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(Re)Imagining Home Care in Portugal: Needs Assessment and Proposals for Innovative, Integrated, and Sustainable Responses

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Executive Summary

Ageing population poses significant challenges for public policies, requiring responses that balance dignity, quality of life, and well-being with social inclusion and economic sustainability. Home care emerges as a preferred response to this reality, enabling care delivery close to home, supporting older people's independence, preventing premature or unwanted institutionalisation, and assisting informal caregivers. However, in Portugal, Home Care Services (HCS) still face gaps in geographical coverage, workforce resource qualifications, and coordination between social and health services. In parallel, a new profile of older people is emerging (greater longevity, increased multimorbidity and dependency, and higher awareness of rights), and informal caregivers (more overburdened, unavailable, or absent). International guidelines converge on the need to reconfigure HCS based on the ageing in place principle (AiP), ensuring stronger integration between the social and health sectors and within long-term care systems.

Recommendations

1 - Redesign public policy on home care through a new legal framework
2 - Revise the funding model to address demographic ageing and territorial challenges
3 - Strengthen the community dimension and socio-spatial planning
4 - Integrate informal caregivers into care planning processes
5 - Guarantee the self-determination and rights of those subject to care
6 - Strengthening upper management organizations capacity and recognise the value of care professionals
7 - Ensuring evaluation, audit, and quality systems are in place
8 - Diversify service provision and expand the use of technological innovation

Policy Brief Target Audience

Ministry of Labour, Solidarity and Social Security; Social Security Institute, I.P.; Institute for Employment and Vocational Training; Ministry of Health; Directorate-General of Health; National Network for Integrated Continuous Care; National Commission for Long-Term Care; Ministry of Finance; Social Security Institutes of the Autonomous Regions (Azores and Madeira); National Confederation of Solidarity Institutions; Union of Holy Houses of Mercy; Association for Home Care Services, Residential Care Homes and Nursing Homes for Older People; National Association of Portuguese Municipalities; National Association of Informal Caregivers; National Council of Professional Associations.

Introduction and Problem Statement

Home care was a significant potential to promote social cohesion and socio-economic development (OECD, 2026), targeting a specific population group that expresses a preference to age at home and within their community. This aligns with the paradigms of healthy ageing and Ageing in Place (AiP) (Fonseca, 2021; 2025).

AiP is conceptualised as both a care philosophy and a strategic approach that responds to individuals' preference to remain in their communities as they age. It requires the provision of supportive environments capable of compensating for age-related changes, while enabling individuals to maintain independence, autonomy, and social participation (Fonseca, 2021).

The integration of Home Care Services (HCS) within this multidimensional framework (Jacobson et al., 2025; Kuryk et al., 2023; Wong, 2022) encompasses physical, social, clinical, and organisational dimensions. It addresses the challenges faced by ageing societies in delivering adequate care to older populations while promoting their well-being (Gil & Patrício, 2025). This approach is adaptable to heterogeneous socio-territorial contexts and diverse individual needs, fostering independence and self-care (Rizzini et al., 2024).

Within this context, the HCS is recognised as the primary modality of long-term home-based care for individuals with functional limitations who predominantly reside in their own homes. It addresses needs related to personal care and activities of daily living, including counselling, needs assessment, practical assistance, provision of equipment, home adaptations, visiting and sitting services, and meal provision (Davey et al., 2024).

In Portugal, HCS is regulated by Ministerial Order No. 38/2013. Its relevance has been further reinforced by the enactment of the Statute of the Older Person (Law No. 7/2026), which is framed within the broader paradigm of the right to access long-term care at home (Council of the European Union, 2022; OECD, 2025a; 2025b; Davey et al., 2024).

HCS is thus acknowledged as a key pillar of social inclusion, contributing to the prevention of loneliness and the reduction of poverty (Fonseca, 2021; 2025; OECD, 2026). Nevertheless, significant territorial disparities persist, alongside structural gaps and operational challenges that affect service responsiveness.

The socio-spatial distribution of HCS is characterised by marked inequalities between urban coastal areas and the rural interior (Álvarez-Pérez et al., 2025). In urban contexts, there is a tendency for services to assume a substitutive role vis-à-vis the family, whereas in rural areas they more often complement family support networks (Barbosa et al., 2018). Such territorial disparities raise concerns regarding the accessibility, coverage, and efficiency of HCS provision (Batista et al., 2024).

