallorcan home, whereas one-in-four has changed residence at least once. One-half live in apartments and half in terraced houses or individual villas with great variation in size and quality. 85% are property owners and 15% are renters. A typical feature of IRM is the seasonal use of retirement homes (Kaiser and Friedrich, 2002). Nevertheless, the average length of stay of Germans on Mallorca is 8.6 months, which already indicates the importance of permanent stays but conceals remarkable differences among the German population: 37% stay between 3 and 6 months, 21% between 7 and 10 months and 42% at least 11 months or permanently. The seasonal migrants predominantly prefer winter and spring months for their stays.

Another important category for the assessment of the migrants' living situation is whether Mallorca has become their exclusive or only additional residence. About 30% have given up their former residence in Germany, with higher proportions for those aged 70+ years (40%) and for those staying at least 11 months (56%). In addition, some of those with official residence in Germany are only formally registered

in the homes of relatives (most often their children) or friends, for health care eligibility and tax reasons.

Regional identity and social networks

An important feature for a successful migration is the integration into the host society. To investigate the topic, the German seniors were asked about their social networks, language skills, relationships with their home country and spatial orientations.

For the analysis of their social networks, the German seniors at the Costa Blanca were asked about with whom in Spain they regularly kept in touch and which of these people were meaningful or important to them. On average, 8.1 people were identified. The networks in the Els Poblets sample showed a distinctively self-contained orientation: six of the 8.1 were residents of the municipality. The number of meaningful contacts develops quickly, but does not change in size appreciably. On the other hand, roles do change. During the initial phase more than one-half (52%) of the people in the network are neighbors and 71% are considered to be good acquaintances/friends. Among households with a longer duration of residence (>2 years), only one-third (35%) of the people in their network were neighbors, whereas 85% were considered to be good acquaintances/friends. Obviously, emotional ties to their interaction partners increase with the length of residence.

The appropriateness of the migrants' living environments for higher support needs with increasing age cannot be assessed without considering social indicators, such as the migrants' neighborhood composition, their social contacts and degree of participation. As has been shown by other authors, the majority of elderly foreigners in Spain tend to stay amongst their own nationals. On Mallorca, 41% of the Germans live in almost exclusively "German" neighborhoods, 37% in internationally mixed neighborhoods (with the British as the second largest group), and only 22% live in neighborhoods that are predominantly local Mallorquin or Spanish. Language skills amongst elderly Germans are not as poor as has been ascertained for the British in Spain. Nevertheless, only about 20% of the interviewees state that they have good or fluent knowledge of Spanish, and hardly anyone has a command of Mallorquin, the island's official language. Poor language skills are both the consequence and cause of limited social contacts with the local population. Although nowadays many matters of everyday life can easily be dealt with in German, language knowledge is still crucial if problems arise, for example when in need of health care or nursing or when local bureaucracy has to be dealt with. Another important indicator of having integrated into the destination community is the intensity of participation in social associations. In this respect, the German senior population is rather self-contained compared with other nationalities (for example the British). 22% participated mainly in activities with their own nationals, 15% with expatriates and 17% with the host society.

Maintaining the option to return to Germany is dependent on the quality of family networks and intergenerational kinship ties. Again, many older Germans with family foster their relationships regularly through mutual visits, phone calls or other modern communications like the internet. Yet many of the interviewed Germans either did not have any children or had lost contact with their offspring.

Finally, we should consider the common argument that transnational communities promote integration across national groups. In the light of our results, this positive assertion cannot be supported. Instead, we observe that the foreign senior citizens live in segregated milieus within the host society. This seems to correspond to the results of studies carried out with migrants from Great Britain, The Netherlands and the Nordic countries. The spatial orientation of the majority is emotionally aligned with Germany: 50% of the sample population regard Germany as "Heimat" (where you feel at home) versus 30% who attached this characteristic to Spain. Only about 6% viewed Germany and Spain as being equally "Heimat".

Potential risk factors in the adjustment process to age-related problems

Important factors for evaluating the migrant retiree population's options, strategies, risk groups and age-related problems with the adjustment process are, besides health are whether they use their Mallorcan homes seasonally or permanently and whether or not they still have a residence in Germany.

An average of a decade has passed since the migration to Mallorca and the survey in the year 2000, and the migrants have aged accordingly. Nevertheless, most interviewees still state that they are in good or satisfactory health, with the exception of those aged 70 or older of whom 13% assess their health condition as being worse.

As various studies point out, seasonal migrants intend to make the best use of the place advantages of both the "home" and "foreign" locations respectively. These advantages can, for example, be related to seasonal climate differences, to differences in the composition of their social networks or to differences in their access to or perceptions of the respective health care systems³. This said, it is mostly those German migrants who live permanently on Mallorca and who no longer have a residence in Germany that could become potential risk groups.

The most obvious factor limiting the migrants' access to the above options is income-related. Those with enough available income and private health insurance have access to private medical treatment, private care services and private nurseries, all of which are offered by German entrepreneurs or German organizations on Mallorca. Therefore, language problems will play a minor role for this group. In contrast, those Germans who came to Mallorca at an early stage in their life, with relatively small pensions, will be unable to afford private services but will have to rely on the services offered by the Spanish health care system. Language competency becomes extremely important for them in order to make themselves understood or feel "at home" when being treated in hospitals or nursing homes.

Fragile social contacts and little or no participation in an active social life (in associations, clubs or churches or in more individual social networks), are risk factors that may eventually lead to social isolation and even loneliness. This effect is worse for those living in instable neighborhoods. For example, inhabitants are more at risk if they live in residential areas, which are predominantly used by seasonal rather than permanent migrants and are therefore largely empty for long periods of the year, or if they prefer a secluded way of life in rural areas. As long as the older migrants have a partner, the situation will be more easily dealt with. However, at least 31% of the older migrants live alone. 17% were already single when they came to Mallorca and 14% lost their partner afterwards.

All but the first three potential risk factors identified for those elderly Germans growing old and frail on Mallorca (permanent stay, no residence in Germany, low language competence, low income, no private health insurance, instable neighborhoods and fragile social contacts, as well as broken ties to kinship) are also relevant for any older person facing severe problems of old age, irrespective of whether they live in Germany or Spain (or Portugal). However, these additional three aspects make an important difference: first, living in a foreign culture and society (even if the living environments of many Germans on Mallorca suggest the contrary); second, not being able to access the German social support system in the same way as those living in Germany; and third, having had lifestyle and amenity-oriented motivations when deciding to move to Mallorca. This last aspect is a central argument, as although the Mediterranean environment (climate, etc.) might alleviate the burdens of old age, the chosen locations and housing types are seldom compatible with the support and care needs of dependent old age. The migrants' (former) lifestyle preferences and their decisions to move to Mallorca permanently might have caused them to disregard other important aspects of quality of life, such as closeness to and good

³ A very common strategy among seasonal migrants on Mallorca is to take advantage of the climate benefits of the island during Winter and Spring time, but to make use of regular medical and dental treatment in Germany, especially when treatment of more severe illness such as cancer is necessary.

relationships with family and friends. From a psychological point of view, those who do not have any other option but to return to Germany in the end, might feel that their life project has failed.

2.5. German preferences for and residential property in Portugal

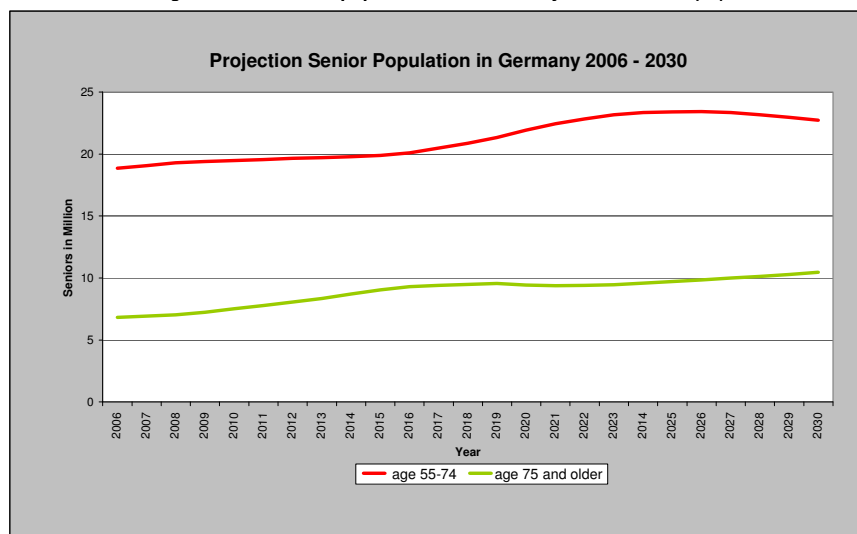
Demographic characteristics and future population trends in Germany

A short overview in some current patterns and future trends of the population in Germany as the country of origin provides information on the likely demographic development of the potential target group of elderly moving to Portugal in the coming decades.

Currently, Germany has a population of about 82,4 million, and it is expected to decrease to about 77,2 million by 2030. This result of the 11th coordinated population projection calculated by the Federal Statistical Office (Statistisches Bundesamt, 2006) is resting upon the assumption of continuation of the current demographic trends (W 1). Reasons for this population decline are the consistently low birth rate and increasing mortality. Both components can no longer be compensated through gains by immigration.

But Germany is not only characterized by a shrinking but also by an ageing population. The country was one of the first modern societies facing fundamental processes of population ageing during the early 1970s. While currently the proportion of 60 years old and newborns is nearly balanced until 2050 the 60 years old will be twice as much as of the newborn due to increasing birth deficit and life expectancy.

Figure 96. Senior population in Germany, 2006-2030 (N.)



Source: Statistisches Bundesamt (2007), 11. Koordinierte Bevölkerungsvorausberechnung.

The expected rapid growth of the older population in Germany over the next 25 years may have an important influence on future immigration to Portugal. As seen in **Figure 96**, the growth of both analyzed groups - the young and the old - has consequences for our topic. The potential group of senior migrants will increase over the next years, which suggests a continuation of elderly emigration to the Mediterranean.

Residential property in Portugal

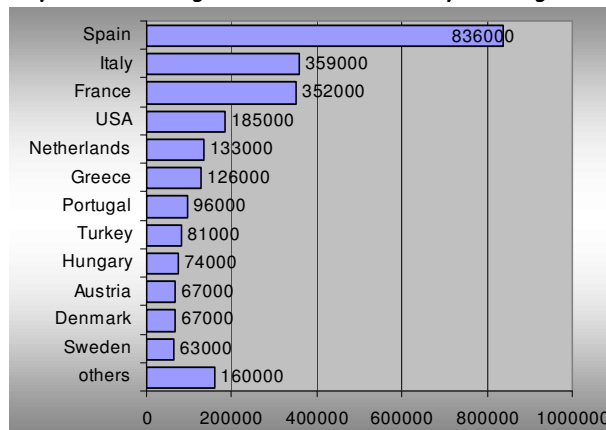
The rapid growth of mass tourism and migration to Mediterranean countries during the last two decades had the consequence that housing developments along accessible Iberian coasts first became evident in

the late 1960s. It was stimulated during the mid 1980s by house price inflation in Northern Europe, and after a lull in the early 1990s again proliferating (Casado-Díaz *et al.*, 2004, p. 355). Property developers and realtors developed new settlement areas and directed by this the spatial distribution of the migrants.

Market analyses pertaining to German residential property abroad are a relatively recent phenomenon, emerging since the 1990s. They have been initiated by two of the leading building and loan associations. *Empirica* (1998) started with a large study covering a representative sample of 10,000 Germans on behalf of the *Landesbausparkassen* (LBS). A follow up study was carried out by *Icon Brand Navigation* (2002) with the same sample design and size. *TNS Emnid* (2003) finally launched a survey with 1,004 telephone interviews on behalf of *BHW Bausparkasse* (building and loan association). The results presented here are drawn from these market studies.

It has already been mentioned that Germans who own residential property in foreign countries, for their own use, view Spain as the most desirable destination in Southern Europe. This is also true for the majority of the households included in the *Empirica* (1998) study. For those interested in purchasing property (*Figure 97*), 836,000 wanted to own it in Spain, followed by Italy, France, USA, The Netherlands and Greece. Portugal ranked seventh with 96,000 potential owners.

Figure 97. Regional preferences of Germans with interest in purchasing a residence abroad (%)



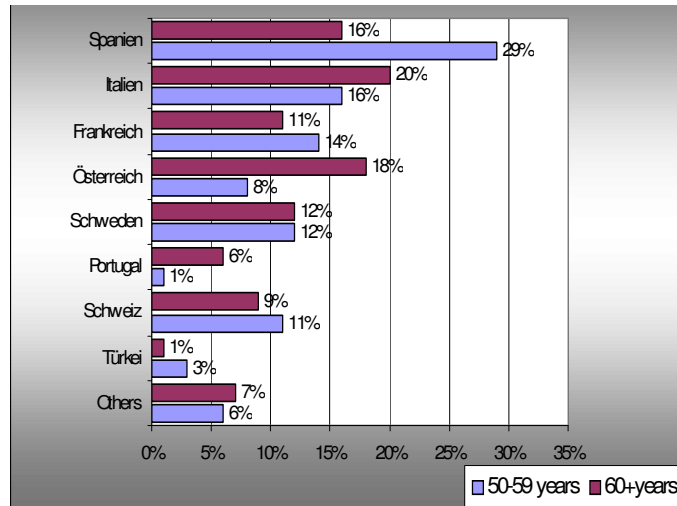
Source: Empirica/LBS, 1998. Own design.

If we break this down by age, again considering those who can imagine purchasing a leisure residence abroad (Emnid 2003), Portugal is similarly positioned with 1.1% of those aged 50-59 years and 6.2% of those aged 60 or more years (*Figure 98*).

Following the results of the *Empirica* study, about 596,000 German private households already own real estate property abroad. This indicates a yearly increase of 43,000 since 1991/92. An examination of potential for future expansion in this area shows that nearly every tenth German household stated an interest in purchasing of residential property abroad:

- ▶ short-range: 220,000;
- ▶ middle-range: 880,000;
- ▶ eventually: 2,5 million.

