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Deposited in *Repositório ISCTE-IUL*:
2026-04-23

Deposited version:
Accepted Version

Peer-review status of attached file:
Peer-reviewed

Citation for published item:
Capucha, L., Calado, A. & Nunes, N. (2025). Portugal: Structural weaknesses of nursing homes network exposed by the pandemic. In Eloisa del Pino and Francisco Javier Moreno-Fuentes (Ed.), Long-term care and older people in Western Europe: Lessons From the COVID-19 Pandemic. (pp. 233-251). London: Policy Press.

Further information on publisher's website:
10.2307/jj.9692559.17

Publisher's copyright statement:
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Portugal: structural weaknesses of nursing homes network exposed by the pandemic

1 Introduction

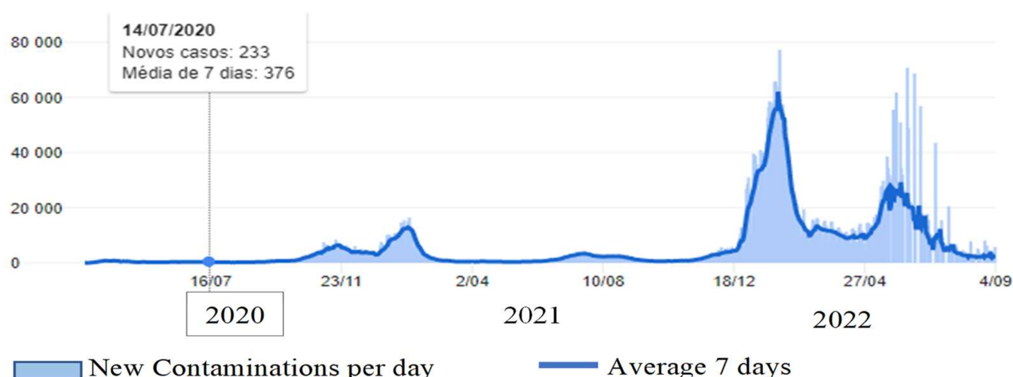
This chapter is about the COVID-19 pandemic in Long Term Care Residences (LTCR) in Portugal from March 2, 2020, to July 15, 2020. It was a dramatic period in which Portuguese society faced an unprecedented threat in the memory of people and institutions, about which little or nothing was known.

One of the most disconcerting facts that occurred was how the pandemic spread to the elderly and, in particular, those who were institutionalized in LTCR. This being the focus, we will only deviate from the topic and the set period when there is a need to frame them, namely regarding the evolution of the pandemic and the evolution of the LTCR network.

Although the period under analysis in this chapter is the 4 and a half months between March 2, 2020, when the first case of infection was detected, and July 15, 2020, when the first cycle of the pandemic ended, it is worth looking at its evolution in a broader perspective. This perspective reveals a much higher incidence of the disease just after autumn 2020 than until then, as shown in Figure 1. In fact, the daily new cases recorded by the Directorate-General for Health were 53 per day, at the beginning of March 2020, increasing to around 350 per day by July of the same year and to close to 750 cases per day in early October 2020.

At that time, a wave of large proportions emerged, reaching a peak of almost 7,000 cases per day in mid-November and 15,000 per day in late January 2021. There are two important phenomena to register: first, the relationship between policies, population behaviour and how the evolution of SARS-COV2 infections was being perceived by people. The effect of the two months of confinement after the first wave of April/May 2020 and the opposite effect of the lifting of restrictions after the confinement that followed the summer and, later, Christmas and New Year, combined with the appearance of new strains, more contagious, of the virus, in a context still without the effects of vaccination, produced moments of euphoria for the success in the fight against the pandemic alternated with moments of panic at the verification of the inability to control its growth.

Figure 1: Evolution of the COVID-19 pandemic in Portugal (2 March, 2020 – 4 September 2022)



Source: General Directorate of Health, 05 August 2022

After February 2021, the incidence dropped again to daily values between 200 and 600, and then, in December, a new wave began, reaching daily values of around 45,000 in January 2022. During 2022, the daily infections ranged between 12,000 and 25,000 almost until the summer, when they declined to values between 2,000 and 4,000.

Interestingly, at the beginning, when there were fewer infections, fear prevailed, while when the infection reached its highest values, society seems to have started to live normally with the disease. The fact that little was known about the disease and how to fight it, the unpreparedness of services and the morbidity up to July 2020 explain the fear, while the arrival of vaccines and then the appearance of new strains, more contagious but less lethal, explain the "normalization".

In total, 5,430,000 people were infected in Portugal between March 2020 and September 2022 (52.7% of the population). Of these, 24,865 died, which represents 0.46%. The daily mean of infections was 5,777. Looking at the period between March 2, 2020 and July 15, 2020, 47,426 people were infected, at an average of 351.3 per day, but of these, 1,676 people died, or 3.5%. The fear did not come, at this time, only from the images of what was happening in China, Italy and Spain. It also came from the lethality of the disease.

More than half of these deaths occurred in LTCR. This justifies the need to understand what happened in these structures that should take care of the well-being of the elderly but appeared to be the most dangerous places where they could be.

This chapter is divided into 3 parts, the first will address the structure and evolution of the social facilities network for the elderly, the second will address the measures adopted to combat the pandemic, especially in the LTCR, and in the third we will present the way in which health and social services were articulated in the LTCR and what lessons can be learned for the future.

