
Portugal

Highlights from *A Good Life in Old Age? Monitoring and Improving Quality in Long-Term Care*, OECD Publishing, 2013.

- The Portuguese population is projected to age significantly by 2050, when 32% of the population is projected to be aged 65 and over and about 11% will be aged 80 and over, compare to an OECD average of 25.7% and 10%, respectively. While spending on LTC – at 0.1% of GDP – remains well below the OECD average of 1.6% of GDP, it is expected to double by 2050 based on 2011 European Commission projection.
- Quality assurance of long-term care services has been a policy priority since the introduction of RNCCI (National Network of Integrated Continuous Care; Rede Nacional de Cuidados Continuados Integrados) in 2007. This is a remarkable example of efforts to setting up an integrated approach involving players across social and health care services. Among the good features of the RNCCI system are:
 - an attempt to integrate information system by making information portable across settings;
 - the use of multidisciplinary care assessment following an integrated evaluation instrument for people in need of post-acute and long-term care;
 - the use of an on-line web-based system allowing the continuous process of need assessment results and ongoing monitoring of care recipients conditions with benchmarking of results at national, regional, local, and unit level, making benchmarking.
 - The use of local co-ordination teams establishing standards mostly on structures and staffing (size of rooms, quality and safety of the building, percentage of providers that receive a 80% score at inspection, staffing ratios).
 - An online data management system (GestCare CCI) records referrals, admissions, transitions, waiting times for admission, as well as outcomes of needs assessments.
- However, Portugal has relatively few trained care workers and few people receive care services. In 2011, there were 4 LTC workers in institutions per 1,000 persons aged 65 or older, compared to an OECD average of 3.2 (OECD Health Data 2012). In 2011, 1% of the population over the age of 65 received LTC in institutions (4% OECD average) with 0.4% of this population receiving care at home (OECD average 7.9%) (OECD Health Data 2012).
- While outcome indicators (such as pressure ulcers and falls) among users of inpatient units and home care have shown some improvement over the last few years, the use of physical restraints has increased from 3% in 2008 to 8% in 2011.

Portugal

Key Facts

- In 2011, 19% of the Portuguese population was aged 65 and over (OECD average 15%) and 5% of the population was aged 80 and over (OECD average 4%). In 2050, approximately 32% of the Portuguese population is projected to be aged 65 and over and about 11% of the population is projected to be aged 80 and over (OECD Historical Population Data and Projections Database, 2013).
- Portugal's public expenditure for long term care (health) was 0.14% of GDP in 2010 (OECD average 1.6%) (OECD Health Data 2012).
- In 2011, there were 4 LTC workers in institutions per 1,000 persons aged 65 or older, compared to an OECD average of 3.2 (OECD Health Data 2012).
- In 2011, 1% of the population over the age of 65 received LTC in institutions (4% OECD average) with 0.4% of this population receiving care at home (OECD average 7.9%) (OECD Health Data 2012).

Background

The provision of long-term care (LTC) services has traditionally been the responsibility of families and charity organisations in Portugal, while the public provision played a minor role (Barros et al., 2011). This has changed when the National Network of Integrated Continuous Care (RNCCI, Rede Nacional de Cuidados Continuados Integrados) began in 2007 under the Law 101/2006. RNCCI is a joint initiative of the Ministry of Health and Social Solidarity aiming to provide all levels of integrated and continuous care to dependent people, with a strong focus on home care. The network (started in 2009) is a partnership of public, private and third-sector organisations involved in care and provided in convalescent centres, medium-term and rehabilitation centres, long-term and maintenance centres, palliative care and integrated home care teams. The policy priorities for the RNCCI are care co-ordination and integration, care effectiveness with monitoring of discharges, the development of individual care plan and patient-centeredness.

RNCCI is decentralised and supported by three levels of coordination: national (implementation, management and monitoring); regional (five regional coordinating teams focussed on identifying regional needs and implementing regional activities); local (local coordinating teams in close relationship with primary care).