Figure 98. Regional preferences of Germans interested in purchasing leisure residence abroad (%)

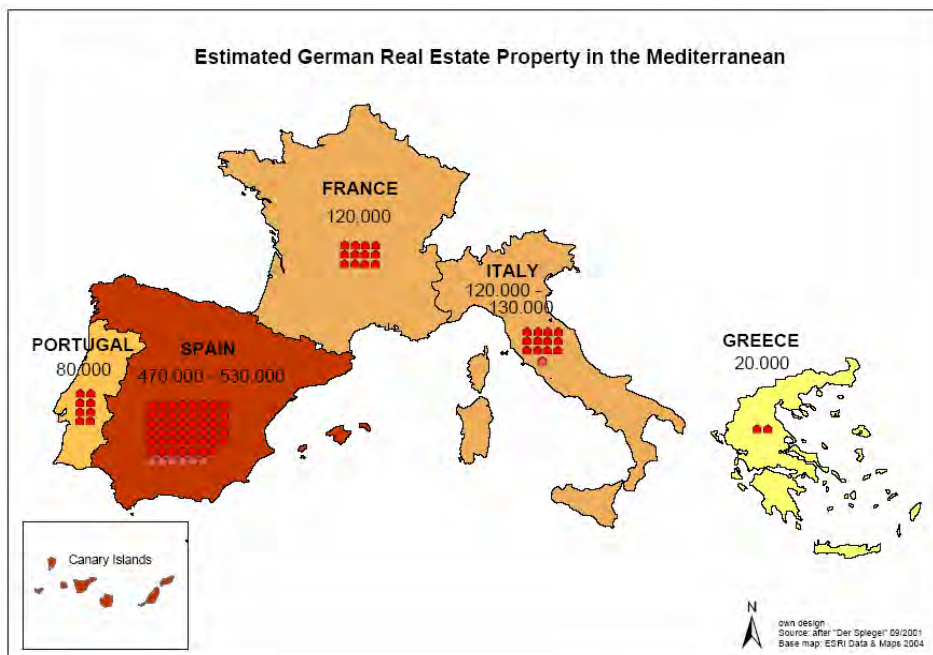


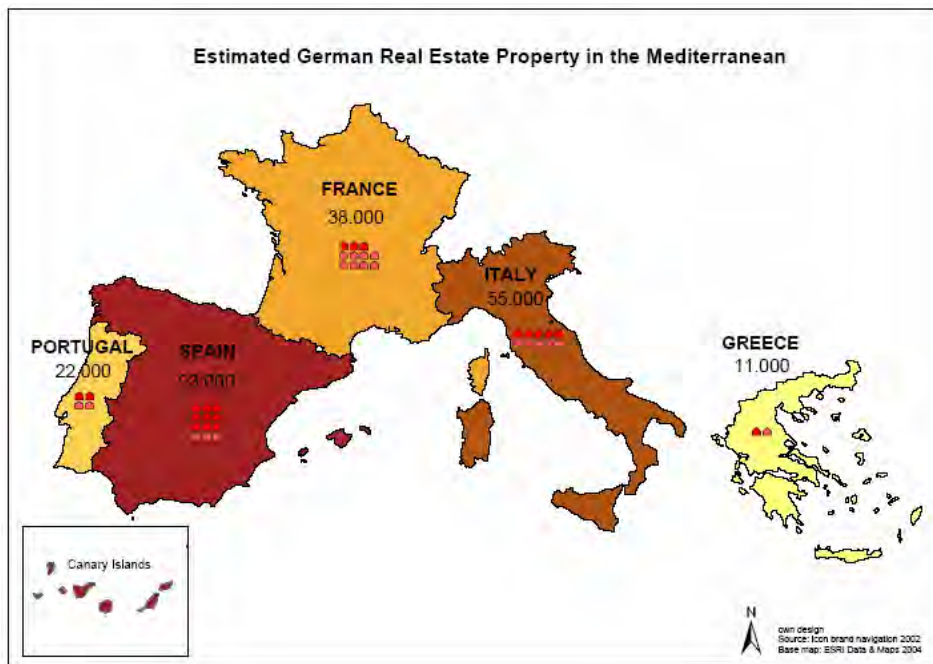
Source: Empirica/LBS, 1998. Own design.

Both the current owners as well as those interested in buying soon are mainly in the retirement (40%) or pre-retirement (17%) life stage (aged 35-64 years old). The self-employed are over-represented, as are those with higher social status. Mean investment price was about 75,000€. The large majority (84%) preferred a coastal location for their real estate.

Whereas these results indicating the preferences and characteristics of real estate property are more or less confirmed by the other studies, there is little evidence concerning amount and regional distribution of the property already owned. There are two estimates that vary considerably from one another: The *Spiegel* estimate is 80,000, whereas the *Emnid* study suggests that there are 22,000 German residential properties in Portugal (Figure 99).

Figure 99. Estimated German real estate property in the Mediterranean (N.)





Sources: Above: Der Spiegel (2001); Below, Icon Brand Navigation (2002).

3. Summary

The primary intention of this market analysis has been to anticipate a significant increase in the number of German retirees intending to live in Portugal. As this country is on the way to becoming a “hot spot” for retirement migration, information about the target group of seniors will be necessary. A market analysis of those German elderly who may be interested in residing in Portugal is as important as understanding the situation of the seniors already living in Portugal. Their circumstances and motivations for selecting their residential location, their socio-economic attributes, their living arrangements, networks, desires and problems are not well understood, as official statistics are fragmentary and there are no surveys available, which provide such information.

The results show that about 50,000 Germans (including 16,000 seniors) currently live in Portugal. Their regional distribution is concentrated in the coastal districts. Both the total and the senior population will increase until 2015 to 86,000 and 24,000 respectively. The German market for real estate property in Mediterranean countries is quite large. The two existing estimates about German-owned residential properties in Portugal are 80,000 and 22,000, which vary considerably from one another. Portugal is ranked seventh regarding the preferred destinations of potential owners. Another market assessment considering the seniors who can imagine purchasing a leisure residence abroad, concludes that 1.1% of those aged 50-59 years and 6.2% of those aged 60 or more years would choose Portugal as a destination.

Because of the poor quality and availability of official data concerning the characteristics of older Germans in Portugal, this report has turned to a Delphi approach and has drawn on the expertise of scholars familiar with such issues and our own experiences gained when carrying out two surveys in Spain. This allowed conclusions to be drawn by analogy. Life for seniors in southern locations is primarily amenity oriented, as we know from the evidence collected in Mallorca. Thus, the socio-economic and demographic status of the migrants is very diverse, although in general it is above average. Most (58%) are seasonal residents and 70% maintain residences in Germany. Their social networks are quite restricted and they mostly have contact with other German nationals. However, for those growing old and frail, the desire to fulfill their ideal of “living in the sunny South” is threatened. Risk factors emerge when they: stay permanently; have no residence in Germany; low language competences; low income; no

private health insurance; live in a peripheral location or in instable neighborhoods; have fragile social contacts, as well as broken ties to kinship. However, three things could be identified as the most important risk factors when seniors adjust to age related problems abroad: first, living in a foreign culture and society, second, not being able to access the German social support system in the same way as those living in Germany and third, having had lifestyle and amenity oriented motivations when they decided to move.

It will be a considerable challenge for the responsible institutions and authorities in Portugal, to develop adequate responses to a growing foreign older population especially as they age. As these people live in rather segregated milieu, easy access to associations will be problematic. Close cooperation between local organizations and German institutions such as churches, social and medical services and the embassy will be necessary, for example, to improve the access that older Germans have to the Portuguese health and age-care system. Another important challenge is to minimize the perceived barriers between the Portuguese administration and the foreign seniors. Because of their poor language skills, foreign representatives (“ombudsman”), like those that exist in certain Spanish communities, could be important intermediaries to the improvement of these relationships.

So far, little is known about the conditions and modalities of the return migration of amenity-led later-life migrants in Europe (recruiting such return migrants for surveys is exceptionally difficult). There is a paucity of case studies about networks and the integration of German seniors, as well as longitudinal surveys, and clearly national and EU-statistics need improvement. There is a need for further research in this area.

MODULE 7

THE ROLE OF MULTINATIONAL COMPANIES

1. The role of the private sector

The role of the private sector as a provider of elderly care services varies across countries. As an example, while in Sweden only 15% of elderly care services are provided by the private sector, in the UK the private sector is responsible for the provision of more than 70% of these same services:

- ▶ Public policy seems to be one of the key catalysts in the development of the private sector, as it has a direct impact on it;
- ▶ The availability of public services, namely the balance between demand and supply both at a national and at regional level;
- ▶ The quality and range of public funded services as well as the frequency of provision of services and the level of qualification of elderly care staff;
- ▶ The incentives to private initiative, namely tax benefits, funding or co-funding schemes of the initial investment or of the services that private players provide, and preferential credit conditions;
- ▶ The incentives to consumers, namely the concession of fiscal benefits to the purchase or co-purchase of elderly care services are some of the examples that can be highlighted.

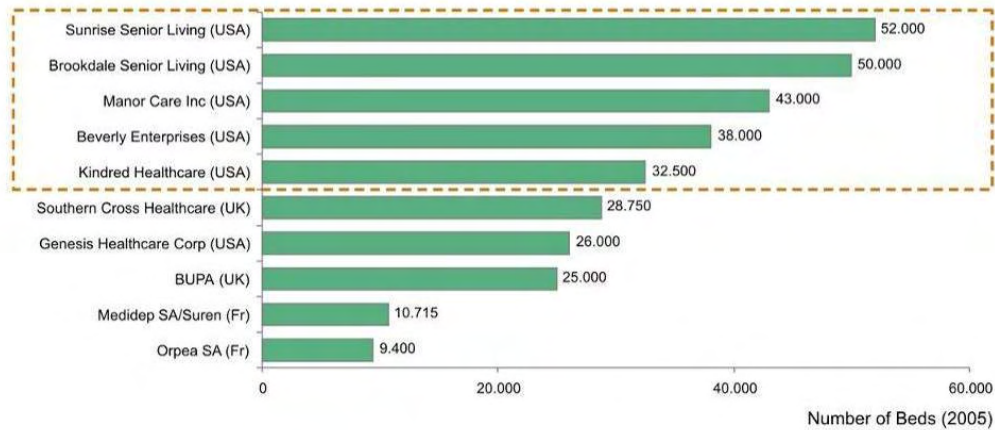
Economic aspects seem to influence, as well, the participation of the private sector in the provision of elderly care, namely the level of income of the elderly (namely pensions and complements to pensions) and respective families (conditioned by the average income and unemployment rates).

In most countries, the private sector remains highly fragmented. Yet, there are exceptions. In Nordic countries, where initially the development of private players was aimed at boosting the efficiency and effectiveness of the industry, the private sector is now more concentrated. These days, major players are driving the consolidation of the industry worldwide, by pursuing aggressive plans of inorganic growth.

In 2005, the world's top 5 players came from the USA and had capacities in residential care that ranged from 32,500 to 51,000 beds. By then, the major European player was Southern Cross, a British company that offered around 30,000 beds.






Due to the high financing needs of the industry, most major players are listed in the stock exchange and have financial service companies (e.g. investment funds and private equity firms) as the major shareholders. Top elderly care players are generally country specific and have residential care as their core business. Currently, some players have widened their activity, achieving a significant international presence, such as Sunrise Senior Living, which operates in the USA, Canada, UK and Germany.

Figure 100. World's ten major elderly care services providers, by number of beds, 2005 (N.)



Source: Van Lanschot Bankiers, OPG Company report.

Figure 101. Profiles of the top 5 players

	Market value and ownership	Portfolio of services provided		Geographic presence
		Focus	Other	
	<ul style="list-style-type: none"> • €1,4 B • Listed in NYSE • Founders: 11% 		<ul style="list-style-type: none"> • Domiciliary care 	<ul style="list-style-type: none"> • USA, Canada, UK and Germany
	<ul style="list-style-type: none"> • € 1,3 B • Listed NYSE • Controlled by PE (Fortress) 	<ul style="list-style-type: none"> • Residential care <ul style="list-style-type: none"> – Independent living – Assisted living – Alzheimer care – Hospice care – Rehabilitation care 	<ul style="list-style-type: none"> • -- 	<ul style="list-style-type: none"> • USA (35 states)
	<ul style="list-style-type: none"> • €3,6 B • Listed NYSE 		<ul style="list-style-type: none"> • Domiciliary care • Out-patient t • Rehabilitation • Pharmacy services 	<ul style="list-style-type: none"> • USA
	<ul style="list-style-type: none"> • €1 B in 2006 • Controlled by PE (Filmore partners) 		<ul style="list-style-type: none"> • -- 	<ul style="list-style-type: none"> • USA
	<ul style="list-style-type: none"> • € 0,6B in 2006 • Listed in NYSE 	<ul style="list-style-type: none"> • Hospital and pharmacies management 	<ul style="list-style-type: none"> • Residential care: assisted living • Rehabilitation 	<ul style="list-style-type: none"> • USA

Source: Websites, Press.

Case Study - Sunrise Senior Living



Sunrise Senior Living is a USA company, which was founded in 1981 by Paul and Terry Klaassen. Aiming to create a pioneer residential care concept that “championed quality of life” and provided “resident-centred care”, Sunrise eventually became the world’s largest residential care provider. At present, Sunrise has revenues of 385 million, runs 440 communities with a capacity for 52,000 elderly and has 40,000 members staff.

So far, half of the growth of Sunrise has been attained organically, while the other half resulted from inorganic efforts. The acquisitions of Marriot Senior Living and Eden Care in 2003, and the acquisitions of Greystone Communities and The Fountains in 2005, were key milestones to Sunrise. These not only allowed Sunrise to grow in size but also to offer a full range of care services to the elderly. In the upcoming years, Sunrise aims to consolidate its position in the USA market and to further expand internationally.

As it entered the NYSE in 1996, Sunrise Senior Living got the necessary funding for its growth. More recently, some new developments and acquisitions have been conducted through joint venture partnerships.

Currently, Sunrise Senior Living provides on a permanent or short-term basis 6 types of services:

- ▶ Independent living with medical and social services available 24h (upon request and extra charge);
- ▶ Assisted Living for dependent elderly offering 24 h nursing and social services (under the Sunrise Living and Neighborhood Gardens brands);
- ▶ Specialized assisted living for patients with Alzheimer and other memory impairment conditions with different needs of support (Terrace Club, Reminiscence Neighborhood, Edna's Place);
- ▶ Domiciliary care for dependent elderly comprising both medical (e.g. 24 h nursing, physical therapy, restorative care) and social (e.g. housekeeping, laundry) services;
- ▶ Hospice care for elderly with terminal illnesses (in partnership with hospice providers);
- ▶ Rehabilitation care for elderly recovering from illnesses or accidents.

Sunrise Senior Living targets the medium-high and high-income seniors in its for-profit business area, but it also manages not-for-profit residential centers.

Sunrise Senior Living is one of the few international elderly care providers, as it already operates in Canada, UK, Germany and Spain. The company is already evaluating opportunities to further expand internationally.



Case Study - Brookdale Senior Living



Brookdale Senior Living was founded in 1981, and it became the largest provider of residential care in the USA in 2006. Last year, Brookdale generated 895€ million in revenues. It now operates 547 own communities located in 35 US states, besides other communities that are leased to third-party institutions. The company employs ~27,500 people.

To face its financing needs, Brookdale became listed in NYSE in November 2005. This allowed it to enlarge its patrimony, which has been its major source of growth. In 2006, various acquisitions were made, in a total of about 2,3€ B. This included American Retirement Corporation, which doubled Brookdale's capacity (by adding ~25,000 beds) and expanded its services portfolio.

Currently, Brookdale Senior Living provides 4 types of services on a permanent or short-term basis:

- ▶ Independent living (both in independent-living-only communities or in the premises of assisted living communities) together with personalized plans of medical and social services tailored to the needs of the client;
- ▶ Assisted Living (in assisted living communities or continuing care communities) for dependent elderly, offering different levels of medical and social support round the clock;
- ▶ Memory care living schemes, for patients with Alzheimer;
- ▶ Rehabilitation care, for elderly recovering from illnesses or accidents;
- ▶ Specialized medical services offered in the communities, for elderly with special needs (e.g. physical therapy, speech therapy, palliative care).

Brookdale Senior Living is targeted at medium-high and high-income elderly. This explains the offer of some distinctive and uncommon amenities (as pool, spa, and luxury restaurants).

In the upcoming years, the company will pursue an aggressive organic and inorganic growth plan. Organically,

Brookdale plans to expand the number of residencies and the capacity of smaller residencies. The plan is to increase the operating profit per residency, by increasing the rates of occupancy, improving the operational efficiency, exploiting economies of scale (e.g. in procurement) and introducing the new “Innovative Care Senior” program in all the residencies. Inorganically, Brookdale plans to acquire communities with opportunities for improvement in the delivery of service, occupancy rates and cash flow generation or, alternatively, to acquire the ownership interest of communities that Brookdale currently leases or manages.