2 Care sector for the elderly in Portugal: a poor coverage of legal and non-legal facilities with contrasting quality

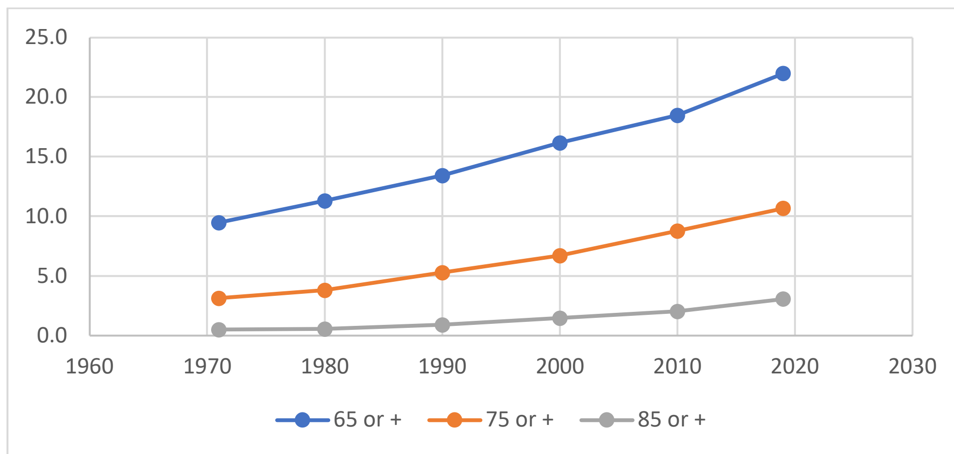
Portugal is the fourth most aged country in the European Union, after Italy, Germany and Greece. Rapid aging, both at the top and at the bottom of the age pyramid, is one of the most characteristic features of the processes of change in Portuguese society, as is the case throughout the world (Capucha, 2014; Silva and Pereira, 2015; Calado et al., 2019).

The aging rate in Portugal (number of residents over 65 years old per hundred residents under 15 years old) went from 30 in 1971 to 161 in 2019, having registered a growing trend in all decades. Likewise, the percentage of people over 65 has grown steadily from 9.5% in 1971 to 22.0% in 2019 (Figure 2).

The percentage of population aged 75 and over grew even more rapidly, from 3.1% in 1971, or from 6.7% in 2000, to 10.7% in 2019. Additionally, the “big elderly” segment, of people aged 85 or more, multiplied their weight by six, from 0.5% in 1971 to 3.1% in 2019.

Women are the majority among the elderly. At all age groups, there are 52% of women versus 48% men. But in the older age segments, women represent 60% of the total population. The “big elderly” contribute the most, since 574,674 women are in the group between 65 and 74 years of age, and 593,066 in the group of 75 years or more.

Figure 2: People Aged over 65, 75 and 85 years old as a percentage of the total population



Source: Pordata, 15/07/2020

Accelerated aging is the result of the improvement in living conditions after the Democratic Revolution of 1974 (Capucha, 2005; Botelho et al., 2015). The country's infrastructure in terms of electricity, sewerage and access to drinking water at home, alongside with the extraordinary development of the national health system and the creation of the universal social protection system, are the main factors that explain this aging trend.

However, progress also brought new problems, such as the elderly dependency rate and its impact on the pension system (Ocampo and Stiglitz, 2018). As lives get extended, situations of dependency to carry out daily tasks become common. There are other delicate issues, namely the provision of care to elder people when they live alone or when they live with another elder person. The isolation of the elderly is, moreover, a reality that is growing rapidly (Mauritti, 2011). The number of households of isolated people in 2019 were 934,100, which represented 22.5% of the total households. Of that total, 513,200 (54.9%) were people aged 65 or over.

Thus, dependent elderly people without family support (or with deficient support, including the frequent practice of domestic violence) are left with the existing responses promoted by the market (Esping-Andersen, 1990), or by civil society organizations (Private Institutions of Social Solidarity – IPSS), partially financed by the State.

2.1 Evolution of Long-Term Care: a sector managed by civil society organizations supported by the State, with a trajectory of growth, but still too short

In 1984, it was published the first Social Security Basic Law, revised in 2007. The Pillar of Social Action was defined in the Basic Law, being integrated in the Solidarity Subsystem in 2007. It includes social facilities promoted by the State, by the solidarity sector (comprised mainly of IPSS connected in different ways with the Catholic Church) and by the market. The system is highly centralized. There are Regional Centres of the Social Security, who inform processes of licensing and control of facilities and social responses. However, they have been increasingly losing autonomy and now they act simply as applicants of the national central directives. The IPSS are supported by the State in the construction of facilities and by financing services for the lower income segments of the population. They form a huge network of civil society organizations functioning at the local level, depending on the National Institute of Social Security. Their scope is local, and they follow national policies and guidelines.

In 2000, the Department of Studies, Prospective and Planning of the Ministry of Labour and Solidarity (DEPP-MTS) published the first characterization of the social facilities network in Portugal, the Social Charter (DEPP-MTS, 2000). The publication included all the existing 7,068 equipment, with its 14,208 facilities, which served 250,894 citizens. The number of social facilities for the elderly was 4,483 and welcomed 142,532 elderly people. The characterization comprised only the licenced social facilities network of the Portuguese mainland (the autonomous regions of the Azores and Madeira are not under the tutelage of the national government in this field).