Additional constraints are identified by União das Misericórdias Portuguesas et al. (2022), including challenges related to financial sustainability, limited-service provision during evenings and night-time, insufficient support for medical appointments and procedures, and lack of coverage in situations of caregiver absence. Ribeirinho and Carvalho (2024) further highlight the need for continuous professional training, external supervision, and enhanced technical and scientific support in both social and health care domains. Moreover, quality management systems remain insufficiently developed and inconsistently implemented (Santos & Rodrigues, 2022).

In response to these challenges, the present study aims to examine how home care services in Portugal are organised and delivered across the for-profit and non-profit sectors, and how they respond to the diverse profiles and needs of older people in different territorial contexts - urban, rural, and mixed. It also seeks to identify the conditions under which HCS can consolidate its role as a cornerstone of long-term care, ensuring that older persons are able to remain in their homes with dignity, safety, and autonomy.

Accordingly, the study pursues the following objectives: (i) to provide a comprehensive assessment of HCS in Portugal; (ii) to identify promising practices; and (iii) to formulate policy recommendations aimed at fostering more innovative, integrated, and sustainable service models.

Methodology

This study adopted a mixed-methods design combining a nationwide online questionnaire survey with qualitative case studies. This approach aimed to capture both the breadth and depth of Home Care Services (HCS) in Portugal, enabling the description of their diversity and the identification of organisational patterns and practices.

The survey was distributed to 2,998 organisations providing HCS across mainland Portugal and the Autonomous Regions of the Azores and Madeira, encompassing both for-profit and non-profit sectors. Data collection took place between November 2025 and December 2025. A total of 510 valid responses were obtained, corresponding to a response rate of 17%.

The case study component focused on 12 institutions identified as developing promising practices. These were selected according to NUTS II regions, sectoral affiliation (for-profit and non-profit), and territorial context (urban, rural, and mixed). Multiple data collection techniques were employed, including document analysis (internal regulations, institutional websites, and SWOT analyses completed by each HCS team), a national online survey, semi-structured interviews with service coordinators (n = 12), and interviews with service users/clients and informal caregivers (n = 24).

Ethical procedures were ensured throughout the study, including the collection of informed consent in accordance with the General Data Protection Regulation (GDPR). The Consent was approved by the Data Protection Officer of the Universidade de Lisboa on 3 November 2025.

The study was conducted at the Centre for Public Administration and Public Policies (CAPP), Institute of Social and Political Sciences (ISCSP), Universidade de Lisboa, and coordinated by Maria Irene Carvalho (Principal Investigator) and Carla Ribeirinho (Co-Principal Investigator). It benefited from scientific advice provided by António Fonseca, faculty member at the Faculty of Education and Psychology of the Portuguese Catholic University, and from institutional partnerships with the Federation of Institutions for the Elderly, and the National Confederation of Solidarity Institutions.

Analysis / Key Findings

HCS organizations and sectoral integration: These organizations are predominantly embedded in the non-profit sector (85.9%), with a large proportion classified as Private Institutions of Social Solidarity (78.4%). They also provide additional services for older adults, particularly Day Care Centers (67.1%) and Residential Structures for Older Persons (44.9%). In terms of organizational size, small (49.8%) and medium-sized (33.6%) structures prevail, based on staff numbers. Leadership typically holds undergraduate or higher academic qualifications, although there are cases of managers without higher education, more common in the non-profit sector and in rural context. The Home Support Service (HCS) within these organizations began in 1964, with significant expansion occurring from 1986 onward (62.5%) in the non-profit sector and from 2006 in the for-profit sector (88.4%).

The target population is diverse and heterogeneous, including older persons, individuals with temporary or permanent dependency, disabilities, neurodegenerative diseases, and mental illness; however, only 10.1% of services explicitly target informal caregivers.

A total of 21,192 individuals are supported by these 510 HCS units through cooperation agreements and operating licenses, with an average of 42 users per service. Not all services reach full capacity (55.9%), mainly due to lack of demand and human resource shortages. This raises questions regarding the capacity of these services to effectively meet the needs of older individuals requiring home-based care.