2. Study of the role of the private sector in selected countries

The role of the private sector in three countries - Spain, UK and Sweden - was studied in more detail. The selected examples are believed to provide valuable insight on: 1) the contexts on which the private sector can emerge; 2) the factors that can trigger the emergence of private players; 3) the type of Government policies that can encourage private initiative. This derives from the fact that:

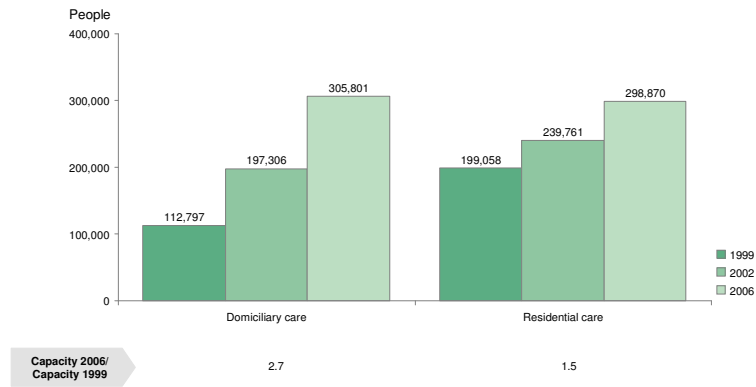
- ▶ In Spain, the participation of the private sector aimed at the rapid expanding of the supply of care services and was attained mostly through governmental funding of privately provided services;
- ▶ In the UK, the involvement of the private sector was intended, in a first moment, at rationalizing costs related with hospitals long-term stays and was mainly achieved by defining a limit to public provision and CAPEX (Capital Expenditures) in the elderly care services;
- ▶ In Sweden, the fostering of private initiative aimed at attaining higher cost efficiency and was mainly achieved by inducing local governments to become “purchaser providers” instead of “direct providers” and by letting consumers to choose care providers (Consumers’ choice directive).

2.1. The Spanish Case Study - promoting the private sector to expand fast the elderly care supply

Elderly care services supply

The elderly care industry in Spain was poorly developed until the early 2000’s. Between 1999 and 2006, both residential and domiciliary care services grew significantly. In 2006, domiciliary care almost tripled its capacity, reaching ~306,000 elderly in 2006, and residential care grew by ~50%, reaching ~300,000 elderly.

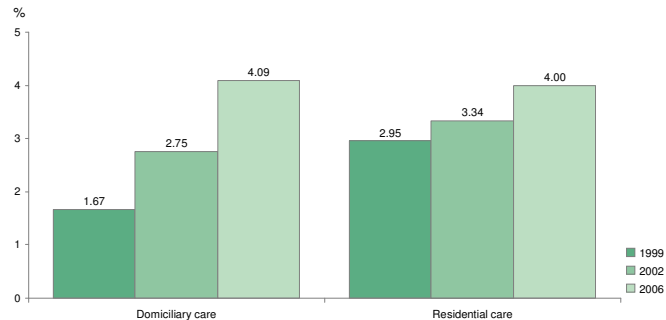
Figure 102. Recent evolution of domiciliary and residential care capacity, 1999-2006 (N.)



Source: Spanish Ministry of Labour and Social Affairs; Reports from the Autonomous Communities and Autonomous Cities; INE Inebase, *Revisión Padrón Municipal*, 1999 a 2006; BCG Analysis.

The lower growth rates experienced by residential care derive not only from the fact that residential care was already more developed in 1999, but also from the Government's goal in promoting alternative elderly care options to institutionalization. The strong growth in supply resulted in a substantial progress in the coverage of elderly care services. Still, in 2006, both domiciliary and residential care only reached 4% of the elderly population.

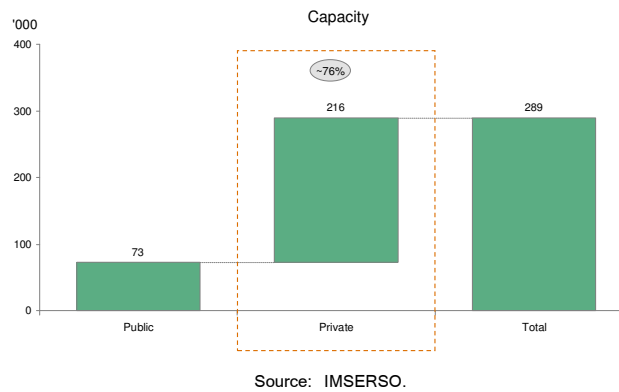
Figure 103. Recent evolution of domiciliary and residential care coverage, 1999-2006 (%)



Source: Spanish Ministry of Labour and Social Affairs; Reports from the Autonomous Communities and Autonomous Cities; INE Inebase, *Revisión Padrón Municipal*, 1999 a 2006; BCG Analysis.

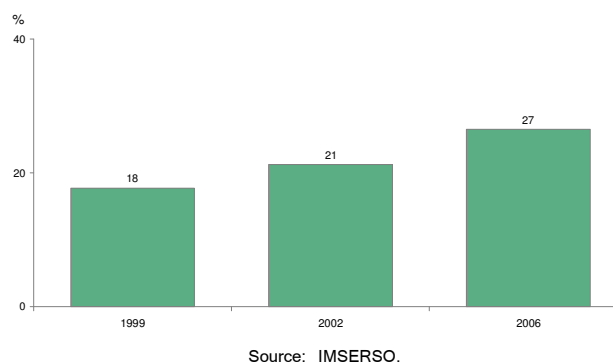
In Spain, the private sector already plays a major role in the provision of residential care. In 2006, ~75% of the residential care capacity was managed by the private sector. The participation of the private sector in the provision of elderly care services was encouraged by two major factors:

- ▶ The improvement of the economic conditions in Spain, which led to an increase in the elderly and families' income;
- ▶ The incentives given by the State to the private sector, aimed at increasing the profitability and attractiveness of the elderly care industry.

Figure 104. Weight of private sector in residential care, 2006 (N.)

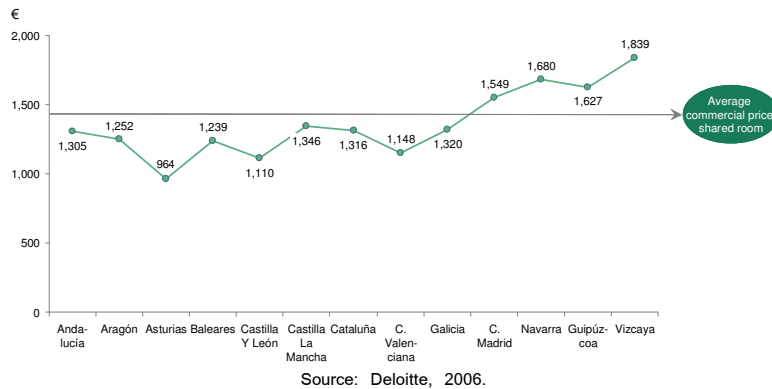
Some governmental measures have encouraged the emergence of private players. On one hand, the Government implemented new legislation that clarified the roles of private players in the Social Public Network as providers, managers, or even substitutes of the Social Public Network is an example of such measures. On the other hand, and on a subsequent moment, the Government granted incentives to the private sector to assume these roles. For instance, local authorities established contracts to fund or co-fund part of the privates' residential capacity at reasonable rates (namely with Sanyres, Grupo SAR and Adavir). In a addition, these authorities outsourced the management of some public residential services (as happened with Mapfre Quavitae and Sanitas Residencial). Lastly, the *Ley de la Promoción de la Autonomía Personal y Atención a las Personas Dependientes* (Art. 17 number 2) was enacted, regulating the co-payment of private services when public services prove to be insufficient.

The theory that the Government acted as a catalyser of the development of the private sector is supported by the fact that the growth rates of funded capacity (+12% p.a. in the last five years) exceeded those of the overall private capacity (+6% p.a. in the same period). The same theory is also supported by the increase in the share of publicly funded residential care capacity, which evolved from 18% in 1999 to 27% in 2006.

Figure 105. Recent evolution of the weight of Government funded capacity, 1999- 2006 (%)

Additionally, it is important to mention that the average governmental funding fees have been associated to the average commercial prices. In 2006, a shared room with shared bathroom costed ~1,400€ per month on average. Public funding fees varied across regions, ranging between 950€ and 1,850€ per month.

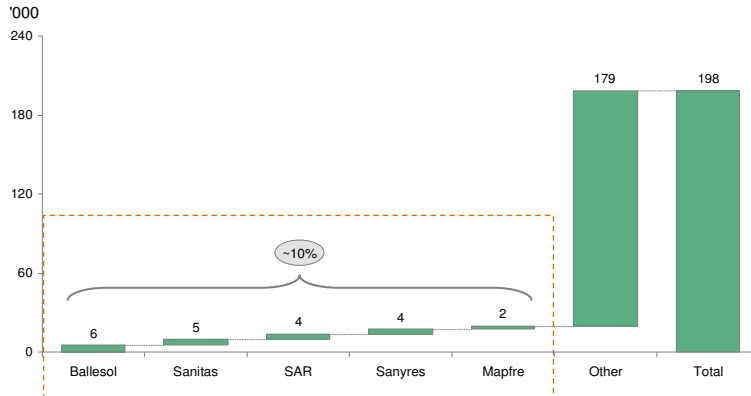
Figure 106. Average monthly fees paid by local Government to private players, 2006 (€)



Major private players

In Spain, despite the major role of private players in the provision of elderly care services, the private sector remains highly fragmented. In fact, the five largest players only managed ~10% of the residential care capacity in 2006. Moreover, only major private players currently exploit economies of scale. Proof of that is the fact that the capacity of ~59% of residential care centers is lower than 50 people. In contrast, the average capacity of the residential of major player’s residential centers was on average three times bigger than the national average capacity.

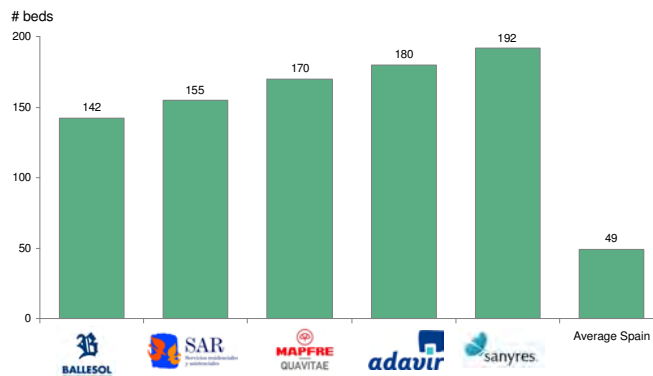
Figure 107. Residential care capacity by player, 2006 (N.)



Source: IMSERSO; Annual reports; Websites.

Figure 108. Comparison of average residential care capacity: major players vs. national average, 2006 (N.)

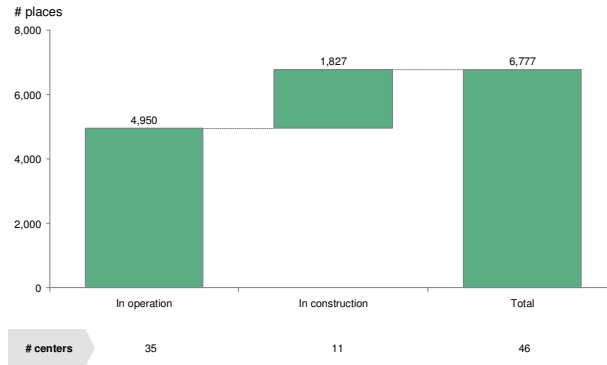
Comparison of average nursing home capacity (2006)



Source: Websites.

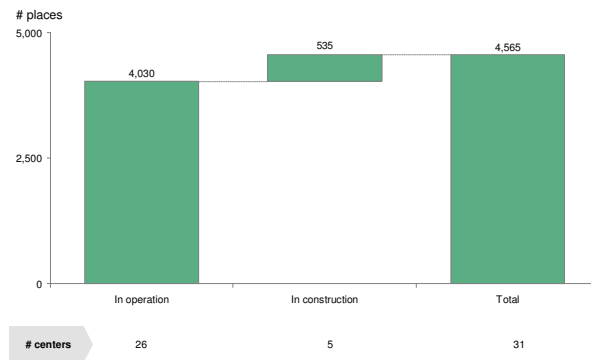
Following the incentives to the participation of the private players in the industry, a few companies have been consolidating their market position by pursuing ambitious growth plans. Most probably due to the prevailing supply shortage of elderly care services, most players are mainly growing organically. Ballesol, for instance, plans to organically expand its residential capacity by 37% until 2009. In a similar fashion, the Grupo SAR plans to organically expand its residential capacity by ~13% (2009).

Figure 109. Ballesol organic growth plans in the residential care business, 2007-2009 (N.)



Source: Ballesol Website.

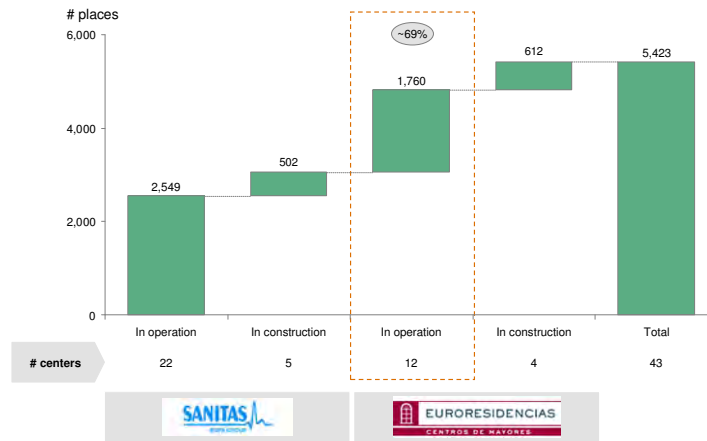
Figure 110. Grupo SAR organic growth plans in the residential care business, 2007-2009 (N.)



Source: Grupo SAR Website.

In parallel, and probably aiming at reaching a top position in the industry, some players are complementing their organic growth plans with inorganic growth. This is the case of Sanitas Residencial (owned by the British group BUPA), who by recently acquiring Euroresidencias was able to grow its residential care capacity by almost 70%.

Figure 111. Impact of the acquisition of Euroresidencias by Sanitas Residencial (N.)

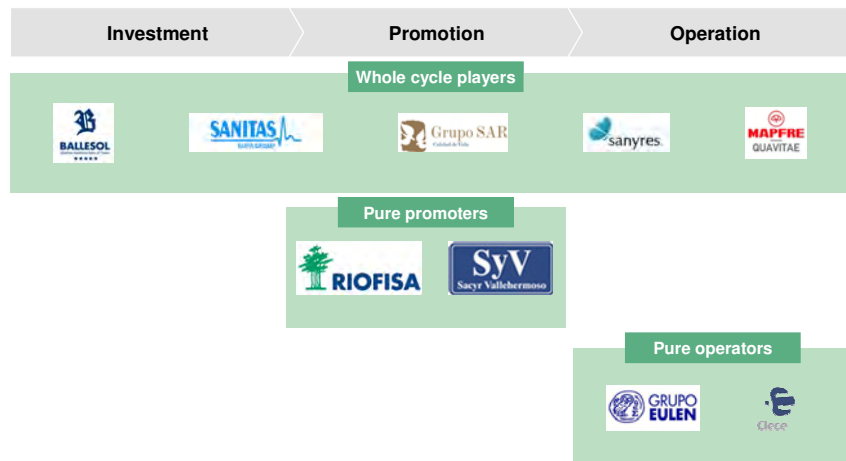


Source: Sanitas Website.

The positioning of major players in the value chain differs. There are three types of players:

- ▶ Whole cycle operators (such as Ballezol, Sanitas Residencial and Mapfre Quavitae), who participate in all the steps of the value chain and are typically controlled by financial or construction firms;
- ▶ Pure promoters (such as Riofisa and Sacyr ValleHermoso), who only participate in the promotion step of the value chain and are typically construction or real estate firms;
- ▶ Pure operators (such as Grupo Eulen and Clece), who only participate in the operation step of the value chain and are essentially service outsourcing firms.

Figure 112. Alternative positioning of major private elderly care players



Source: IESE research; BCG analysis.