The typology of social facilities for the elderly in Portugal, from the mid-1970's to 2000, was as follows:

1. Day Centres (DC) and Convivial Centres - appeared as an experimental area in the mid 1970's, with the objective of keeping people at home. In 2000, there were 1,339 Day Centres, of which 253 started their activity between 1975 and 1985, 727 between 1986 and 1995, and 281 between 1996 and 1998 (Table 1). There were 399 Convivial Centres in 2000, 20 of which were created before 1974, 106 between 1975 and 1985, 198 between 1986 and 1995, and 75 between 1996 and 1998 (Table 1). The Day

Centres had a capacity of 45,946 users in facilities from the solidarity sector and 327 users in facilities from the market sector. The State did not promote Day Centre facilities. By 2000, Day Centre's capacity represented 3.2% of the population aged 65 and over, and 8.3% of the population aged 75 and over. However, the occupancy rate was 78.5%, corresponding to 36,328 users. The Convivial Centres had a capacity for 29,670 users in the solidarity sector and 162 users in the profit sector, which together represent 2.1% of the population aged 65 and over, and 5.3% of the population aged 75 and over. The utilization rate was 85.3%, corresponding to 25,315 users. The greatest demand is among people between 70 and 74 years old (24%), followed by people between 65 and 69 years old (21%), and people between 75 and 80 years old (20%). Over that age, the values decrease to 14.5%. Women are 59% in both types of social facilities.

2. LTCR for the Elderly (ERPI) - The historical origin of LTCR are the nursing homes. Before 1974, they welcomed, without any kind of dignity, the elderly without a family. Nowadays, the situation is quite different, since the number of old people is much bigger and the demand in the search for well-being is greater. Individual social homes have very little expression (there were only 33 in the solidarity network and 6 profitable in 2000). Homes are collective residences that aim to provide housing in a humanized environment, provide permanent personal and health services, ensure basic needs, and create conditions that allow preserving family relationships, without dependence of the elderly from their relatives. In 2000, the official licenced facilities were constituted by 805 LTCR of the solidarity network and 376 LTCR of the profitable network. The installed capacity was for 49,934 users, distributed by 41,951 in the solidarity network and 7,108 in the profitable network. These numbers corresponded to 3.5% of the population aged 65 and over and to 9.0% of the population aged 75 and over. The occupancy rate in the solidarity network was 95.9%, while in the profitable network it was 85.2%. About 72% of users were aged 75 or over (5.7% in this segment), while 48% of users were 80 or older (9.2% of the total population in that group). Women represented 64.5% of users. In terms of the activities organized in these facilities, approximately 75% of LTCR organized trips for their users, 50% ateliers and occupancy activities, and 65% other cultural and recreational activities. Regarding health assistance, 88% had medical and/or nursing support. Medical staff was constituted by employees, by personnel hired as independent services providers (48% of medical support and 43% in nursing), or

through protocols with public health services (22.7% of medical staff and 17.9% of nursing were in this condition). In 2000, of the 10,900 people who provided services in LTCR, only 2,400 were technical personnel, of which 27% were nursing personnel, 21% medical personnel, 4% social workers, 1% psychologists, 6% monitors, 5% therapists, and 36% Directors or coordinators. The non-technical staff, comprising the remaining 8,500 employees, were 19% family helpers, 60% auxiliary, 1% drivers, 4% administrative staff, 1% barbers, 8% cooks and 7% "others".

3. Home Support Service (HSS) - This measure aims to provide specialized home care to families and individuals who, due to illness or disability, are unable to meet their basic needs and, at the same time, avoid isolation by maintaining elders at home. In 2000 there were 1,269 responses (Table 1). They cared for 38,022 people, corresponding to 2.6% of people over 65 and 6.8% of those over 75. The average utilization rate was 90%. Those over 80 years old represent 34.5% of users, while the group between 75 and 80 years old represented 27%, and the group between 70 and 74 years old represented 19%. Women represented 57% of users.
4. Family Care for the Elderly - This measure aims to provide the elderly with an environment alternative to the family of origin. In 2000, it was in an embryonic stage, with only 110 foster families (Figure 3). 94% of beneficiaries were over 70 years old and two thirds of them were women.
5. Holiday Centres - this measure is residual. In 2000 there were twelve holiday centres with 393 beds in Mainland Portugal (Figure 3).

Figure 3: Evolution of the number of social facilities for the elderly in Portugal*, from before 1974 to 2000

	Before 1974	1975-1985	1986-1995	1996-1998	2000
Day Centres	-	253	980	1261	1339
Convivial Centres	20	126	324	399	399
LTCR for the Elderly	154**	334**	651**	787**	1181
Home Support Service	15	154	902	1269	1269

Family Care for the Elderly	-	-	-	-	106
Holiday Centres	-	-	-	-	12

* Data regards mainland Portugal

** Data regards only the solidarity network

Source: Social Chart, MTSS

2.2 Long-Term Care nowadays – consolidation of the scarce network which also provides continuing care services

After the revision of the Social Security Act (2007), the State withdrew from the system. The option was to reinforce the financing of the IPSS, and in return they would practice "social prices" for the poorest segments of users (Ferreira, 2015). As these responses are markedly insufficient for the growing needs of the population, clandestine LTCR residencies proliferated in the informal market, often operating in very precarious conditions and without any type of supervision.

In 2018, according to the Social Charter, the Social Services and Equipment Network included, for all categories, 11,500 equipment, which represents a growth of 62.7% when compared to 2000. The promoted facilities were around 17,900, which represents an increase in more than 3,500 when compared to 2000. Owners grew from 4,000 to 6,500, 71% of which were non-profit entities and 29% were market entities. Considering the number of equipment, the percentage in the third sector increased to 83.4%. Of the 18,400 existing facilities, 41.2% (about 7,600) were aimed at the elderly. The growth in the number of responses was higher than the average, with 67% of the new equipment created between 2010 and 2018 being LTCR (36%), Home Support Services (17%) and Day Centres (14%).