Access to HCS and user/client profile: The first contact with HCS is most frequently initiated by son(s)/daughter(s) (92.0%), followed by spouses, hospital staff; and the users themselves (54.7%). During this contact, information outlined in the service regulations is provided, and services are subsequently defined through contract signing. However, contracts are not always signed by the user or their legal representative (35.3%), raising concerns about respect for user autonomy and self-determination. Users are predominantly female (58.9%). The youngest users age range from 13 to 85 years old (mean = 55.57), while the oldest age range from 63 to 106 years old (mean = 95.27), increasing the complexity of care personalization due to population diversity and wide age range.

Operating hours and services provided: Service schedules vary. In the non-profit sector, services typically operate 8 hours per day, 7 days a week, or 5 days a week, whereas in the for-profit sector, services often operate 24 hours per day, 7 days a week. Service provision was measured on a scale (0 = never; 1 = sometimes; 2 = always), showing that personal care services (personal and household hygiene) are most frequently provided (mean = 1.45), followed by meal provision (mean = 1.17). The four most common services are personal hygiene, meal preparation and delivery, household cleaning, and laundry

service. Additional activities may be provided depending on the territorial context, as expressed by the user/client.

> *"They come to deliver meals (…). Then, whenever I am having difficulty with something, I ask them and they sort it out for me.""(…) I am like that—I ask for whatever is needed, 'look, could you feed the goats or take care of the kitchen' (…)"*
> (HCS, non-profit, rural context, user/client 2).

Support for caregivers presents a significantly lower mean (0.90), despite being recognized as highly relevant by caregivers.

> *"They taught me how to change the diaper and included me in an informal caregiver support group*." (HCS, Autonomous Region of Madeira, caregiver 1)

The least frequently provided services are related to health and psychosocial support, leisure and recreational activities (mean = 0.65), and other additional services (mean = 0.58).

> *"If anything is needed, I always have someone available—whether to go to the pharmacy, the primary health care centre, or the supermarket."*
> (HCS, non-profit, urban context, user/client 1).

Service provision differs between sectors: in the non-profit sector, personal hygiene and meals predominate, whereas in the for-profit sector, caregiver support, health and psychosocial services, recreational activities, and other differentiated services are more prominent. Differences are also observed in the user-to-care worker ratio (1:6 in the non-profit sector vs. 1:1 in the for-profit sector). Additionally, time allocation per user differs: in the non-profit sector, services typically last less than one hour or between 1-3 hours whereas; in the for-profit sector, services may extend to 8-11 or 12+ hours. This leads to greater service differentiation but also introduces social inequality in access to HCS.

> *"We take care of everything, and families highly value this, as they do not need to concern themselves with anything at all."*
> (HCS, for-profit, coordinator 1).

Human resources and recruitment challenges: These services employ a substantial number of human resources (9,134 professionals). Of these, 41% are "direct care workers" with permanent contracts, primarily in the non-profit sector. In the for-profit sector, "family aides" (17.8%) are more prevalent, often working under freelance arrangements, a situation affecting 82.6% of the sector and representing a structural limitation.

Recruitment difficulties are common across both sectors (54.7%), including the hiring of untrained personnel (43.9%) who acquire skills through on-the-job experience. Training needs primarily focus on communication with people with dementia and teamwork. Most workers are Portuguese (62.5%), with 22.3% originating from Latin American countries, of whom 15.1% are absorbed by the for-profit sector.

Average salary ranges align with the national minimum wage in both sectors. While 51.2% of workers have a defined career path, such progression is largely absent in the for-profit sector (75.5%). Thus, despite offering more integrated services, the for-profit sector shows weaknesses in human resource valorisation.

Funding model: The funding model is partially accepted in the non-profit sector, though concerns are raised regarding long-term sustainability. Suggested improvements include increasing co-financing rates, accounting for staff costs (14 salaries per year), travel distances, and rising operational expenses, exacerbated by inflation. The for-profit sector proposes direct funding to families.

User/client fees differ by sector: in the non-profit sector, fees are based on income, expenses, and number of services, ranging from €100 to €300; in the for-profit sector, fees depend on service hours and frequency, ranging from €501 to €1,500.