Case Study - Grupo SAR, a whole cycle operator

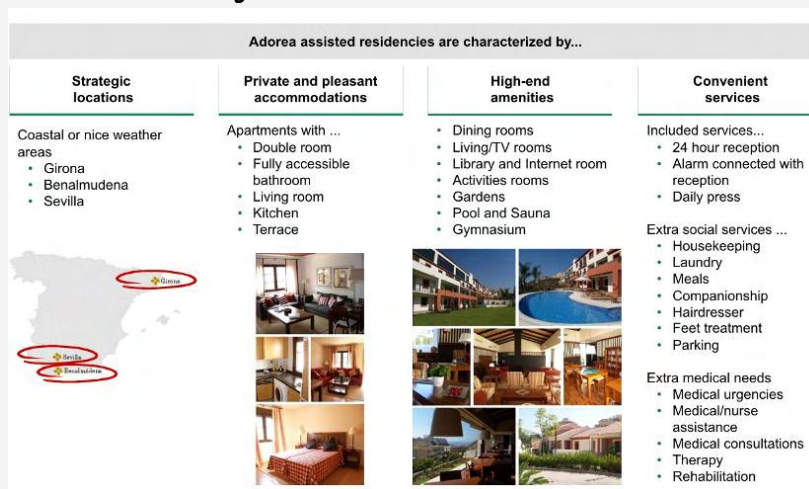


Founded in 1982, Grupo SAR is a privately run group focused on the care of elderly, impaired and people in need. Confide Residencial SL, a real estate company, is the group's major shareholder with a ~60% stake. Despite

providing both domiciliary and residential care, Grupo SAR focuses on the latter. Services in that business area are marketed under two brands: Adorea and *SAR Residencial y Asistencial*.

The luxury brand Adorea currently markets three complexes of assisted residencies for national and foreign (namely British and Swedish) active elderly. Strategically located in coastal regions, these complexes offer high-end accommodation and "hotel-like" services. As for the SAR Residencial y Asistencial brand, it provides specialized nursing home services for dependent elderly in 26 fully operational residencies with a total of 4030 places. These are located in Málaga, Madrid, Toledo and Andorra.

Figure 113. Adorea assisted residencies



Source: Website.

In addition to residential care, Grupo SAR offers domiciliary care services under the SAR Domus brand nationally, although offering a wider range of services in the Catalonia region. Domiciliary services targeted at the elderly comprise a wide variety of medical services as well as phone assistance services.

Grupo SAR has been substantially growing organically in the last few years and has doubled its residential capacity since 2002. In the next two years, Grupo SAR plans to invest 60€ million to increase its capacity by 13%. In addition, it plans to enter international markets. A project for the Brazilian region of Ceará, worth 300 million euros, is expected to be approved in the upcoming months.

Case Study - Grupo Clece, a pure operator



Clece is a private group fully owned by the construction company ACS that provides a wide range of outsourcing services, from social services to ground handling services in airports, among others.

Regarding social services, Clece prefers a global, integrated perspective, by offering:

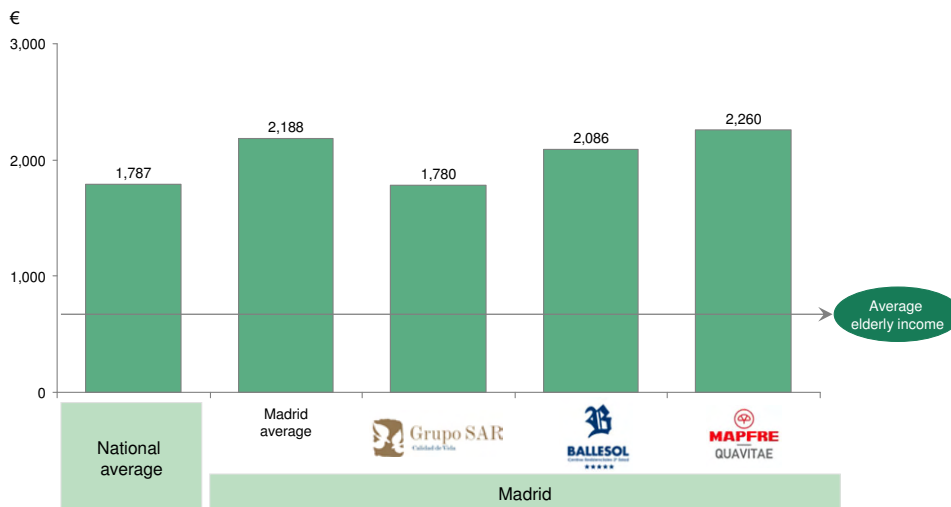
- ▶ Domiciliary care services;
- ▶ Day centre management;
- ▶ Management of residencies for the elderly and the disabled;
- ▶ Management of children's education centers;
- ▶ Management of care centers for minors;
- ▶ Socio-cultural services;
- ▶ Social services (professional support, catering, maintenance of facilities, etc.).

Around 85,000 people are served by Clece's social services, ~25% of which are elderly. At present, Clece is one of the major managers of centers for the elderly. Currently, it manages more than 3,000 residential places in 12 Autonomous Regions. This includes the full or partial management of residential centers for third parties (currently 21 centers are fully managed and 12 centers partially managed), and the full management of 23 day centers. Besides, Clece owns one residence for elderly with Alzheimer and one general elderly residence. In addition, it offers domiciliary care services to 17,000 elderly through 40 service centers

Social services targeted at the elderly have been growing at more than 15% per year. Stronger growth is expected for the upcoming years. The company is active in Portugal (through Guia Lda. and Astrolimpa), but only in the cleaning services business.

Similarly to the general practice within the private sector, most major players target at medium income elderly. Evidence of this are the monthly fees charged for residential care in Madrid (>2,000€), which are more than three times higher than the elderly average income, but in line with the average fees for this city.

Figure 114. Average prices of individual rooms in private residential centers located in Madrid, 2006 (€)



Source: Estudio Info-residencias; Phone interviews.

Range of services provided by the private sector - business as usual with some particularities

Current Business

In Spain, private players provide all key types of elderly care services, namely nursing homes, assisted residencies, day centers and domiciliary care. Yet, some particularities distinguish the Spanish elderly care industry, namely:

- ▶ The organization of residential centers in specialized care units;
- ▶ The proliferation of a new concept of assisted residencies: “Senior resorts”;
- ▶ The proliferation of a new concept of phone assistance: “tele-asistencia”

The module system

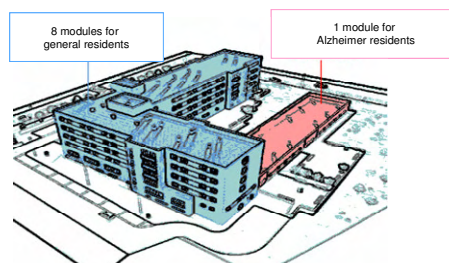
As previously mentioned, major private residential players have been building large-scale residential centers so as to explore economies of scale. As exploring economies of scale can negatively affect the personalization and quality of the services provision, in Spain, some major players, such as Adavir, have implemented the module system.

Adavir residential centers have, as a rule, the capacity for 180 elderly. These buildings are organized in nine modules of 20 people each. Every module includes most common amenities (such as the socialization lounge and the dining room). Other amenities, such as pool, rehabilitation room or hairdresser, are shared by all modules so as to explore scale effects.

The modules system offers several advantages:

- ▶ It offers to the residents a more cosy and “home-like” environment;
- ▶ It gives residents, regardless of their physical and mental condition, easy access to most used amenities;
- ▶ It makes possible the investment in amenities which requiring scale (e.g. pool, gymnasiums);
- ▶ It favours the establishment of tighter bonds between the residents and with the staff;
- ▶ It allows for personalized care, by making it easier for the staff to know and meet the specific needs of each resident;
- ▶ It prevents the “competition for attention” by residents.

Figure 115. Adavir residential centers



Source: Adavir Website.

Specialized units

Adjustment of the module system so as to provide specialized care is also a common practice in Spain. Care specialization aims to better meet specific needs of each elder and to increase the quality of the services provided. In addition, it aims, on one hand, at minimizing the contact of independent elderly with extreme dependency situations and, on the other hand, at avoiding the discrimination of dependent elderly by independent ones.

Grupo SAR is one of the major players who organizes residential centers in several units specialized in different kinds of care. Typically, Grupo SAR nursing homes comprise the following 5 specialized units:

- ▶ Geriatric attention units, for elderly needing help in daily life activities;
- ▶ Psycho-geriatric attention units, for elderly suffering from some kind of dementia (e.g. Alzheimer);
- ▶ Physical rehabilitation units, for elderly with special physical condition (e.g. Parkinson);
- ▶ Convalescence units, for elderly recovering from illnesses or accidents;
- ▶ Palliative care units, for elderly with terminal illnesses.

Each specialized care unit profiles are then tailored to the specific problems of its residents, namely:

- ▶ Special medical needs (e.g. 24-hour medical assistance, intravenous medication, individualized rehabilitation therapy);
- ▶ Special social needs (e.g. assistance in daily life activities, stimulation activities);
- ▶ Safety needs (e.g. control of entrances and exits, video-surveillance).

Senior resorts

Senior resorts are a growing reality in Spain. Between 2004 and 2006, the capacity of senior resorts grew by 45%, reaching ~2,300 residential units. Consisting on small luxurious cities, senior resorts are targeted at active and independent people aged 55 or more looking for a pleasant place to live, nice weather and sea view. Most resorts are located in Alicante (~20%), Málaga (~20%) and Barcelona (~16%).

Besides magnificent residencies (commonly designated as “villas”), senior resorts offer a wide range of services (both social and medical) and other amenities (e.g. pools, spas, cinemas, shops, restaurants).

Senior resorts are sensitive to price speculation. Recently, as Spain started losing its price competitiveness against new destinations such as Morocco and Eastern European countries, the demand for senior resorts began to decelerate.

Case Study - Sanyres

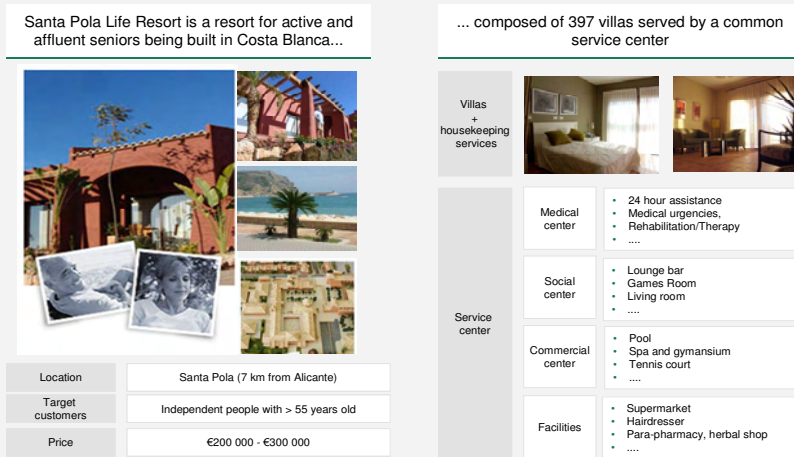


Sanyres - owned by José Romero González - is a private player specialized in elderly resorts. In 1999, the company acquired its first resort, backed by the property group Prasa. Today, the company has 16 centers in operation and ten more under construction.

In order to finance the high construction investment, Sanyres is supported by 3 bank entities (Bancaja, Cajasur and Caixa Catalunya) which back up the initial investments in exchange for a stake in the resorts.

Some of Sanyres' resorts are targeted at a specific international market. Marbella's resort, for instance, is targeted at German elderly and managed in partnership with Margarethenhof, a German company that also manages residencies for seniors. The Costa Blanca resort Alfaz Sol follows a similar model and is managed in partnership with Selvaag Gruppen, a Swedish group with a 50% participation in the resort. Partnering with international players seems to be crucial to capture foreign clients. Santa Pola Life Resort - located in Alicante - is one of Sanyres most recent high-end resorts. Targeted at active and affluent seniors, it has almost 400 villas and a wide variety of amenities and services.

Figure 116. Santa Pola Life Resort



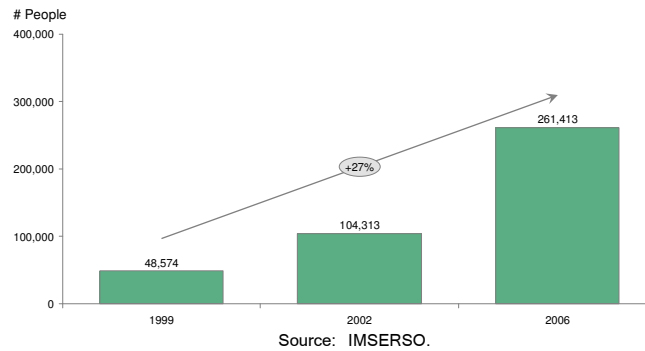
Source: Website, Press.

Tele-asistencia

Phone assistance has been the fastest growing service in the last few years in Spain. Between 1999 and 2006, its capacity grew more than five times (from 48,000 to 261,000 elderly). This tremendous growth suggests that the service has been well received by the elderly population. Phone assistance commonly includes:

- ▶ Regular contact to ensure the wellbeing of the client;
- ▶ 24h phone assistance (social and medical);
- ▶ Medical assistance in cases of emergency;
- ▶ Alerts to the family when needed;
- ▶ Companion conversation;
- ▶ Psychological support;
- ▶ Medication reminders.

Figure 117. Recent evolution of the capacity of the phone assistance service, 1999-2006 (N.)



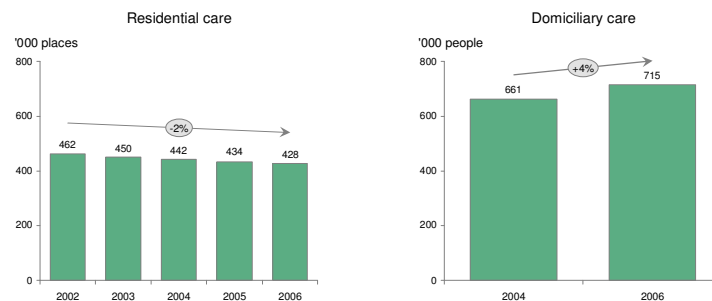
Major players such as Ballezol, Grupo SAR, Mapfre Quavita, and even the “pure operator” Grupo Eulen offer this service. Average price of the service is ~35€/month, which makes it accessible the majority of seniors. Major players typically provide this service only in those geographic areas where they provide residential and domiciliary care services.

2.2. United Kingdom - fostering the private sector to rationalise cost on long-term hospital stays

Supply of elderly care services

In the last five years, the supply of residential care (comprising both residential and nursing homes) in UK has steadily declined at a ~2% rate. In contrast, the supply of domiciliary care has grown at an average of 4% per year. Thus, in 2006, the coverage of residential care was of ~5 out of 100 elderly, while that of domiciliary care was of ~8 out of 100.

Figure 118. Recent evolution of residential and domiciliary care, 2002-2006 e 2004-2006 (N.)



Source: MDB research (2007).

The divergent evolution of residential and domiciliary care mainly derived from the Government’s goal to redirect care away from institutions, which was firstly promoted in the 1993 Community care reforms. Some years later, the Government introduced the Single Assessment Process (2001). According to it, local authorities had to assess the needs of the elderly and apply pre-defined protocols to determine the optimal care option. These protocols posed high standards for eligibility to residential care, and replaced a demand-led system that distributed residential vouchers to eligible elderly without verifying their actual need for residential care.