In 2006 it is implemented the PARES Program, which goal was to finance the expansion of social facilities in Portugal promoted by third sector entities with public support for construction and operation. The planning, coordination and financing of social action policies go on being central, while the participation of local authorities is by granting of land to build the facilities. As a result of the PARES Program, the installed capacity in

the Network of Services and Social Equipment grew drastically between 2000 and 2018, from 400 thousand to 1,100 thousand available facilities and from a little more than 400,000 users (with over occupation) to 900,000 users. However, the exponential growth of population aged 65 years or more did not allow a big increase in the coverage rate. In 2018, the occupation rate in Homes for the Elderly was 93%.

Regarding services and equipment for the elderly, there has been an increase in the type of social facilities, which have come to be named: "Residential Structures for the Elderly (ERPI)" (LTCR and Residences), Day Centres (CD) and Social Centres (CS), Home Support for the Elderly (ADI), Family Reception (AF) and the new measure of Night Centres (CN). The number of responses grew sharply in the 20 years between 1998 and 2018 (around 89.3%, corresponding to an additional 3,400 new responses), with the most accentuated increase being in ADI – the main response in the community environment – with a 108% growth, and in ERPI with 105% growth. In 2018, there were 7,300 responses in the ERPI, ADI (the two most frequent valences) and CD.

In 2018, DC provided for 23.6% (65,000) of facilities for the elderly, however only 64% of the capacity of those facilities was used. LTCR covered 36.5% of facilities for the elderly, HSS covered 40% of the capacity of facilities for the elderly, and DC provided for 23.6% of facilities for the elderly. In LTCR, the capacity was close to full use (93%), with about 63% of users covered by cooperation agreements, through which the State finances the institutions that host them. HSS and DC registered around 62% of people under the age of 80 years, while LTCR users were, in half the cases, people aged 80 years or older.

As summarized in Figure 4, the total capacity of the facilities in 2018 was close to 274,000 users, which represents an increase of 104% compared to 1998 (139,200 available seats). These places provide a coverage rate for the population aged 65 and over of only 12.6%.

Figure 4: Social Services for the Elderly, Portugal, 1998 and 2018

	Facilities	Users	Places	Coverage Rate (%)*
1998	4.310	132.240	139.200	6,2
2018	7.600	254.820	274.000	12,6

* Population aged 65 or more/Places

Source: Social Chart, MTSS

It is important to notice that the network for the expansion of the social facilities was renewed in 2020, under the PARES Program 3.0, with an investment of 110 million euros.

The PARES Program also aimed to increase inspection and closure of private structures, some clandestine, other legal, which did not meet the requirements for operation, set out in the Law. The more common issues are the dimensions of the facility and its rooms, the guarantee of users' privacy, the qualification and number of technicians and employees, the conditions of accessibility and the security of the infrastructures.

Continuing Care, a social and health facility addressed to people who need intense and daily health care for the rest of their lives, but not needing inpatient hospital services, is not considered in this typology. Nevertheless, according to the Director of a Misericórdia interviewed, they are extensions of LTCR. This official also argued that this issue needs urgent clarification by the Government. The fact that LTCR are at the present functioning partially as health services in the field of palliative care, impacts negatively on their capacities to respond to the pandemic in a proper way.

There were several problems with the LTCR network, already identified before the pandemic. The measures taken during the pandemic, however, were not aimed at solving these problems. On the contrary, processes were facilitated by allowing the facilities to start operating by means of a simple communication to the Ministry of Labour and Social Security, instead of a double license (one of the municipalities for use and another of the MTSS for operation) that was previously required. The simplification of procedures aimed at streamlining processes and combating illegal facilities, but it was not accompanied by an update of the requirements for operation, to be established later. The leaders of the institutions operating in the sector doubt that the effect of reducing illegal activity will be verified.

It is estimated that there are more than 3,500 illegal LTCR currently in operation in Portugal. In fact, the situation of generalized and little repressed clandestine facilities became evident to the municipalities, through the Civil Protection Commissions, with their emergency responses to the COVID-19 (which, fortunately, were never necessary).

Many municipalities carried out inspections of these structures, often almost invisible, and the list of known cases of illegal LTCR has increased, and there are even counties where it has doubled. At that time, attention was drawn to the need to know how many of these “social facilities” exist, how many people live there, and under what conditions, for an effective fight against the pandemic, in the context in which it was most reproducing. According to the testimonies collected, when people have to place their families in private LTCR, they first look for those who are supervised by Social Security. However, frequently they are unable to pay the prices requested for private LTCR with quality, and then they look at the other options, usually with poor quality and, in fact, largely clandestine. The difference in quality crosses all domains, from the material conditions of residence to the services provided, to the qualification and quantity of personnel to the type of approach, with the substitutive human relationships of the family being decisive.

2.3 Role of families in Long-Term Care

Traditionally, the woman provides the care needs for dependent elderly people inside the family. However, daughters and daughters-in-law are less and less available, as female participation in the labour market is high. The female activity rate has been above 54% since 2002, having reached 54.7% in 2019. The female employment rate was 50.8% in the same year (55.3% in total). Even so, in cases of illness, it is estimated that 80% of the continued care for the elderly is provided by the family (Nogueira, 2012), the vast majority by other elderly people, whether spouses or sons aged 65 or over (Herlofson and Brandt, 2020).