Measuring Quality in LTC

RNCCI is responsible for monitoring of all providers within the network. Quality indicators are collected at provider, regional and national level through compulsory data submissions. Providers are required to report data for a minimum data set. A web-based data management system (GestCare CCI) supports the continuous and up-to-date monitoring of recipients across transitory care and LTC services at provider, regional and national levels. Hospital discharge management teams, primary health care centres, local co-ordination teams, regional coordination teams and national coordination all have access to the information.

Portugal

In addition to the assessment and review of user satisfaction and user claims, all network units and teams are subject to periodic evaluation by regional coordination teams (Ribeiro, 2009).

Data on referrals, admissions, transitions, waiting times and patients waiting to be admitted, as well as outcomes of care are collected and indicators are comparable across geographical areas and over time. Clinical indicators include pressure ulcers, falls, unplanned weight loss, discharges with attained individual care plan objectives, physical autonomy. There are also user surveys and audits related to things such as staff, use of multidisciplinary teams, patient rights, individual care plans, promotion of physical autonomy, discharge planning, facilities infrastructures, and prevention of infections. Outcome indicators among users of inpatient units and home care have shown some improvement over the last few years (UMCCI, 2012).

Regulation

Portugal has an accreditation system for home care providers and nursing homes. All providers in the RNCCI have to follow common standards in order to receive public subsidies. Five regional co-ordinating teams monitor compliance according to minimum standards for providers participating in the continuous care programme and produce annual audits. Standards and measures of quality are audited on a regular basis.

Standardisation and monitoring of processes

Needs assessment is carried out by a multidisciplinary team following the Integrated Evaluation Instrument for bio-psychosocial evaluation of users in need of post-acute and long-term care. It focuses on functional and cognitive capacities, such as need for help with daily living activities or medical need. This assessment tool is divided into three areas (Bio, Psycho, and social). The results of needs assessment are registered on the GestCare CCI platform, allowing the continuous monitoring of the results of assessment. This also allows benchmarking of results at a national, regional, local, and unit level. The evaluation provides a core set of baseline information that is transmitted to the provider and can be followed up over time. After assessment, the implementation of an recommended individual care plan is coordinated across physicians, nurses, social workers, and other members of the multidisciplinary care team.

Portugal does not have formal practice guidelines but there are recommendations related to care and quality. The RNCCI elaborated a Continuous Quality Improvement manual. Other manuals and documents that promote the standardisation of LTC service quality can be found around the development of individualised care plan, hospital discharge management, management of referrals, infection preventions and controls, medication management, and pressure ulcers.

Care coordination

One of the policy priorities of the Portuguese LTC system is care coordination and integration. Contracts monitored by Local Coordination Teams establish standard which state that providers must have multidisciplinary teams, meet certain staff ratios and have good facility environment (e.g., on things such as the size of rooms, the quality and safety of the building, the percentage of providers that receive a 80% score in a inspection). Comprehensive multidisciplinary care involves high-risks screening to identify frail

Portugal

people at risk, assessment for further evaluation, and multidisciplinary care management. Hospital teams prepare patient discharges to other settings, while mixed teams provide primary health care and social support in health, social service facilities, and at home. Mixed teams in hospitals and in the community also provide support and counselling for palliative care. Referral routes are centrally defined; this encourages interdisciplinary teams to operate at regional and local levels and patients referrals in accordance with local capacity (Ribeiro, 2009).

Patient-centeredness

Patients are allowed to choose 1 to 3 different carers related to the type of care they wish to receive. When admitted to a hospital or nursing home, they can also ask to change to another carer and be transferred accordingly, if there are available places. After assessment of need, the implementation of individual care plans is coordinated with physicians, nurses, social workers, and other members of the multidisciplinary care team. There is a periodic evaluation of user satisfaction.

Public reporting

A bi-annual report presents data on a number of indicators, including administrative and process data (e.g. the number of beds and home care places, contracts with the different providers of care, number of referral teams in hospital and primary care, time for identification of provider and admission by regional co-ordination teams, the number of patients referred to RNCCI and/or for admission, number of patients waiting to be admitted, demographic and social characteristics of patients, occupation rates, professional training) as well as information on quality (physical autonomy, prevalence and incidence of pressure ulcers, falls, mortality rate).

References

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Portugal

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<http://www.oecd.org/health/health-systems/good-life-in-old-age.htm>