Contributions, limitations, and innovation capacity: The main contributions of HCS, as recognized by respondents, are user-centered particularly enabling individuals to remain at home with dignity, reducing social isolation, and providing needs-based responses that mitigate loneliness.

> *"Before receiving HCS, I felt more alone; now, people come here every day (…)." (HCS, non-profit, rural context, user/client 3).*
> *"Someone always comes in, because the place is very isolated (…) there are days when the only people we see are the staff who come from the HCS."* (HCS, non-profit, rural context, user/client 4).

The limitations identified by respondents include human resource constraints, especially the difficulty in retaining staff; financial and logistical sustainability challenges; insufficient training; and limited communication with informal caregivers. There is also a need to

improve responsiveness to complex and urgent situations.

Service quality assessment is not consistently systematic: 65.3% of services conduct occasional and informal evaluations, while 37.1% use formal but weakly systematized mechanisms. Nevertheless, structured work practices are in place, indicating a degree of functional specialization.

> *"The hands that provide care are not the same as those that serve meals (...) I have care workers responsible for hygiene and personal presentation; others who deliver meals; and staff who carry out household cleaning."* (HCS, non-profit, urban context, coordinator 1).

These services maintain extensive partnerships, especially in the non-profit sector. Technological adoption remains limited, primarily used for promotion rather than enhancing care delivery or diversifying services. However, some services use digital applications for care monitoring and cognitive activities.

> *"We have a tablet in each home, which we also use to install cognitive stimulation applications."* (HCS, for-profit, coordinator 2).

Promising practices: Approximately 49% of services report initiating project applications aimed at developing alternative and complementary services, strengthening integration between health and social care, and diversifying service provision.

> *"(…) within the scope of the (funded) project, we have a nursing team and a psychologist, and we have recently expanded the team to include an occupational therapist and a psychomotor therapist."* (HCS, non-profit, rural context, coordinator 2).

These initiatives are recognized as inspiring practices (46.7%) and are at different development stages: some are in planning particularly those focused on caregiver support and dementia care while others are already implemented, including professional training programs and strengthened partnerships with healthcare organizations and universities.

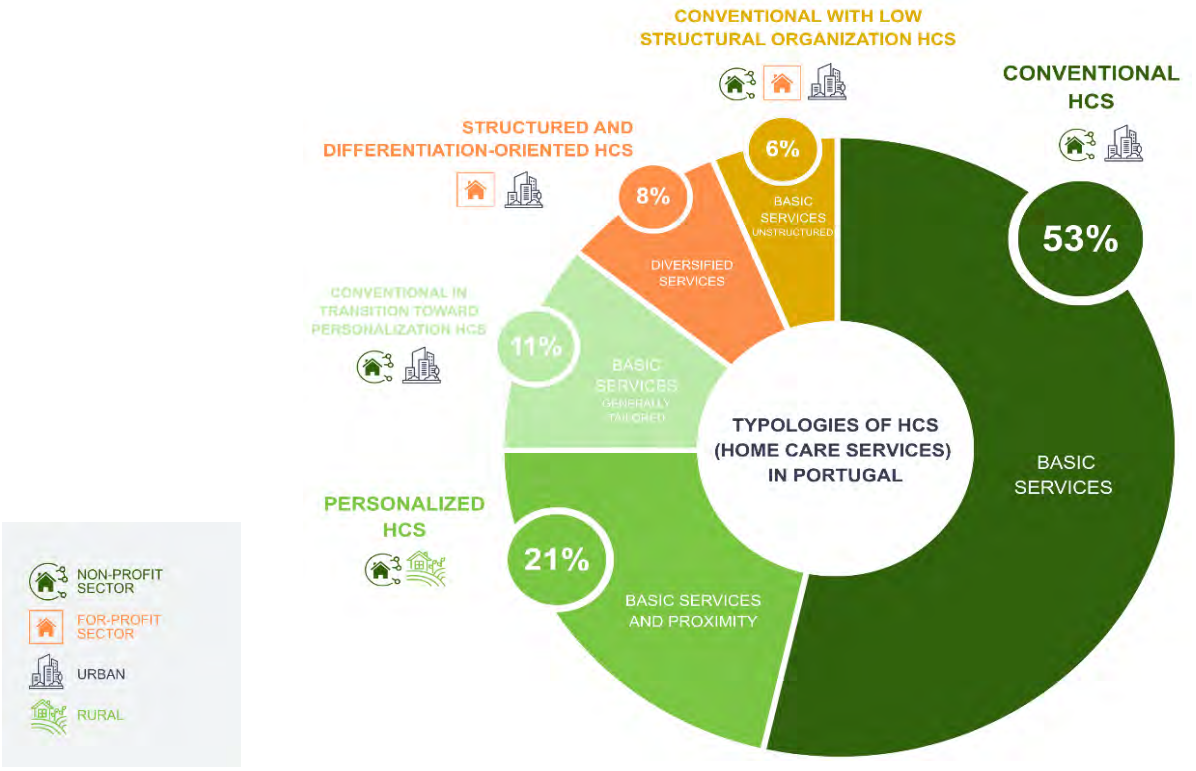
> *"…extension of services beyond conventional operating hours, structured support for informal caregivers, support for people with dementia or other degenerative diseases, and the promotion of users' quality of life."* (HCS, for-profit, coordinator 1).