Families are still the main resource, on three levels: (1) partial financing (as a supplement to pensions) the LTCR frequency; (2) the provision of care, mainly by daughters and daughters-in-law; and (3) the provision of services by spouses who are also elderly. The problem with the first solution is that, in the context of a crisis, many of these families bring the elderly to their homes, to use their income as a “resilience” strategy (Estevão, Capucha & Calado, 2017). The problems of the second are the frequency of situations of domestic violence, the low quality of services and the double workload of women who provide care alongside their professional activity. The big problem of the third is the

precariousness and low quality of the services provided, although the affectivity tends to be great.

2.4 Long Term Care debates before the pandemic

In Portugal, the debate on the social services system for the elderly revolves around three main issues. Firstly, the problem of supply and coverage rates. Scarcity is large and widespread around the country. The question, therefore, is of the possibilities for growth in supply.

Second, the issue of average quality and its control is pressing. The main problem is that, due to the scarcity of supply in face of demand, clandestine private homes of very low quality (both in terms of conditions and services) proliferate. The inspection is largely tolerant, since the State does not have alternatives to families. This is the reason why, despite campaigns to close homes in terrible conditions, their impact is residual. This situation allows many private homes to be maintained without conditions, even when they are legalized and licensed. In addition, there are also many problems regarding the quality of services provided on the social network, namely in health care and entertainment activities, given the limited funding by the State.

Finally, there is a debate around governance, which takes two directions. One focuses on the effects of the monopolization of the system by social network structures, favoured by the State, to the detriment of other more flexible community-based responses, supported by neighbourhood networks. The other criticizes the State's delegation of its responsibilities to Third Sector Organization, with gains for the budget (mainly because they practice lower salaries than in the public sector), but with less control over the quality of supply. For this reason, the debates tend to concentrate around the level of financing by the State, with small consideration of quality, either in terms of network and number of facilities, or in terms of the services they provide.

3 Policies to combat the pandemic in Long Term Care sector in Portugal

Health services have never reached a situation of disruption during the COVID-19 pandemic, nor have their professionals ever had to decide between two patients, which one would be in intensive care or connected to a ventilator. Only at the end of 2020 there were warnings, by some doctors, regarding the danger of saturation of the health system in the Lisbon and Tagus Valley (LVT) region. Afterwards, by December 2020/January 2021, hospitals were close to exceed their capacities, However, they never reached the limit. The percentage of patients who required hospitalization was 9%.

From an early stage, in the first half of March (with only 785 infected), "… *the entire hospital network was ready to receive patients. This means creating circuits within the hospital itself, in which patients are divided into two large groups (with and without symptoms)*", informed the Director General of Health. The care models introduced for COVID-19 were established, compelling people who felt symptoms, to first look for help through the telephone service, from where they were referred to the health services, if necessary. This avoided congestion at hospitals and other emergency services. Health services have proven to be able to respond to a number of hospitalized patients that does not exceed around 450 cases, at the peak point of the two first vacancies of the pandemic.

Early policies to combat the pandemic consisted in public investment in the Public Health System (SNS), to purchase equipment such as ventilators and personal protection, and stimulating the intervention of local governments to create "campaign hospitals", that were spread all over the country. This was a priority because SNS had been under strong financial pressure and staff shortages. The Council of Public Finances, an entity that monitors State accounts created during the crisis of 2011-2014, recently reminded (July 22) that the pandemic had exposed the fragility of the SNS and its financial stability. The accumulated deficit of € 2,796 million between 2013 and 2019 was at stake, and so did the debt to suppliers, which equals to € 1,589 million in 2019.

Still, it was necessary to hire 1,800 professionals. The number of beds in intensive care increased by 35%, between March 1 and May 2 (from 528 to 713). 500 ventilators were purchased from China, the first 100 of which arrived between May 19 and 23, 2020. On the other hand, on 16 March 2020, the SNS suspended scheduled activities, so that on the 19th of the same month, almost 1.4 million consultations and 51,000 surgeries had been postponed.

This strategy was supported by the recent macroeconomic situation. In 2019, for the first time in the history of Portuguese democracy, the State budget balance was positive. The external debt was in a process of marked reduction. Both factors created conditions for the government to invest in strengthening the health system and in the effort to prevent redundancies and the destruction of the productive fabric. However, the reports presented to the Portuguese Parliament in the third week of July 2020 pointed to a 9% drop in GDP. It is estimated that the State had revenue losses of around €2,423 million and expenditure increases of €1,319 million. In 2'019, public debt estimated at €117.7% of GDP, increasing to 135.9%. The European response to the crisis has become indispensable (Eurofound, 2020).

Internally, there is a problem of government that matters. There is virtually no link between health authorities and social security authorities in practice. The regulations and norms related to health conditions in LTCR and other social facilities for elderly people were initially defined in the law with contributions from Health authorities (based on the Protocol of Action for Social Support), but the collaboration ended there. The decisions to support the promoters, licensing and inspection were entirely the responsibility of Social Security.
However, at the local level, the institutions were in articulation with the Health Centres. This translates into the provision of outpatient nursing support to users of Home Support Services and in monitoring users of LTCR for Elderly People to consult. This collaboration was focused on routine and preventive health care, vaccinations, and advice. It was mainly performed by nurses, although many LTCR facilities also have had contacts with doctors. So, health services assist the Nursing Homes when problems arise, as with any other institution or individual citizen, but there is no permanent collaboration plan. Facilities are required to have no more than very tight internal health services, and this does not help to improve collaboration either.