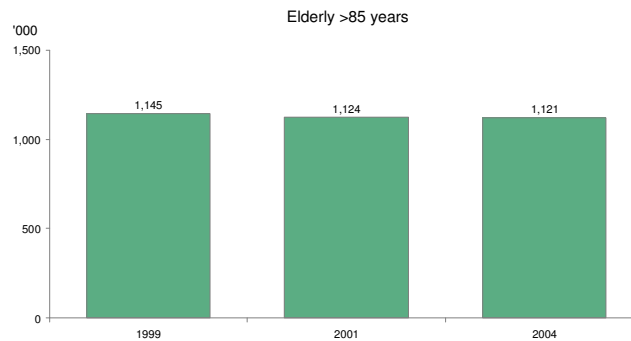
Later on, in 2003, the rationing in the elderly care budget forced by the Community Care Act gave local authorities incentives to search for more efficient and inexpensive ways to provide care. This was one additional incentive to the substitution of care in residencies by care at home.

Another important measure was the transformation of the underused direct payment model into an Individual budgets scheme in 2005. These new individual budgets were directed at dependent elderly, yet managed by State counsels to avoid discretionary use by the elderly. This prevented unnecessary use of residential care.

In parallel, measures were pursued to promote alternative forms of care. In 2002, the Health Secretary revealed a package of measures conceived to promote domiciliary care. These measures included the expansion of the range of domiciliary care services and the facilitation of access to community equipment (e.g. handrails, ramps). Benefits to home carers, like the Carer's Allowance and the possibility to request flexible working hours, were also legislated in 2004 and 2005 to increase the proportion of care provided within the family and friends.

According to MDB Research, the recent decline in the segment of elderly aged 85 years old and more, deriving from lower birth rates during World War I, also favoured the decline in residential care. Yet, the impact of this demographic factor was probably very limited, as the decrease in residential capacity was five times bigger than the reduction of elderly aged 85 years old or more (~24,000 elderly).

Figure 119. Evolution of elderly aged 85 years old or more, 1999-2004 (N.)



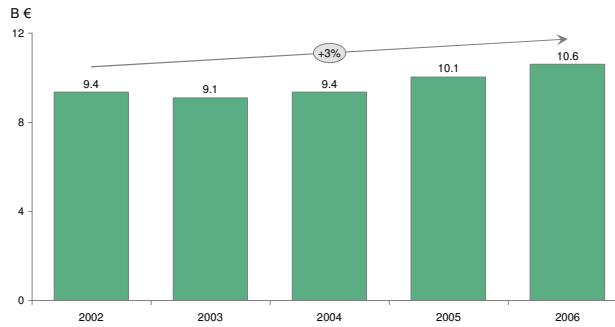
Source: MDB research, Press; BCG analysis.

Recent legislation favouring domiciliary care and extra-care housing pose additional threats to the residential care business. New regulations contemplate: reinforcement of investments in preventive technologies (e.g. tele-care): design of a training program for home carers (the Expert Carers Program); creation of the Extra-Care Fund to finance extra-care housing projects.

Despite the decrease in the supply of residential care, the nominal value of the residential care business grew at 3% per year (from ~9,4 million euros to ~10,6 million euros). This growth was supported by an annual 5% increase in fees in the last five year period, making them rise from an average 20,236€ per year in 2002 to 24,760€ in 2006.

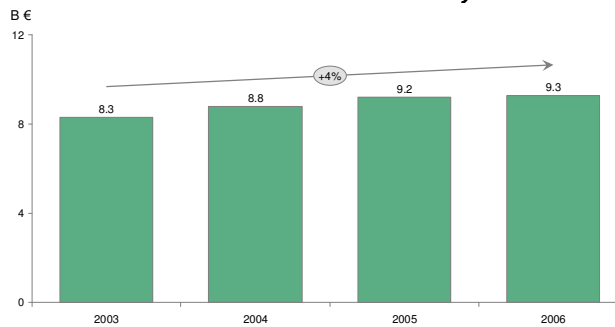
As to the nominal value of the domiciliary market, it has increased in line with volume (4% per year). This has raised revenues in this business by 1 million euros in only four years, reaching a market value of 9,3 million euros in 2006.

Figure 120. Recent evolution of revenues in the residential care business, 2002-2006 (€)



Source: MDB research.

Figure 121. Recent evolution of revenues in the domiciliary care business, 2002-2006 (€)



Source: MDB research.

The role of the private sector

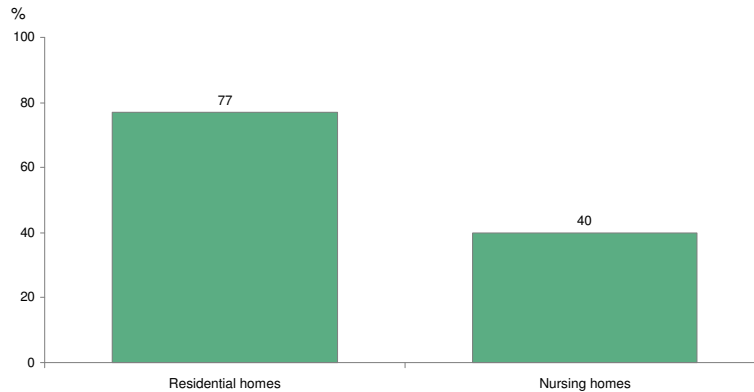
In the UK, the private sector plays a major role in the provision of both residential and domiciliary care. In 2006, ~78% of the residential care capacity and ~76% of the domiciliary care capacity was run by private entities.

According to MDB Research, the strong expansion of the private sector in residential care, which began in 1993, was supported by the Government, who wished to reduce long hospital stays. This started with the decentralization of the provision of elderly care from the Government to local authorities, and the implementation of the “Mixed Economies” system, in that same year. According to this system, local authorities had to reduce at least 85% of provided care services to the private sector (both for-profit and voluntary). Furthermore, a limit for capital expenditure CAPEX in elderly care facilities was defined.

Later on, the Government introduced the Choice Directive. This directive gave to the elderly people eligible for residential care the right to choose their provider. In addition, a Residential Allowance that could only be claimed by low income elderly living in private residential centers was created. The impact of all these measures was the gradual withdrawal of local authorities from direct provision of care to older people.

In 2001, the Government enacted free nursing care for all elderly living in a nursing home, through the Health and Social Act. This measure involved a substantial subsidy to all self-funded residential care recipients. In addition, a large share of residential care recipients (~77% of elderly in residential homes and ~40% of residents in nursing homes) are as well funded or at least co-funded by the Government. The Government inclusively finances a large part of the customers of large private groups. This happens for example with Southern Cross, where 81% of the care recipients are funded or co-funded, and also with Asbourne Living Homes, which has 60% of its residents supported by the Government.

Figure 122. Share of residential care recipients publicly funded and co-funded, 2006 (%)



Source: MDB research.

At present, the Government is seeking new ways to increase the financial capability of elderly, so as to grow the share of self-funded care recipients. Currently, the Government is evaluating the possibility of local authorities conceding loans to the elderly, secured by the value of their houses.

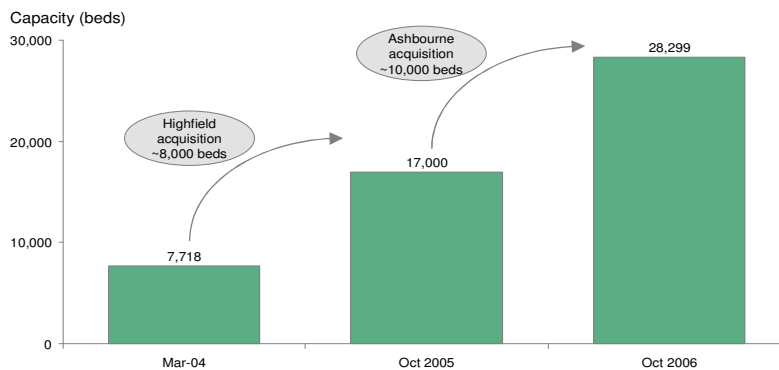
Major private players

According to MDB research, residential care was until the early 2000’s a “cottage industry” dominated by a large number of small “owner-managed” residential centers. Yet, concrete measures taken at the beginning of this decade drove many small players out of the market. On one hand, strict minimum standards for residential care (such as space ratios, staff ratios and staff qualifications) were defined in the Care Standard Act of 2000. On the other hand, regulatory bodies were created in 2003 to control the compliance with these standards.

The reduction in the demand for residential care driven by public policy together with the payment by local Government of low fees, which were at times insufficient to generate an adequate return on capital, has also put significant financial pressure on small inefficient players and pushed many out of the market.

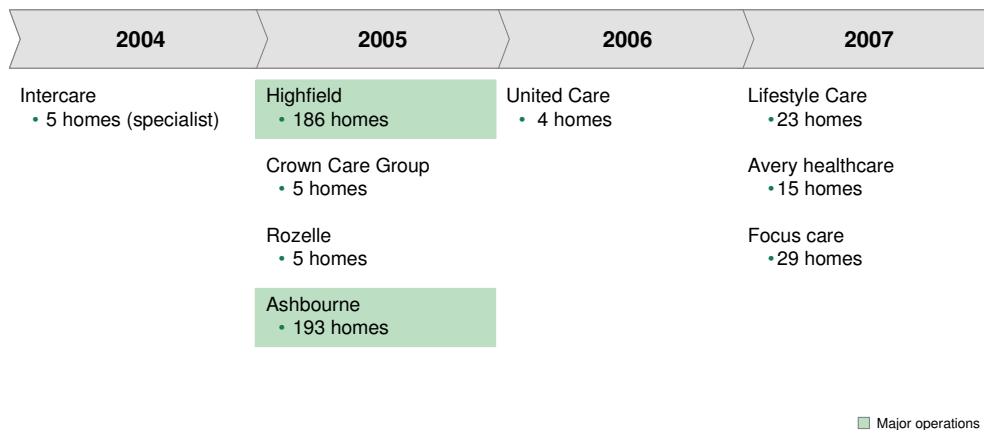
Currently, major players (such as Southern Cross and Four Seasons Healthcare) already play an important role in the private sector, namely in the residential care business. MDB research estimates that 46% of residential homes and 52% of nursing homes were run by major private players in 2006.

Figure 123. Recent evolution of Southern Cross care capacity, 2004-2006 (N.)



Note: Includes all types of care homes (not only elderly care homes).

Source: Southern Cross Annual Report; Website; Press.

Figure 124. Recent acquisitions conducted by Southern Cross, 2004-2006 (N.)

Note: Includes all types of care homes (not only elderly care homes).

Source: Southern Cross Annual Report; Website; Press.

Besides, and given the aggressive inorganic growth strategies that have been pursued, the role of major players is expected to increase further. Southern Cross, for instance, has managed to multiply by four its residential care capacity in only two years, with the acquisition of Highfield (8,000 beds) in 2004 and Ashbourne (10,000 beds) in 2005.

Due to the high financing needs of the elderly care industry, major private players tend to be listed and have financial institutions as main shareholders. Thus, Southern Cross, Care UK, Four Seasons Healthcare and Nestor Healthcare are all listed. In addition, Care UK and Four Seasons are both controlled by private equity firms while Southern Cross' major shareholder is an investment bank. There is also the case of some players, such as McCarthy & Stone, tried going public, but did not resist the pressure for fast profitability imposed by investors.

More recently, innovative sources of funding have emerged. Thus, major players' organic growth has been in some cases funded by sale and leaseback agreements whereas inorganic growth has been financed by venture capitalists (e.g. acquisition of Trinity Care by Southern Cross).

Major players provide different ranges of services but, as a rule, focus on residential care. In addition, they usually only operate in the UK. Yet, there are exceptions: BUPA operates internationally (in Australia and Spain) and Nestor Healthcare focuses on domiciliary care services.

Case Study Southern Cross Healthcare Group



Southern Cross Healthcare - with a 6% market share - is the largest provider of care homes for the elderly in the UK. It renders specialist services for people with physical and/or learning disabilities. In 2007, Southern Cross operated 710 care homes with 36,186 beds and employed 41,000 people. Southern Cross went public in July 2006.

Southern Cross operates under the following three brands:

- ▶ Southern Cross Healthcare - providing a range of residential care services (both residential and nursing homes) for dependent elderly;
- ▶ Ashbourne Senior Living - offering the same services as Southern Cross Healthcare. It is however positioned as a premium brand and targeted at high income dependent elderly;
- ▶ Active Care Partnerships - rendering long-term care services for people with physical and/or learning disabilities and for younger people with complex forms of challenging behavior.

Care services are provided to most local authorities in the UK that, together with the NHS, represent ~70% of the company's revenues. Southern Cross' care homes portfolio is largely purpose-built with a high percentage of single occupancy rooms. Although the typical length of stay in its homes is only one year on average, the strong demand for places has enabled occupancy to remain at around 91% in recent years.

Southern Cross operates under a particular business model, based on the leasehold of the properties that it operates. This has allowed the company to expand rapidly without repeated appeal to equity financing. In fact, the company has grown predominantly through acquisitions, leading consolidation movements in the UK elderly care industry. Major acquisitions include Highfield (~8,600 beds) and Ashbourne Homes (~10,000 beds), both of which were subject to sale and leaseback transactions. 1600 extra beds were added in the last two years, with a similar funding format.

Future growth is expected to come from the expansion of existing residential centers and from opportune acquisitions. No plans for internationalization have been announced so far.



Case Study - Nestor Healthcare Group Plc



The Nestor Healthcare Group is a holding of subsidiaries providing social and primary care in the UK. Listed in the London Stock Exchange, Nestor has the investment bank Schroders as its major shareholder, with a 22% stake.

Nestor's customers include hospital trusts, nursing and residential homes, prisons, and private individuals. Yet, the elderly are their major customers in the social care business. In what concerns elderly care, Nestor provides both social and medical services.

Social services provided include:

- ▶ Assistance in routine activities (e.g. housekeeping, laundry, meal preparation) and hygiene care (i.e. bath);
- ▶ Companionship (e.g.. at home, walks, concerts, exhibitions, shopping, tuck in for the night);
- ▶ Sitting (day, night, 24 hour);
- ▶ Occupational activities;
- ▶ Control of medication administration;
- ▶ Assistance to the special needs of people with mental and physical conditions;
- ▶ Urgent assistance;
- ▶ Comfort check.

Medical services provided include:

- ▶ Phone medical consultations;
- ▶ In person (at home or in primary care center) medical consultations (urgent or routine);
- ▶ Managed care/in-home hospitalization (24 hour):
 - Disease management;

- Recovery/convalescence care;
- Chronic/terminal diseases care;
- Palliative care;
- Treatments (e.g. intravenous medication, blood transfusions, dialysis, chemotherapy).

Medical services are provided by subsidiaries, which do not exclusively target at the elderly segment. Nonetheless, four of Nestor's subsidiaries focus exclusively on the provision of social elderly care services:



<http://www.country-cousins.co.uk>/<http://www.goldsborough-home-care.co.uk>/<http://www.goldsborough-home-care.co.uk>/<http://www.goldsborough-home-care.co.uk>

Nestor has recently raised new funds, with the aim of returning to the previous acquisition programme. The goal is to keep adding small domiciliary care businesses in geographic areas where the current network is not present, as well as more specialized services, for example in learning disabilities, thus enlarging the Group's expertise and service offering.

Range of services offered in the United Kingdom - business as usual, with some particularities

Current service

In the UK, the private sector provides all key types of elderly care services, both residential and domiciliary. Yet, some particularities distinguish the country's elderly care industry, namely:

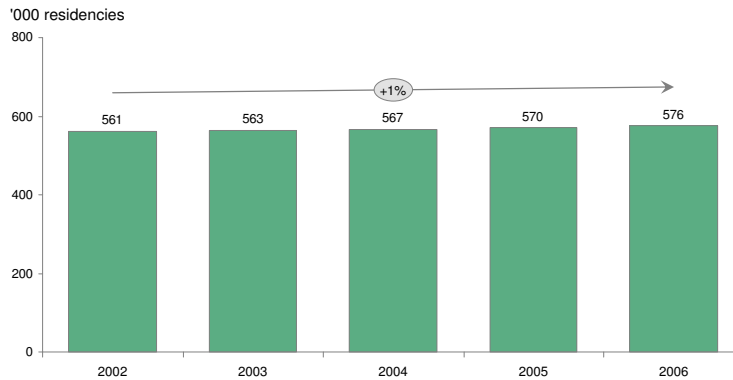
- ▶ The important role of sheltered housing as an alternative to residential care;
- ▶ The proliferation of a new concept of residential care: "dual residencies";
- ▶ The creation of specialized homes for elderly with specific mental or physical conditions.