Respondents (41.1%) proposed policy measures emphasizing the need for a more personalized model tailored to complex user needs. These needs require extended time at home, implying, among other factors, longer service provision hours.

HCS typologies

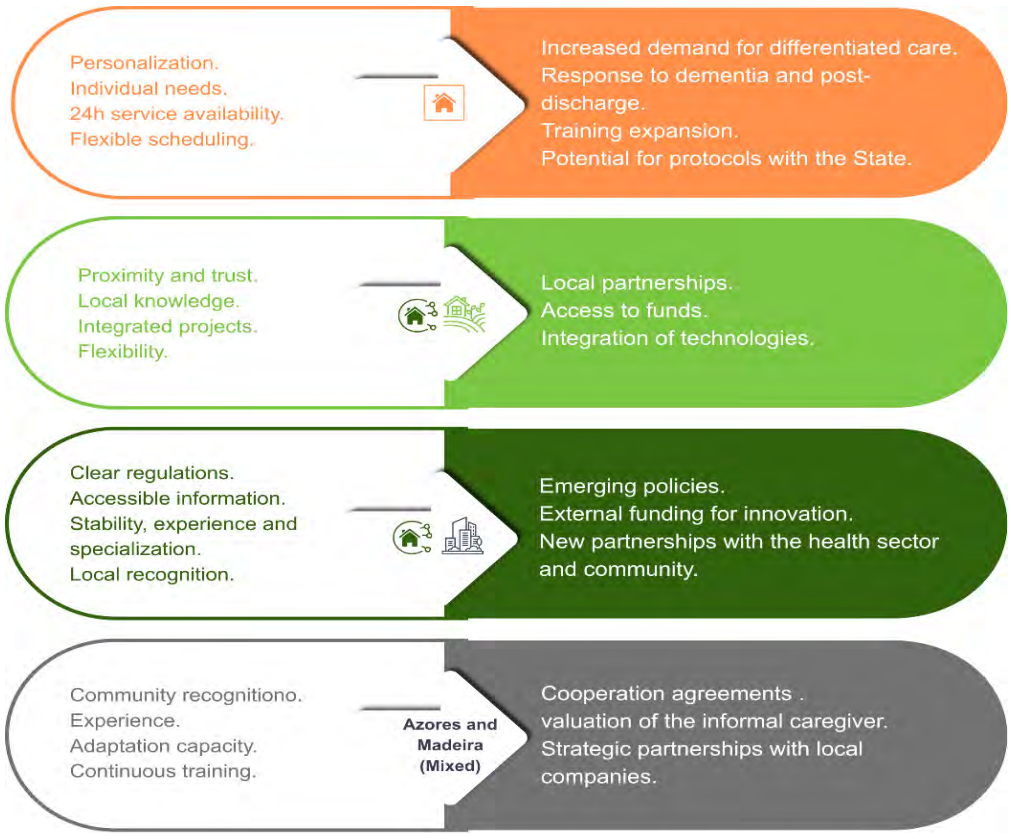
Cluster analysis identified five HCS typologies: conventional; personalized; conventional in transition toward personalization; structured and differentiation-oriented; and conventional with low structural organization (Figure 1). Good practices observed in case studies reinforce these typologies (Figure 2).