During the pandemic, cooperation was strengthened, naturally, by force of circumstances: the LTC residences were the place where the very vulnerable population was and constituted critical points of contamination, which forced a double care of attendance and reinforced prevention, but only while the pandemic lasted. With its demise, some LTC services were reinforced with crisis response structures (for example, easily deployable rear beds), but both systems proved resilient, returning to the normal state, staying apart.

4 Description and analysis of the measures adopted to address the impact of the pandemic on the residential care sector for the elderly

4.1 Preparedness for the Crisis in the Long-Term Care system

The pandemic as a health crisis of large proportions hit Portugal completely by surprise. There is no notice about any prevention approach to a pandemic or type of crisis management plan or protocols. There were plans to fight against other risks, mainly natural and associated with buildings and equipment, but not against a pandemic. There was no national plan to deal with a situation of the kind. All the actions were taken under the pression of a dramatic situation. This was something that the LTCR system, like other sectors, had to face in an unexpected way and all the answers were to be found after the disease arrived.

Exceptionally, one year before the pandemic, the General Inspection of Health promoted a visit of a pedagogical nature to several LTCR. During these visits, it was noticed the existence of facilities with insufficient levels of health care; the lack of rigor in the documentation such as records of nursing acts; the absence of systems for regular assessment of the degree of dependence of users or lack of monitoring of users in their night shifts; the lack of definition of the medication circuit; and the shortage of nursing staff, in view of the residents' problems. The report that resulted from it re-emerged as early as mid-July 2020, given the visibility that the problem had gained. The situation of "Portugal at the tail of Europe" in number of formal caregivers per 100 elderly people, was then added to the diagnosis. Only Poland and Greece were in a worst position (OECD, 2020; Tello et al., 2020).

4.2 Policy measures to combat the pandemic and its impact on the Long-Term Care system

Even before the first case registered in Portugal, the Social Security and the National Health Department, by January 27, 2020, presented orientations to all social facilities,

which were revised and updated on February 29 and on March 4. In addition, measures regarding the health services, as well as the creation of "dedicated areas" in all emergency services in hospitals and health centres (community health units existing in all municipalities), were part of the strategy to combat the pandemic right from the start. However, equipment that would be considered decisive was not available.

When the epidemic started to be perceived as a real threat, the main objective of the government was to keep the levels of the infection relatively low, between 0.9 and 1 infected by each patient. The strategy was to "flatten the curve". This would be decisive, on one hand, to avoid the collapse of the Health Services and, on the other hand, to create good conditions for the resumption of economic activity, something that was then thought to be a quick process, taking into consideration the evolution of the pandemic in China.

The first phase of the political response to COVID-19 was called the "mitigation phase" and lasted from the 2until 17 March 2020. Visits to hospitals and prisons were suspended, day centres for the elderly were closed, institutions (universities, schools, companies, public services, etc.) started to define "contingency plans" according to the instructions from the Health General Directorate. People with symptoms were required to test and, in the case of a positive test, were kept in quarantine, under police control.

On March 11, 2020, the WHO declared the state of pandemic. On the same day, the General Health Department published an orientation report regarding the procedures to the LTCR, to the Integrated United of Continuous Care (UCCI), to the National Network of Continuous Care (RNCCI), and other social responses for elders, and institutions of care for at risk children and youngsters. In addition, the District Centres of the Social Security put in place a plan for the IPSS to develop and implement contingency plans. Visits to structures of residential care were suspended by March 14, 2020.

On March 18, 2020, the state of "National Emergency" was declared by the Portuguese government. It was the first time this constitutional rule was declared. The state of "National Emergency" reinforced the measures taken before and added confinement of people at home. There were a few exceptions: (i) health professionals and other workers who work in essential activities, such as transporting patients, selling food, sanitation and cleaning and public safety; (ii) all workers who were unable to stay on lay-off or tele-work (for example, cleaning services, civil construction, manufacturing industry; and (iii) leaving home to go shopping for food, walk pets, physical exercise, and care for

dependent family members. Universities, schools and day care centres were closed, medical consultations and non-urgent treatments were postponed. Bars, clubs, show venues, beaches and other leisure spaces, libraries, archives, museums, monuments, art galleries, concert halls, auditoriums, hairdressers, manicures and the like, as well as commercial spaces, with the exception of those selling food, pharmacies and other essential goods, were closed. The frequency of public transport was greatly reduced, while the means of transport on service should do so with only 2/3 of the seats, which was materially impossible to fulfil. In some counties, a "sanitary belt" was imposed for a period. 1,222 prisoners were released. Funerals were limited to maximum of 5 persons attending. Regarding the residential care sector, Day Centres were closed and visits to LTCR were prohibited. It was enacted to maintain very restrictive rules for spatial distance. Infringements could be punished with fines. The borders were closed, reopening only on July 1, 2020, with pomp and circumstance.

In terms of future impacts, along with the confinement and closure of schools and social facilities for children, the most emblematic measures was the advice of tele-work, both in the private sector and in the State, and the creation of special rules for simplified lay-off in companies.

Distance education was even more controversial, since most teachers were not prepared for the pedagogical and technological requirements of this educational modality, and a very significant part of the students did not have electronic equipment to follow the classes and perform the proposed exercises. Anyway, the system went on working and some of the solutions, like "Tele-school" – school on TV, were welcomed by the families and pupils, while many teachers rapidly acquired new e-learning competencies.