Sheltered housing

The development of sheltered housing dates back to the 1950s and resulted from the Government's goal to build houses tailored to the needs of the elderly who did not require constant care. Sheltered housing (also known as retirement housing) consists of an apartment or bungalow located in a block of 15 to 40 properties where all other residents are elderly. Properties are designed to be accessible by wheel chair and equipped to better fulfill the needs of the elderly. Additionally, they are connected to an alarm service for emergencies.

In the last years, sheltered housing has been growing steadily (at an annual rate of ~5%). This growth has been partially encouraged by the Government, which has focused on redirecting care away from institutionalization.

Figure 125. Recent evolution of sheltered housing capacity, 2002-2006 (N.)



Source: MDB research (2007).

Sheltered housing, which can be bought or rented, usually has communal amenities such as socializations lounges, laundry rooms, guest suites and a garden. A warden who lives in the block or nearby manages and guarantees maintenance of the block.

New forms of sheltered housing - extra-care housing - targeted at frailer and more dependent elderly have emerged recently. Extra-care housing schemes usually provide some services, such as housekeeping and meals.

Case Study - McCarthy & Stone



McCarthy & Stone claims to be UK's leading sheltered housing builder, with a market share of ~70%. With over 30 years of experience, McCarthy & Stone has built over 40,000 sheltered housing apartments under two typologies (1 bedroom and 2 bedrooms) tailored to the needs of elderly people. The company was public for more than 20 years but reverted to private ownership in 2006. Currently, it is controlled by HBOS, which is UK's major mortgage provider.

Special features of McCarthy & Stone sheltered housing developments include: fully wheelchair accessible divisions, a fitted kitchen, lifts, a 24h alarm connected to Careline (providing social and medical services), intruder and smoke alarms, a security entrance system and common amenities (e.g. laundry room, guest room and a socialization lounge). As they are targeted at independent people, sheltered housing developments do not offer support services, exception made to maintenance of the building, which is guaranteed by a warden (designated as the house manager).



Although sheltered housing continues to be McCarthy and Stone's core business, the company has also been operating in the residential homes business since 1999. In the upcoming years, McCarthy & Stone plans to offer a full range of residential care services. Thus, the firm plans to consolidate its leadership position in the sheltered housing business, geographically expand the residential homes business and enter the nursing home business.

Dual homes

Dual homes are residencies that offer both residential and nursing care. Within these residencies, different types of care are available for elderly with different levels of dependence and personalized plans of services are defined for each resident. Services' plans are periodically adjusted so as to meet changing needs of the elderly. Dual homes were created for two types of customers:

- ▶ Couples who require different degrees of care;
- ▶ Individuals whose needs are expected to evolve relatively quickly.

Major players, such as Southern Cross and BUPA, already offer these types of homes.

Specialized homes

The need to differentiate from competitors led major groups to gradually evolve from standardized to tailored services. Following on this trend, specialized homes were created. These consist of nursing homes for elderly with particular physical (e.g. Parkinson) or mental (e.g. Alzheimer) conditions, in convalescence from accidents or illnesses (e.g. strokes), in post-operative periods (e.g. pacemaker operations) or with terminal illnesses (e.g. cancer).

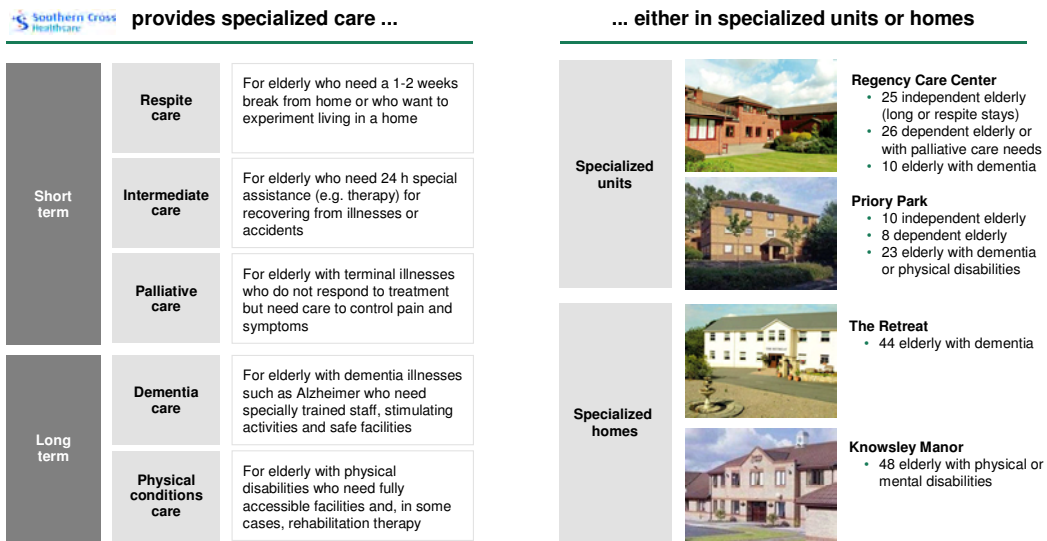
These homes are advantageous as they offer a range of services tailored to the special conditions of the elderly they target, namely:

- ▶ Specialized medical services (e.g. neurology practices, rehabilitation therapy, palliative care, pain control);
- ▶ Specialized social services (e.g. mental or physical stimulating occupational activities, staff specially trained to deal with Alzheimer or Parkinson);
- ▶ Adapted facilities (e.g. fully accessible accommodations and amenities);
- ▶ Special security systems (e.g. video-surveillance, controlled exits and entrances).

In addition, specialized homes avoid exposing the slightly dependent elderly to very advanced stages of dependency and, on the other hand, try not to subject extremely dependent elderly to the discrimination of slightly dependent ones.

Major groups such as Southern Cross, BUPA and Four Seasons Healthcare manage specialized homes. Some of these groups, instead or besides specialized homes, build specialized units within general nursing homes. Small-scale private players, on the contrary, integrate elderly with special conditions in general nursing homes or do not accept those in advanced stages of dependence at all.

Figure 126. Specialized care provided by Southern Cross



Source: Southern Cross Healthcare Website.

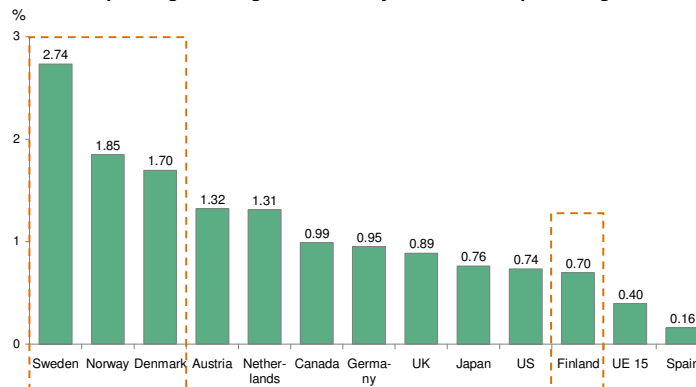
2.3. The case of Nordic Countries - promoting the role of the private sector to attain cost-efficiency. The Swedish case

Elderly care industry supply

Nordic countries are social welfare States and elderly care is a universal right of the responsibility of the Government. Thus, relative public spending of Nordic countries in elderly care is among the highest in the world, although ranging from 0.7% of GDP in Finland and 2.7% of GDP in Sweden. The following graph illustrates the importance of public elderly care spending worldwide.

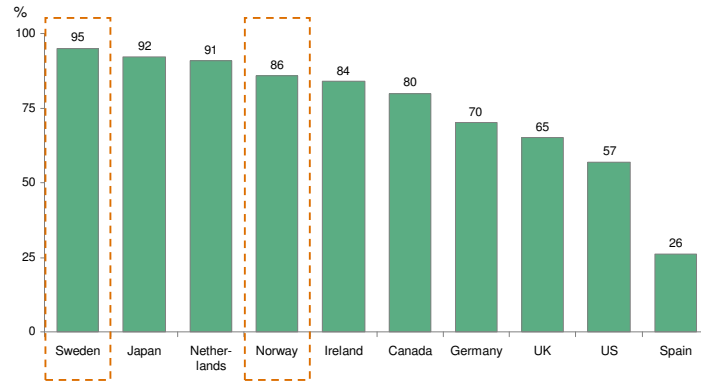
Due to their social welfare status, Nordic countries register high participations (>80%) of the public sector in the funding of elderly care. These participations are among the highest in the world, and are financed by tax revenues. In the following Figure, the participation of the public sector in different countries is compared.

Figure 127. Public spending in long term elderly care as a percentage of GDP, 2000 (%)



Source: OCDE health project long term care for older people (2005).

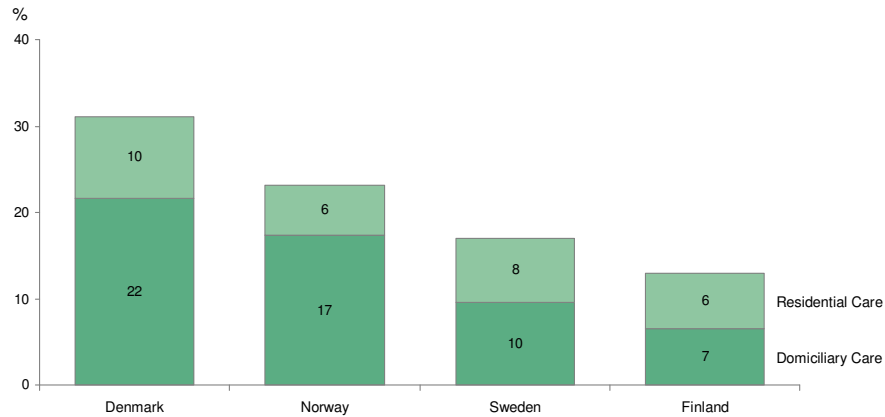
Figure 128. Share of long term elderly care financed by the Government (%)



Source: OCDE health project long term care for older people (2005).

Elderly care penetration rate and associated services varies across Nordic countries, as illustrated in the graph below. In Denmark and Norway, elderly care has almost a 30% penetration rate and domiciliary care predominates, whereas In Sweden and Finland, elderly care has only a ~15% penetration rate, almost equally split between domiciliary and residential care.

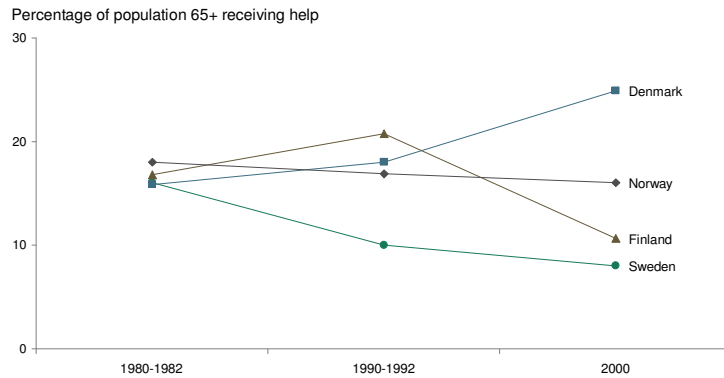
Figure 129. Percentage of +65 years population benefiting from care (%)



Source: OCDE Health data 2007.

All Nordic Governments claim to favour domiciliary care. By doing so, Governments expect to make it possible for the elderly to stay longer in their homes. Yet, domiciliary care has developed differently in the four countries. In Denmark, domiciliary care has grown significantly, and in Norway, it has remained stable, while in Finland and especially in Sweden, it has declined. According to Trydegard, Denmark seems to be the most “Nordic Country” in terms of domiciliary care. Sweden has chosen to decrease the number of domiciliary care recipients and provide more care hours to fewer elderly.

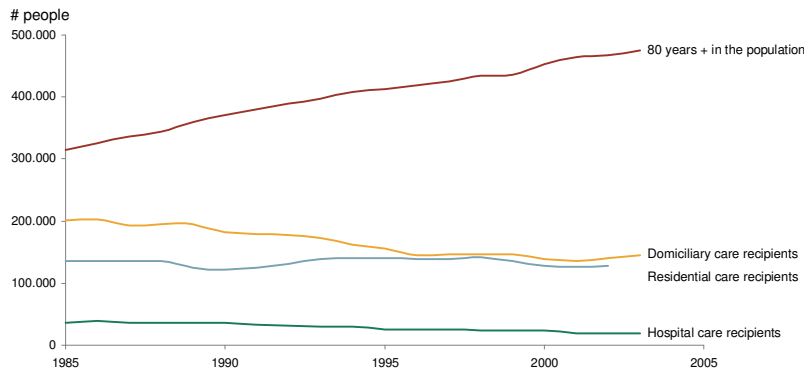
Figure 130. Evolution of domiciliary care coverage in the Nordic countries, 1980-2000 (%)



Source: NOSOSCO, 2002.

Although Nordic regions continue to follow social welfare principles, elderly care has gradually become less universal. This situation was triggered by the economic crisis of the 90's, which dictated the rationing of elderly care budgets. In this context, Nordic countries were forced to reform elderly care policies, trimming down the provision of services and limiting the access to them. From then on, the Government focused on the provision of services with a medical nature and on the elders in most need. The downward trend of supply has been reversed in the last years. The *Figure 131* below evidences the Sweden case.

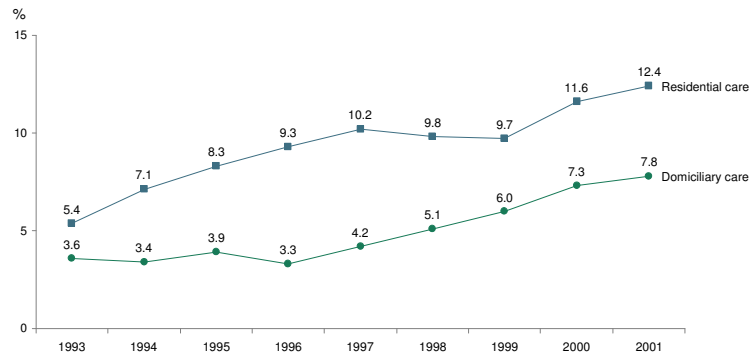
Figure 131. Evolution of elderly care recipients in Sweden, 1990-2005 (%)



Source: Szebehely 2002; Thorslund & Larsson 2002.

The role of the private sector

The private sector continues to have a minor role in the provision of elderly care services in Nordic countries. In Sweden, only ~11% of domiciliary care (in terms of care hours) and 14% of residential care (in terms of care recipients) were provided by the private sector in 2006. But these numbers hide a strong evolution in the last decade, as can be seen in the following graph (*Figure 132*).

Figure 132. Evolution of share of elderly receiving private services from the private sector, 1993-2001 (%)

Source: Socialstyrelsen (2001).

Until the economic crisis of the 90's, the private sector was almost absent from provision of elderly care. The emergence of private players followed the implementation of the Adel Reform (1992), which aimed at increasing the efficiency and effectiveness of elderly care provision.

