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Ten Years after the Creation of the Portuguese National Network for Long-Term Care in 2006: Achievements and Challenges☆

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ABSTRACT

The Portuguese National Network for Long-term Integrated Care (*Rede Nacional de Cuidados Continuados*, RNCCI) was created in 2006 as a partnership between the Ministry of Health and the Ministry of Labour and Social Solidarity. The formal provision of care within the RNCCI is made up of non-profit and non-public institutions called Private Institutions of Social Solidarity, public institutions belonging to the National Health Service and for-profit-institutions. These institutions are organized by type of care in two main settings: (i) Home and Community-Based Services and (ii) four types of Nursing Homes to account for different care needs. This is the first study that assess the RNCCI reform in Portugal since 2006 and takes into account several core dimensions: coordination, ownership, organizational structure, financing system and main features, as well as the challenges ahead. Evidence suggests that despite providing universal access, Portuguese policy-makers face the following challenges: multiple sources of financing, the existence of several care settings and the sustained increase of admissions at the RNCCI, the dominance of institutionalization, the existence of waiting lists, regional asymmetries, the absence of a financing model based on dependence levels, or the difficulty to use the instrument of needs assessment for international comparison.

1. Policy background

The current demographic and epidemiological transition is posing more challenges in developed countries, namely due to the increasing percentage of elderly and changes in patients' morbidity (e.g. increase of chronic diseases with longer treatment times) [1]. With a rapidly ageing population, Portugal is not an exception. This situation has worsened due to the effects of the economic crisis, which resulted in the emigration of fertile and active citizens [2].

Conscious that the adoption of new policies to (re)configure the health and social care is essential to face these new challenges, several historical milestones and partnerships between the Ministry of Health (MoH) and the Ministry of Labour and Social Solidarity (MLSS) culminated in the formal creation of the current National Network for Long-term Integrated Care (*Rede Nacional de Cuidados Continuados Integrados*, RNCCI).

Based on already existing institutions, the RNCCI has, as its backbone, the non-profit and non-public institutions known as Private Institutions of Social Solidarity (*Instituições Particulares de Solidariedade Social*, IPSS) [3], with the *Misericórdias* (religious non-profit-making institutions with a charitable background) being the main providers [4,5]. Based on the work developed with the IPSS, and in line with the redefinition of long-term care (LTC) services in many European countries due to the increasing number of dependents (Table 1) [6–9], the RNCCI was launched in 2006 [10]. Since then, besides the IPSS and public institutions, a growing number of for-profit-institutions with protocols with the MoH have emerged to provide LTC.

This is the first time that information about the RNCCI has been collated and made available to an international audience, as well as analysed to provide a thorough assessment of its achievement while providing some guidance to policy-makers on potential improvements and future challenges.

2. Main features of the Portuguese LTC system

The RNCCI embraces all forms of continuous, rehabilitation, palliative and nursing care for people with mental and physical lim-

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Table 1
Main characteristics of the long-term care system in selected countries.

Countries	Beneficiaries	Coordination	Organizational structure	Needs assessment instrument	Financing system*	Beds per 1000 inhab. ≥ 65 years**	Individuals treated per 1000 inhab. ≥ 65 years (NH/HCBS)**
France	Dependent persons (mainly individuals aged ≥60 years)	Central government (National Solidarity Fund for Autonomy) and departments (*les Conseils généraux*).	Personalized allowance for autonomy (*Allocation personnalisée d'autonomie*, APA), households (*etablissements d'hebergement pour personnes agées*) and long term inpatient units (*unités de soins de longue durée*).	• Dimensions assessed: ability to perform ADL. • Instruments used: a) Individuals aged up to 60 years: *Guide d'évaluation des be-soins de compensation des personnes handi-capées* (GEVA) (no dependence levels); b) Individuals aged over 60 years: *Autonomie, Gérontologie, Groupe Isso Ressource* (AGGIR) (4 dependence levels).	• Public spending on LTC as% of GDP: 1.89% (20% via cash benefits, 80% in-kind). • LTC as a share of current healthcare expenditure: 17.1%.	53.1	n.a./n.a.
Germany	All insured persons depending on the extent of LTC needs, regardless the age	Central Association of Health Insurance Funds (*Spitzenverband*), Federal Association of LTC Insurance Funds (*Spitzenverband Bund der Pflegekassen*) and the Confederation of Municipal Authorities' Associations (*Bundesvereinigung der kommunalen Spitzenverbände*)	Home care (in-cash and in-kind), in day- or night-care institutions and nursing homes.	• Dimensions assessed: ability to perform ADL and IADL. • 4 dependence levels (I, II, III and hardship cases).	• Public spending on LTC as% of GDP: 1.91% (31% via cash benefits, 69% in-kind). • LTC as a share of current healthcare expenditure: 17.1%.	54.4	48.0/121.0
Italy	Dependent persons (mainly elderly)	Central government (*Istituto Nazionale Previdenza Sociale*), local health units (*aziende sanitarie locali*) and municipalities.	Community care, residential care and cash benefits.	The instrument used differs according to each region. Nevertheless, the multidimensional assessment is based on validated international standards.	• Public spending on LTC as% of GDP: 0.91% (42% via cash benefits, 58% in-kind). • LTC as a share of current healthcare expenditure: 10.1%.	18.5	34.4/68.2
Netherlands	Dependent persons (mainly elderly)	Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*), regional care offices (*zorgkantoren*) and municipalities.	Home care, nursing homes and cash benefits.	• Under responsibility of the Centre for Care Assessment (*Centrum Indicatiestelling Zorg*). • Dimensions assessed: somatic, psycho-geriatric, physical, sensory or intellectual handicap, psycho-social problems. • There are no levels of dependence.	• Public spending on LTC as% of GDP: 3.96%. • LTC as a share of current healthcare expenditure: 37.4%.	73.9	84.2/183.7