By May 2020, the main indicators of the pandemic had dropped to levels that were considered consistent with the objectives of the strategy, which led the government to enact the end of the National Emergence and the beginning of a deconfinement phase. To the success of the strategy, so far, contributed the Public Health Service, but also the Media – there was a serious compromise to support the objectives of combating the pandemic and appealing to citizens to comply with all indications from the government and health authorities, from the Political Parties that have refrained from making politics around the pandemic, and from the government that has promoted transparency of information and the involvement of all political agents in the consensus of the measures to be taken, suggested by experts.

The new phase was planned to be divided into two periods. One until May 18, 2020 and the next after an assessment of what happened. What happened was the increase in the number of cases of infected in LVT. Thus, in June 2020, the country started to be in a "state of alert", except for this region, which was in a "state of calamity". This meant, for example, that clusters of more than 20 people were not allowed in the streets, reduced to 10 in the AML and 5 in 14 of its parishes. The Rt remained around 0.9 (1.07 in the AML).

Visits to LTCR were resumed, but with new rules - one visitor per user, by appointment and at most for 20 minutes.

Portuguese mainland entered the second phase of deflation, which foresaw the lifting of several restrictions. For example, visits to prisoners and young people hospitalized in Educational Centres were resumed and the tele-work regime was no longer mandatory, except for groups at risk. Many people misperceived the signals sent as the end of special care and organized parties, that generated outbreaks of contamination. The rate of contamination among young people doubled after the deconfinement. Other outbreaks appeared in industrial companies among the less qualified workers, many of them immigrants, in neighbourhoods of social housing, and, in continuation of what had happened before, in Nursing Homes.

After the deconfinement, the numbers skyrocketed. They did not reach the numbers of the beginning of March 2020, but still a frequency above the desired. The image of the successful country fighting the pandemic was followed by another one, marked by panic due to the decisions of other countries, in particular the United Kingdom, to impose quarantine on those traveling from Portugal, strongly affecting Tourism.

The government's initial message, pressured by international comparisons and with different European countries closing borders for those traveling from Portugal, was that the increase in cases was due to an increase in testing. In fact, testing went from 490,000 in May 6 to more than 1,500,000 on July 26. Still, the fact was that the number of positives was increasing and not decreasing.

The LTCR sector benefited from a special testing effort, as would later happen with vaccination, in which it was a priority.

On July 2020, the Minister of Labour announced the adoption of more agile measures for the licensing of LTCR, while referring to the joint number of tests carried out on

employees of social facilities (120,000), as proof of the consideration that Portugal was one of the most proactive countries applying tests. However, it was not until the end of June that the Parliament passed a measure to pay 100% of the wages to workers discharged by COVID-19.

5 Challenges for the future of LTC: lessons to learn from the Covid-19 pandemic in Portugal.

The pandemic brought a situation that there is no memory in the homes of the Elderly and in the promoting institutions. The total closure of Day Centres left users unresponsive and, both in LTCR and Home Support Service, the routines were totally changed. In addition to the negative effect of ending family visits.

On the other hand, the financial impact on promoters is high, due to the costs of protective materials in a context of speculation in the market. "*This was all very fast, nobody was prepared. However, in our case, we already had previous procedures, as well as a code of conduct, so it was not difficult to implement an emergency plan*", said the person responsible for a LTCR that performed well in the context of COVID-19. In the case of a LTCR that performed badly, a certain disbelief and disorientation was revealed. Not everyone was prepared the same way, and the virus showed it. But the difference was mainly due to the adoption of more strict rules of visits and contacts with the outside world, in the good performing case.

When the pandemic was declared there were no clear views about what had to be done. For example, the initial message from General Direction of Health considering the use of masks, was that they were not recommended, since they created a false sense of security (there were no masks available in the market, anyway). When they were recommended it was very difficult to acquire them. Companies started to produce them on a voluntary basis, and started to distribute them to LTCR centres, trough the Union of the IPSS of Portugal. The municipalities also decided, in all places, to acquire masks and other equipment, and distributed them to health services, LTCR and other services. This was

an important help, since the LTCR promoters were facing difficulties to support the costs of equipment and tests.

A criticism that emerged strongly in this field was directed at the policy measure taken in 2012, during the intervention of the Troika formed by the European Commission, the IMF and the European Bank, to authorize the accommodation of three elderly people per room in the LTCR. Subsequent governments, while proclaiming an end to austerity, in fact maintained most of the measures then taken, which proved fatal during the pandemic. There was no specific financial support from the government. Only municipalities have allocated small sums to purchase equipment and to cover urgent expenses. Private entities have also donated, mainly for protective equipment. From the State, the LTCR only received guidelines and rules to follow.

An article published in June (Gil, 2020) on the performance and working conditions of "home helpers" shows that overwork, poor working conditions, associated with the lack of training and the excessive turnover of human resources, have adverse consequences on the quality of care that these professionals provide, but also on their physical and mental health, and on employment.

The system was not prepared to respond effectively to a pandemic like this. According to one of our interviewees, the problem is structural. Most of the people institutionalized in LTCR are very old, have problems of illness, and very strong disabilities. They needed health support that LTCR could not provide. Continuing Care Units are the structures that, due to their nature, should respond to the real needs of most "interned" in LTC. However, in this area the responses are very scarce. On the other hand, Home Support is insufficient to accommodate all the elderly who could remain in their homes. Thus, people residing in LTCR become particularly exposed to the pandemic. Particularly those from LTC, who contributed to 50% of the total of deaths.