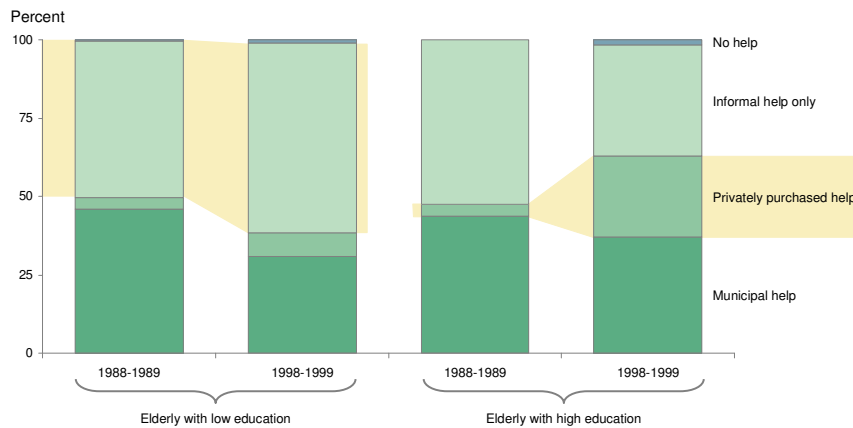
According to Trydegard, the Adel Reform introduced two of the key "New Public Management" concepts: marketization and privatization. In the scope of the reform, the provision of elderly care was decentralised from county councils to municipalities and market-oriented indicators (such as unitary costs, productivity and quality levels) began to be systematically controlled. To increase elderly care efficiency and effectiveness, municipalities adopted the "purchaser-provider model", thus separating the evaluation of needs from the provision of care. On top, care provision units were transformed in profit centers and forced to compete with private players. Competition took the form of competitive tendering for contracts. In 2006, almost 50% of municipalities had granted elderly care contracts to private players.

Later on, some municipalities, such as Stockholm, implemented the consumer choice model. In this model, after the assessment of needs, the elderly receive a "virtual" voucher to purchase the recommended service from a public or private provider of their choice. In the case of choosing a private provider, "extra services" can be acquired by the elderly with his own funds. The success of this model is still unknown, yet in some countries the elderly people have faced difficulties in making well informed choices.

The involvement of the private sector in the provision of elderly care services was also encouraged by the economic crisis of the 90's. Consequently to the rationing of elderly care budgets, the number of self-funded elders acquiring services from the private sector increased. According to Trydegard, high income and high education elderly people replaced public sector services by formal services whereas low income and low education elders opted for informal services. These two phenomena were designated as the "marketization" and "informalization" of the elderly care industry.

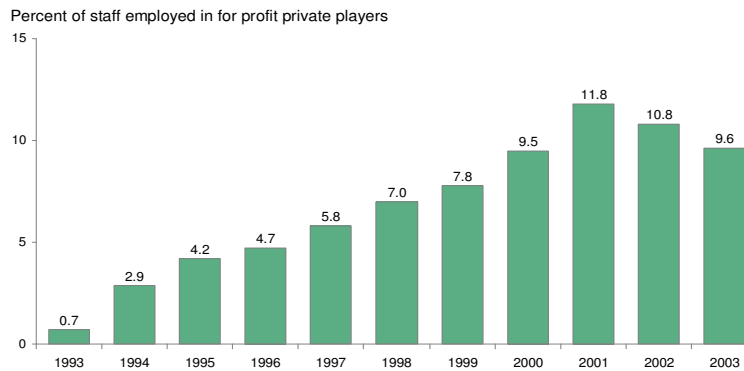
In the end of the 90's, the participation of the private sector had increased significantly. In a ten year period (from 1993 to 2003), the share of carers employed in the private sector had grown from 0.7% to 9.6%, and had reached a peak in 2001 (11.8%).

Figure 133. Sources of help to dependent elderly, 75-84 years (%)



Source: Swedish welfare Commission (SOU 2001, 79).

Figure 134. Private provision of public financed elderly care, 1993-2003 (%)



Source: Trydegård, 2005.

A research study conducted by Trydegard in 2001 revealed that the private sector had a higher presence in the municipalities that were more densely populated and had a higher share of voters of the Moderate Party, with a stronger shortage of elderly care and larger size caretakers. Furthermore, it had a lower presence in regions where residents had lower education levels. In the capital Stockholm, for example, 50% of residential care was already contracted to private players in 2006.

According to the National Board of Health and Welfare, services contracted to the private sector have, as a rule, lower prices. Yet, there is no evidence of significant differences in quality between private and public provided services.

Last July, the Government has enacted another law that will, most probably, favour a further involvement of the private sector in the provision of elderly care. The new law allows the elderly to deduct from taxes annual expenses on social services up to ~10,800€ (such as housekeeping, laundry or personal care). The privatization of healthcare provision (including elderly care) is currently a hot topic in Sweden.

Major players

The Swedish private sector is quite concentrated. According to Trydegard, in the end of the 90's, the four largest elderly care providers (Aleris Äldreomsorg AB, Attendo Care AB, Carema Äldreomsorg AB and Förenade Care Ab) controlled half of the contracts granted by local municipalities. Given that the

largest consumer of elderly care services - municipalities - pursue cost effectiveness, the high concentration of the private sector most probably aims at exploiting scale economies.

Major players in Sweden provide basic services and seem not to invest significantly in service sophistication and innovation. This most probably derives as well from the fact that municipalities are the largest client of the private sector.

Similarly to other countries and due to industry's high financing needs, many major players have financial companies as shareholders: Aleris Group, Attendo Care, Medivire and Carema are controlled by the following private equity firms respectively: EQT III, Industri Kapital, MD Funds and 3i). Some other major players are controlled by healthcare service providers, such as Ambea and Förenade Care. Due to the limited size of the Nordic markets, major private players are, in general terms, multi-nationals operating in various Nordic countries. The M&A activity and the organic growth plans pursued in the last years suggest that, in the upcoming years, the concentration of the Swedish elderly care industry will increase.

Figure 135. Nordic major players

		Major players				
		Aleris	ATTENDO SENIOR CARE	carema	Förenade Care	MEDIVIRE
Geographic presence	 Sweden	✓	✓	✓	✓	
	 Denmark	✓	✓		✓	
	 Finland			✓		✓
	 Norway	✓		✓		

Source: Trydegård, 2005.

Case Study - Attendo Senior Care

Attendo - previously Svensk Hemservice - was the first private firm to be granted an outsourcing contract by the Government in the late 80's. Today, Attendo is the largest Swedish elderly care private player and operates as well in Denmark. Since January 2007, Attendo has been controlled by Industri Kapital, a private equity firm. Before that, Attendo was controlled by Bridgepoint and some small investors.

Attendo's main business is elderly care, which accounts for ~90% of the firm's revenues. Besides elderly care, Attendo provides care services to disabled people (mentally and physically), people with some type of abuse (e.g. alcohol) and to children and families at risk (e.g. abused women and children).

In what concerns elderly care, Attendo provides the following services on a permanent or short term basis:

- ▶ Domiciliary care limited to social services, such as housekeeping, laundry, meal preparation, personal care and sitting (24h, night, day);
- ▶ Residential care comprising:
 - Assisted living for independent elderly, providing 24 h access to social and medical care (extra payment and upon request) and shared amenities (like restaurants and lounges);
 - Nursing homes for dependent elderly, providing permanent medical and social services;
 - Own homes, providing flexible (e.g. short-term) nursing home arrangements for elderly.

Attendo is certified to provide services to municipalities and private consumers (both self-funded and in the scope of the consumer-choice model). Local municipalities are Attendo's major clients.

Attendo has been expanding fast, both organically and through acquisitions. In 2005, Attendo's revenues grew by 74%. Acquisitions (namely the one of the care business of Capio Omsorg AB group) were the major source of growth, allowing Attendo's revenues to grow 55%. In a five-year time, Attendo aims to triple its sales not only by growing organically and inorganically not only in the Nordic markets but also in international markets such as Germany, UK or Spain.

**3. Summary**

- ▶ In Spain, the supply of elderly care services has grown significantly in recent years:
 - Domiciliary care almost tripled its capacity and residential care increased it by 50%;
 - The low coverage of elderly care services in the early 2000's was most probably motivated the high growth rates experimented by the supply of elderly care services.
- ▶ Fostered by Government policies, the private sector has already attained a major role in the provision of elderly care services:
 - Public funding of privately provided services at rates that equal commercial prices, which was the main driver of the development of the private sector as an elderly care provider;

- Economic growth also supported the emergence of private players;
- Currently, ~75% of the residential care capacity is already controlled by private players.
- ▶ Although major players have been consolidating recently, the private sector remains highly fragmented:
 - Aggressive organic growth plans have been pursued by major players;
 - In some cases, organic growth plans have been complemented with acquisitions;
 - In 2006, major players only controlled ~10% of residential care capacity.
- ▶ The elderly care industry in Spain has some particularities:
 - The division of large residential care centers into smaller units, or modules;
 - The split of clients according to their specific needs (allowed by the modules system);
 - The proliferation of senior resorts, which are small luxurious villages for active elders;
 - The mass usage of phone assistance services.
- ▶ In the last years, the UK Government has implemented measures to redirect care away from institutionalization:
 - Thus, while the supply of residential care has been steadily declining at a ~2% rate, the supply of domiciliary care has been growing at an average of 4% per year;
 - In 2006, the coverage of domiciliary care (which was of ~8 out of 100; elderly) exceeded that of residential care (which was of ~5 out of 100 elderly);
 - Governmental measures to promote care options alternative to institutionalization include Individual budgets managed by State counsels with a bias against residential care and Carer's allowance, which aim to encourage informal elderly care by families.
- ▶ As a result of governmental measures implemented in the 90's, the private sector currently dominates the provision of elderly care services in UK:
 - In the early 90's, by defining maximum limits not only to the CAPEX that could be invested in elderly care but also to the weight of direct provision of services, the Government encouraged the participation of the private sector in the elderly care industry;
 - More than 75% of the elderly care capacity is controlled by private players.
- ▶ Although major players are close to dominate the private sector, they have been strengthening their leadership positions by pursuing aggressive inorganic growth plans:
 - Major players, which are commonly country specific and focused on residential care, already control ~ 50% of the residential care capacity;
 - Due to the high financing needs, major private players are public, have financial groups as shareholders and apply innovative financing schemes (e.g. sale and lease backs);
 - Southern Cross - the market leader - has managed to multiply by four its residential care capacity through several acquisitions in only two years;

- Governmental measures, such as the definition of strict minimum standards for residential care and the creation of regulatory bodies to control the compliance with these standards, have led many small players out of the market;
- ▶ The elderly care industry in UK has some specificities:
 - The important role of sheltered housing as an alternative to residential care;
 - The proliferation of a new concept of residential care: “dual residencies”;
 - The creation of specialized homes for elderly with specific mental or physical conditions.
- ▶ The supply of elderly care services in the Nordic countries contracted in the 90’s decade, in spite of these countries’ “social welfare” policies:
 - The economic crisis of the 90’s dictated the rationing of elderly care budgets and the decrease in universal access;
 - However, the relative spending of Nordic countries in elderly care (in terms of GDP) and the high participation of the public sector in the funding of this industry remained among the highest in the world;
 - The downward trend in supply has been reversed in the recent years.
- ▶ Elderly care penetration and service mixes vary across countries:
 - In Denmark and Norway, elderly care has more than 20% penetration and domiciliary care predominates;
 - In Sweden and Finland, elderly care has a penetration of about 15% and domiciliary and residential cares have similar penetration rates.
- ▶ Although Nordic Governments have been encouraging the participation of private players in the provision of elderly care, the private sector still plays a minor role in the industry:
 - Aiming to reach higher cost efficiency, the Nordic Governments implemented, after the 90’s economic crisis, reforms that encouraged the participation of private players, namely:
 - The introduction of competitive tendering between public and private players for provision of public funded elderly services;
 - The enactment of the consumer choice model which gave consumers the opportunity to choose between public and private care providers.
 - Despite the governmental efforts, in Sweden, for instance, only ~11% of domiciliary care and 14% of residential care were provided by private players in 2006;
 - Largest players (Aleris Äldreomsorg AB, Attendo Care AB, Carema Äldreomsorg AB and Förenade Care Ab) control more than 50% of the contracts granted by local municipalities;
 - The focus of private players on cost efficiency explains the high concentration of private players, who aim to explore scale economies.

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ANNEXES

ANNEX A

METHODOLOGICAL NOTE

Survey objectives

The survey “Study to Address the Needs of Senior People in Portugal” main purpose was to obtain primary information about the Portuguese senior population. It provides comprehensive data about their social, economical and demographic profile(s) as well as some characteristics about daily practices and also their perception of needs.

Survey sample parameters

The following parameters were established:

- ▶ Senior population - individuals with 55 years or over;
- ▶ Residents in Mainland Portugal regardless of nationality or place of birth.

Survey Sampling

The number of seniors who participated in the sample was of 1,324. The sampling was carried out in twelve municipalities in Mainland Portugal.

The sample was geographically segmented in 8 initially defined municipalities in Mainland Portugal (*Figure A*). The selection of these municipalities was the result of a clustering process based on three criteria:

- ▶ demographic - municipalities were classified according to their population age structure:
 - variable: percentage of seniors (55 years or over) in the total district's population;
 - source: INE, Census 2001;
 - basic parameters: Average (M=32,7%) and Standard Deviation (DP=7,8%);
 - clusters:
 - very aged municipalities: [$>40.5\%$ ($>M+1DP$);
 - aged municipalities: [32.7% a 40.5%] (M a $M+1DP$);
 - young municipalities: [25.4% a 32.7%] ($M-1DP$ a M);
 - very young municipalities: $<25.4\%$ [$<M-1DP$].
- ▶ settlement: municipalities were classified according to their urbanization rate
 - variable: percentage of population living in predominantly urban parishes, medium urban parishes and predominantly rural parishes, in the total district's population;
 - source: TAU, DGOTDU;
 - clusters:

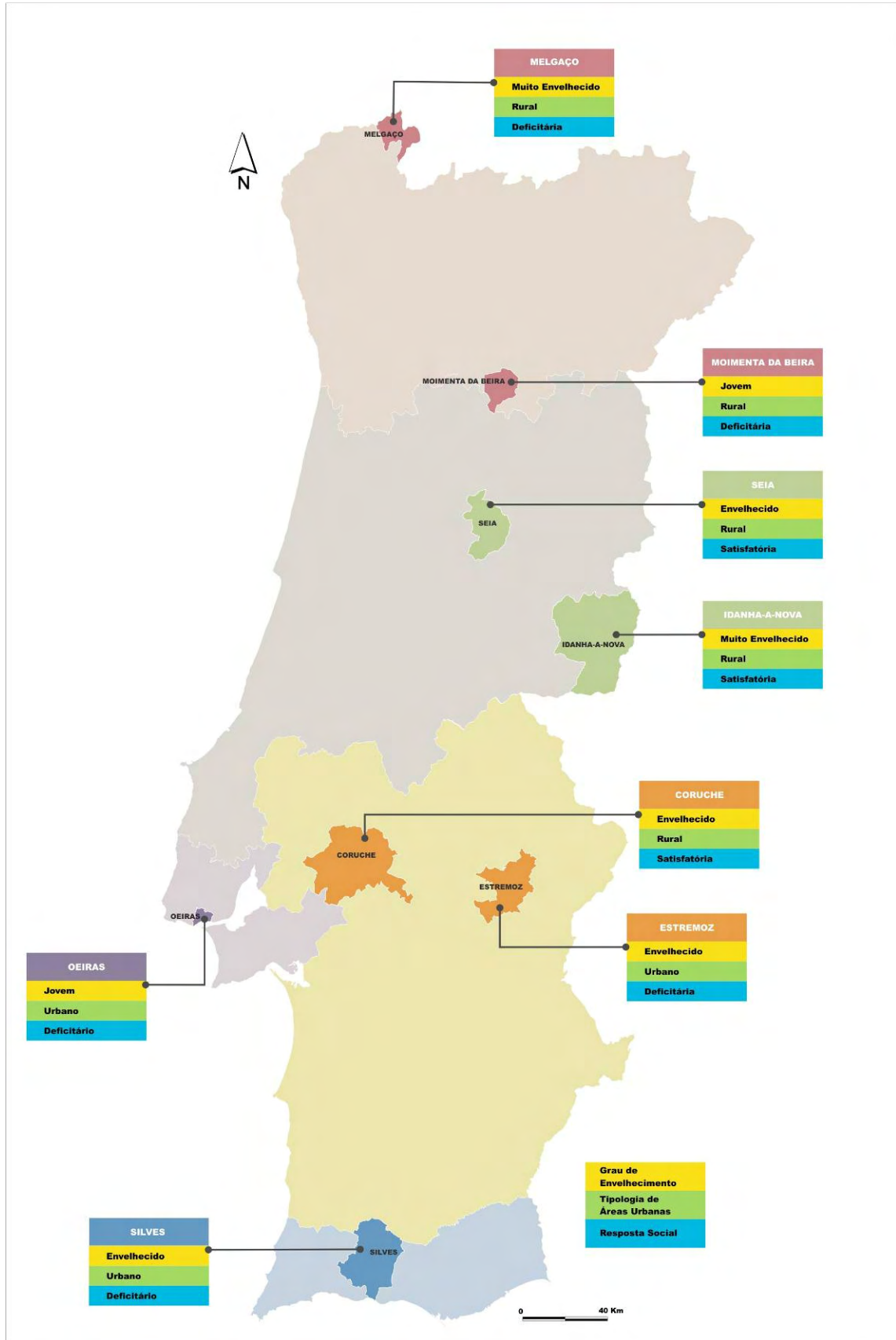
- predominantly urban municipalities: >50% of the population living in APR;
 - medium urban municipalities: >50% of the population living in AMU;
 - predominantly rural municipalities: >50% of the population living in APR.
- ▶ Social responses (for senior people): municipalities were classified according to their performance in providing places in retirement homes and day centers
- variable: number of people with 55 years or over per place in retirement homes and day centers compared to the Mainland's average;
 - source: Social Chart 2007 (DEEP/MTSS);
 - clusters:
 - low performance municipalities: <44.1%] (in retirement homes) and <44.0%] (in the day centers);
 - satisfactory performance municipalities: >44.1%[(in retirement homes) and >44.0%[(in the day centers).

After this clustering procedure based on dichotomies aged-young, urban-rural, sufficiency-insufficiency of social answers - there was a pre-identification of relevant profiles, discharging the following:

- ▶ very young demographic municipalities;
- ▶ medium urban municipalities or with a weakly defined urban-rural profile;
- ▶ municipalities with mixed situations of social solutions for elderly people in the above mentioned services.

As a result of this procedure, a final typology was created and segmented in eight profiles, from which it was extracted one municipality as a representative of each cluster. At this stage, the selection of the municipalities had into account a fourth criteria, of subjective application, that sought to obtain a balanced territorial distribution: at least one municipality selected in each NUTS II regions; North-South and coastal/inland.

Figure A Initial selection of municipalities



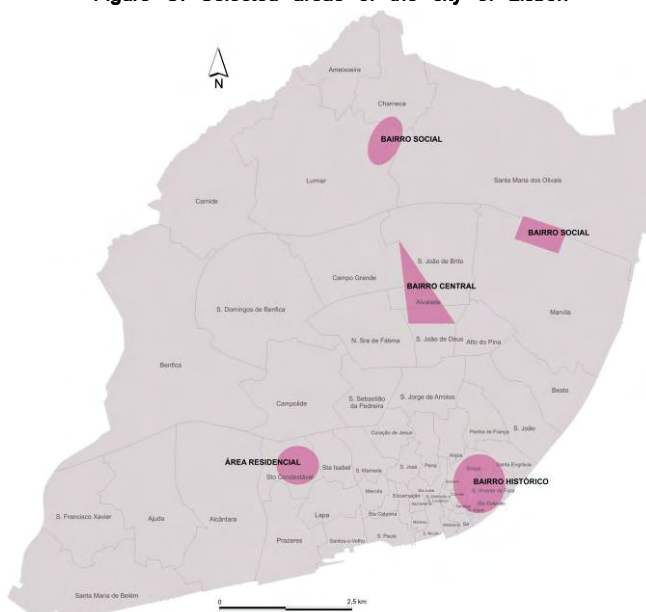
The exception to this methodological procedure was a specific approach of the AML, for it is a very important territory and should lead to an in-depth analysis. Thus, it was appropriate to select a group of municipalities that represented the AML social mosaic: two municipalities of the north bank (just one, because Oeiras was already selected), two from the south bank and Lisbon municipality (*Figure B*).

Figure B Selected municipalities in the Lisbon Metropolitan Area



In order to obtain a portrayal as reliable as possible of the reality of the elderly population living in each of the selected geographic units, the group of questionnaires was carried out in different areas of the municipalities. In the specific case of the city of Lisbon, the survey was carried out in five different areas: central area; residential area; historical neighborhood; recent social neighborhood (Alta de Lisboa); early social neighborhood - Chelas/Zona J (*Figure C*).

Figure C. Selected areas of the city of Lisbon



Questionnaire

The data collecting tool used was a questionnaire, carried out in an indirect way (the inquirer did the questions and registered the answers). It is structured in eight parts: i) Characterization of the individual; ii) Housing Context; iii) Economic Profile; iv) Family Dynamics and neighborhood relations; v) Migrations;

vi) Health and well-being; vii) Equipments and health and social services; viii) Perception of the elderly concerning their needs and expectations.

Each one of these parts includes both open and closed questions.

Inquirers

The filling up of the questionnaires was carried out by 16 collaborators (college students or with a recent college degree in Social Sciences, some of them living in the selected municipalities). Those are regular CEDRU collaborators in similar tasks that have received specific training for the development of this work and a continuous follow-up under the supervision of a coordinator.

Time frame

The questionnaires were carried out between October and November 2007.

Sampling Error

The maximum sampling error, for a degree of reliance of 95%, is $\pm 2.69\%$.

ANNEX B

QUESTIONNAIRE

STUDY TO ADDRESS THE NEEDS OF THE SENIOR PEOPLE IN PORTUGAL
M. I. Demand side analysis
Questionnaire – Senior People



SURVEYOR: _____ PLACE: _____ SURVEY'S REF.: _____

I. SOCIO-DEMOGRAPHIC PROFILE

1.1. Gender	Male		Female										
1.2. Civil Status	Married		Companionate marriage		Single		Divorced		Widower		Other: Which?		
1.3. Age													
1.4. Level of Education	Illiterate		1 st Stage of Basic Education		2 nd Stage of Basic Education		3 rd Stage of Basic Education		Secondary Education		Medium level course		Higher Education
1.5. Nationality													
1.6. Birth Place													
1.7. Residence	District					Parish							

II. HOUSING CONTEXT

2.1. House occupancy system?

Own house ___ Total rent ___ Partial rent ___ Free conveyance ___ Other: Which? _____

2.2. Type of house?

House ___ Apartment ___ Social apartment ___ PER apartment ___ Shanty houses ___ Part of the house ___ Other: Which? _____

2.3. Number of divisions of the house? | ___ 2 ___ 3 ___ 4 ___ 5 ___ > 5 ___

2.4. State of preservation of the house?

Good ___ Reasonable ___ In need of small interventions ___ Degraded (in need of great interventions) ___

2.5. Identification of the house's infrastructures which are used by the individual.

Essential infrastructures:	Domestic work support equipment:	Audio/video and communications:
Kitchen	Stove	Telephone
Water supply system	Washing machine	Mobile
Sewer system	Fridge	Television
Complete sanitary facilities		Computer with Internet

III. ECONOMIC PROFILE

3.1. What is your situation in what work is concerned?

Active ___ Housewife ___ Retired ___ Unemployed ___ Other: Which? _____

3.2. If you are retired: Active ___ Non-Active ___

3.3. What is your job situation?

Employed ___ Self-employed ___ Unpaid family worker ___ Employer ___ Other: Which? _____

3.4. If active, what is your job? _____

3.5. If retired (active or non active):

3.5.1. Reason for retirement? _____

3.5.2. Reason to keep working after retirement? _____

3.6. Structure of household's monthly net revenue, according to revenue type (€).

Earned income		Welfare benefits Which?	
Pensions		Other monetary revenues: Which?	

3.7. Structure of the domestic household's average monthly expenses, according to type (€)

Typology of the Expenses	€
Foodstuff and beverages	
Health (Medical assistance, medication, ...)	
Transports	
House (rent, water, electricity and gas expenses, etc)	
Other goods and services: Which?	

3.8. Indicate the means of transportation you use more often

Own vehicle		Relatives vehicle		Public transportation		Taxi		Other: Which?	
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STUDY TO ADDRESS THE NEEDS OF THE SENIOR PEOPLE IN PORTUGAL
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IV. FAMILY DYNAMICS AND NEIGHBOURHOOD RELATIONS

4.1. Household characterization

	Individual 1	Individual 2	Individual 3	Individual 4	Individual 5
Gender (M/F)					
Age					
Degree of relationship					
Situation in what work is concerned *					

(* Use categories established in Group "III. Economic Profile".

4.2. Frequency of contact with children and grandchildren.

	Regularly (> once/week)	Occasionally (< once/week - > once/month)	Rarely (< once/month)	Never
Children				
Grandchildren				

4.3. Are you institutionalized? Yes ____ No ____

4.4. If no, do you intend in doing it? Yes ____ No ____

4.5. Who supports or will support the financial expenses of you institutionalization? In what proportion?

The senior himself		Direct relatives		Other relatives		Other: Who?	
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4.6. Do you take care of a senior? Yes ____ No ____

4.7. If yes, what would be important to improve that assistance? _____

4.8. Help/Support which you benefit from.

Care Provider	Domestic tasks	Personal care	Financial support	Mobility	Health care	Leisure	Other: Which?
Family							
Friends							
Neighbors							
Institution							
State							
Other: Which?							

V. MIGRATIONS

5.1. NATIONAL

5.1.1. Year you left your home land? _____ **5.1.2. Reason?** _____

5.1.3. Do you keep connections with your homeland? Yes ____ No ____

5.1.4. If yes, of which type?

Own house		Family ties		Investments	
Other goods		Friendship ties		Other: Which?	

5.1.5. If yes, how often do you visit.

Regularly (> one visit/month)	Occasionally (<one visit /month)	Rarely (<one visit /year)	Never

5.1.6. Do you think about returning to your homeland definitely? Yes ____ No ____

5.1.7 Why? _____

5.2. INTERNATIONAL

5.2.1. Year you left your home country? _____ **5.2.2. Reason?** _____

5.2.3. What is you situation concerning entry and residence in Portuguese territory?

Type of Visa	Types of residence permit	Long-term resident status
Temporary residence	Temporary	Illegal permanence
To obtain residence permit	Permanent	Other: Which?

5.2.4. In case you already have Portuguese nationality, in what year did you obtain it? _____

5.2.5. Knowledge of the Portuguese language? Good ____ Reasonable ____ Bad ____

5.2.6. Do you keep connections with your home country? Yes ____ No ____

STUDY TO ADDRESS THE NEEDS OF THE SENIOR PEOPLE IN PORTUGAL
M. I. Demand side analysis
Questionnaire – Senior People



5.2.7. If yes, of which type?

Own house	Family ties	Investments
Other goods	Friendship ties	Other. Which?

5.2.8. If yes, how often do you visit?

Regularly (> one visit/month)	Occasionally (<one visit/month)	Rarely (<one visit/year)	Never
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5.2.9. Do you think about returning to your home country definitely? Yes ___ No ___

5.2.10. Why? _____

VI. HEALTH AND WELL BEING

6.1. Do you have any illness that requires regular medical care? Yes ___ No ___

6.2. How do you evaluate your health condition? Good ___ Reasonable ___ Bad ___

6.3. What meals do you have daily? Breakfast ___ Lunch ___ Snack ___ Dinner ___

6.4. Who cooks your meals at a regular basis and where do you get it/eat (multiple answer).

Eats at its own house	Eat out of the house
The senior himself cooks	At relative's '
Relatives	At friends'/ Neighbors'
Friends/Neighbors	At a bar/restaurant
Bar/Restaurant	At Day Care
Other private entity	In another private location
Social Institution	In another equipment of social nature

6.5. Domestic tasks and its frequency (multiple answer).

Typology of domestic tasks	Frequency			
	Daily	Regularly (> once/week)	Occasionally (< once/week-> once/month)	Rarely (< once/month)
Prepare meals				
House cleaning				
Laundry				
Regular groceries shopping				

6.6. What activities do you develop in your leisure time, according to frequency?

Typology of Activities	Frequency			
	Daily	Regularly (>once/week)	Occasionally < once/week -> once/month)	Rarely < once/month
Study				
Domestic work				
Family care				
Watching TV				
Reading				
Computer/Internet				
Fraternize with family/friends				
Walking				
Going to cultural events				
Going to libraries				
Sports				
Hobbies, Play games				
Is a member of a recreative society				
Volunteer activities				
Other. Which?				

6.7. Do you travel often? Yes ___ No ___

6.8. If yes: In the country ___ Abroad ___

6.9. In the country, how often? <once/year ___ once/year ___ 2/3 times/year ___ > 3 times/year ___

6.10. In the country, with whom? Alone ___ With relatives ___ With friends ___ On tours ___ Other. Which? ___

6.11. Abroad, how often? < once/year ___ once/year ___ 2/3 times/year ___ > 3 times/year ___

6.12. Abroad, with whom? Alone ___ With relatives ___ With friends ___ On tours ___ Other. Which? ___

STUDY TO ADDRESS THE NEEDS OF THE SENIOR PEOPLE IN PORTUGAL
M. I. Demand side analysis
Questionnaire – Senior People



6.13. Are you a member of any Institution? Yes _____ No _____

6.14. If yes, Which one?	Institution 1	Institution 2	Institution 3
Identification			
Activities			

6.15. What is your religion?

Christianity					Hinduism	Islamism		Judaism	Other: Which?
Anglican	Catholic	Romano- Catholic	Evangelic	Orthodox		Sunnite	Shiite		

6.16. How often do you go to your place of cult? _____

6.17. Degree of satisfaction regarding the occupation of your leisure time.

Totally satisfied		Satisfied		Unsatisfied		Totally unsatisfied	
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VII. EQUIPMENTS AND SOCIAL AND HEALTH SERVICES

7.1. Characterization of the use and access to health equipments.

	Health Care Center/Extension	Hospital
Do you use it?		
Where do you usually go?		
Frequency of access and use		
Motive		
Are you satisfied?		
Main limitations in access and use		

7.2. Characterization of the use and access to social equipments.

Typology of Social Response	Uses		Motive		Frequency of use
	Yes	No	For using	For choosing the equipment	
Household service					
Emergency CAT					
Leisure Centre					
Day Care Centre					
Holiday Centre					
Night Care Centre					
Home Residence					

7.3. Evaluation of the satisfaction and perception of users.

Typology of Social Response	Global Evaluation (Good, Reasonable, Bad)	Family Contribution	
		(Very expensive; Expensive; Reasonable; Cheap)	Who ensures payment?
Household service			
Emergency CAT			
Leisure Centre			
Day Care Centre			
Holiday Centre			
Night Care Centre			
Home			
Household service			

VIII. PERCEPTION OF NEEDS

8.1. What are your mains needs, according to type (specify)?

Domain	Needs
Personal Care	
Domestic tasks	
Housing (other)	
Mobility	
Health	
Leisure	
Other: Which?	

8.2. What is you main wish for old age? _____

Thank you for your cooperation.



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