The mortality numbers, as well as the incidence of cases, in LTCR that are accessible are proxies, since the collection of data on the field has been problematic, not being assured common standards in terms of coverage of all types of residences (particularly the clandestine network), timeline considered in the input of data, and the classification of cases. The situation regarding the collection of data is illustrative of the extension of the stress that the pandemic is posing to LTCR, the lack of coordination between institutions and actors on the field, and the lack of existing policies and instruments to monitor and evaluate the LTCR system.

The heads of LTCR promoted by IPSS go further and question the very model that governs social action policies in the field of social facilities. The State limits itself to inspecting and subsidizing the promoting institutions (without actually cooperating with them) to which it transfers contributions according to the number of users with lower incomes. But, these reimbursements are far from covering operating costs. The problem is that the State, more than money, transfers responsibilities. According to the representatives of the sector, this is a contributing factor to keeping low wages in the sector. That is to say, the State handed over social facilities to the third sector because it practices far lower wages than those paid to public workers, with the same qualifications and equivalent work. Even so, for example, wages absorb 70% of the revenues of the Misericórdias, an important sector of Third Sector Organizations, which for that reason are obliged to offer places in the market, with which, together with other revenues (including patrimonial) they finance the social component of the responses.

It thus seems clear that a fundamental overhaul of social action policies is an urgent need. With a lack of resources less exposed than that of health services, the LTCR network has deficiencies and weaknesses that strongly expose its users, not only to frequently unworthy living conditions, but also to increased health risks.

The few discussions about the impact of COVID-19 in social facilities clearly concludes that a large-scale program for the rehabilitation of social housing, to fight the factors of poverty among residents; policy measures to promote access for the most disadvantaged and least qualified to technologies; and the revision of social facilities policies and model of governance, are unavoidable social and health requirements.

All developed countries face ageing scenarios, particularly in Europe, although with varying degrees of incidence. In the Portuguese case, the weak social support to the elderly by the State stands out. The State mainly delegates responsibilities to families, or to institutions partially supported by the social security services. This creates a context in which the market fulfils the demand for residential care home, a sector that is very weak in the number of care workers and in specialized health and social services, mainly without supervision and quality control. These structural features have manifested themselves in the way the elderly care sector has dealt and is currently dealing with the COVID-19 crisis.

Bibliography

Botelho, Maria do Carmo, Nuno Nunes, Rosário Mauritti, and Daniela Craveiro (2015), 'Tendências de mudança das funções do Estado em Portugal' in: A.F. Costa and R.M. Carmo (eds), *Desigualdades em Questão. Análises e Problemáticas*, Lisbon: Mundos Sociais, pp. 59-75.

Calado, Alexandre, Luís Capucha, and Pedro Estevão (2019), "Welfare state development in Portugal: From "stage zero" to the postcrisis "leftist" compromise against austerity," *Comparative Sociology*, 18(5), pp.658-686.

Capucha, Luís (2005), *Desafios da Pobreza*, Oeiras, Celta Editora.

Capucha, Luís (2014), "Envelhecimento e políticas sociais em tempos de crise", *Sociologia, Problemas e Práticas*, 74, pp. 113-131.

DEPP-MTS (2000), *Carta Social*, Lisboa.

Esping-Andersen, Gøsta (1990), *The Three Worlds of Welfare Capitalism*, Princeton, Princeton University Press.

Estevão, Pedro, Luís Capucha and Alexandre Calado (2017), "Resilience: moving from a "heroic" notion to a sociological concept", *Sociologia, Problemas e Práticas,* 85, pp. 9-26.

Eurofound (2020), *COVID-19: Policy Responses Across Europe*, Publications Office of the European Union, Luxembourg.

Ferreira, Sílvia (2015), "New Paths for Third-Sector Institutions in a Welfare State in Crisis: The Case of Portugal", *Nonprofit Policy Forum*, 6 (2), pp. 213-241.

Gil, Ana Paulo (2020), "Estruturas Residenciais para pessoas idosas: relação entre qualidade dos cuidados e qualidade do emprego", *Cidades, Comunidades e Territórios*, 40, pp. 67-87.

Herlofson, Katharina, and Martina Brandt (2020), "Helping older parents in Europe: the importance of grandparenthood, gender and care regime", *European Societies*, 22:3, 390-410.

Mauritti, Rosário (2011), *Viver Só. Mudança Social e Estilos de Vida*, Lisboa, Mundos Sociais.

Nogueira, Maria Assunção (2012), "A doença e dependência na família", in Cláudia Moura, *Processos e Estratégias do Envelhecimento – intervenção para um envelhecimento ativo,* Euedito.

Ocampo, José António, and Joseph Stiglitz (2018), *The Welfare State Revisited*, New York, Columbia University Press.

OECD (2020), *Who Cares? Attracting and Retaining Care Workers for the Elderly*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/92c0ef68-en.

Silva, Pedro Adão and Mariana Trigo Pereira (2015), *Cuidar do Futuro – Os Mitos do Estado Social Português*, Lisboa, Clube do Autor Editora.

Tello, Juan E., Hector Pardo-Hernandez, Ricardo Rodrigues, Stefania Ilinca, Kai Leichsenring, Isabel Yordi Aguirre, Manfred Huber, and Erica Barbazza (2020), "A services delivery perspective to the provision of long-term care in Portugal", *Portuguese Journal of Public Policy*, 5(1), pp. 8-27.