Figure 1: Typologies of HCS in Portugal



Legend: Sectors and Territories

Figure 2: Promising Practices for Future HCS (Case Studies)



Source: Authors' own elaboration

Policy Options and Recommendation

The policy recommendations presented result from the diagnostic assessment and from the integration of the most relevant contributions identified in each cluster, articulated with national and international good practices that shape the home care model of the future.

1 – Redesign public policy on home care through a new legal framework

Objective: To integrate public home care policy into a national long-term care strategy aligned with active, healthy, and community-based ageing paradigms, promoting social inclusion and health integration.

Measures: Develop a comprehensive legislative framework establishing a home care model capable of responding to emerging challenges, defining standardised rules and criteria for both for-profit and non-profit sectors, and ensuring articulation with the Social Network and the National Network for Integrated Continuous Care (RNCCI). Integrate HCS into national long-term care policy in accordance with the 2030 Agenda and international guidelines (EU/UN). Strengthen interministerial coordination mechanisms, particularly through the National Interministerial Coordination Commission for Long-Term Care (Order No. 3202/2026) and consolidate innovative initiatives such as HCS+Health pilot projects.

2 – Revise the funding model to address demographic ageing and territorial challenges

Objective: To revise and diversify funding models, combining structural financing for organisations with direct support mechanisms for families, adjusted to care complexity, territorial specificities, and the social function of HCS.

Measures: Develop a funding model based on service typologies and care characteristics (e.g., dependency level, dementia, prevention) and territorial context (urban, rural, and mixed), taking into account logistical costs, geographic constraints, and social vulnerability. Redefine sectoral financing based on equity and case complexity to ensure sustainability. Incorporate users' clinical and social profiles (care intensity and duration) into funding calculations, as well as increased operational costs in peripheral and low-density areas. Include private HCS providers in public funding schemes under social responsibility frameworks, particularly in response to complex hospital discharges in urban and mixed contexts. Implement mechanisms of user choice (vouchers, tax deductions, co-payments) as complementary not substitutive funding instruments.

3 – Strengthen the community dimension and socio-spatial planning

Objective: To integrate the community dimension of HCS in alignment with the Ageing in Place paradigm, reinforcing local coordination, systematic socio-spatial planning, and the valorisation of volunteering.

Measures: Establish local coordination structures for home care, articulating public and community actors to ensure integration, continuity, and territorial responsiveness. Strengthen the role of municipalities and local networks in risk identification, resource mobilisation, and proximity-based responses aligned with Ageing in Place. Involve community teams in preventing isolation, supporting highly dependent individuals, and assisting informal caregivers in coordination with health and social services. Develop a socio-spatial analysis system to map ageing-related risks and care accessibility, informing decisions on funding, licensing, and service organisation.

4 – Integrate informal caregivers into care planning processes

Objective: To recognise informal caregivers as an explicit target group of HCS, ensuring structured support in terms of training, respite care, emotional support, and follow-up.

Measures: Recognise informal caregivers as beneficiaries of HCS, acknowledging their central role in care continuity and quality. Integrate caregivers into care plans by assessing their needs, goals, and well-being, and develop tailored interventions such as training, emotional support, peer support, psychosocial follow-up, and respite measures, including for those without formal caregiver status. Articulate caregiver support with HCS+Health initiatives and community teams,

ensuring inclusion in complex case management.

5 – Guarantee the self-determination and rights of those subject to care

Objective: To ensure respect for individuals' autonomy and will, guaranteeing proper identification of legal representatives when individuals are unable to express informed consent.

Measures: Ensure that access to HCS respects individual preferences and, where this is not possible, applies the Legal Framework for Accompanied Adults (Regime Jurídico do Maior Acompanhado). Clarify that family members are not legal representatives unless formally designated, with mandatory registration. Verify and record the existence of legal representatives or designated trusted persons in HCS case files. Strengthen informed consent procedures, ensuring comprehension and participation in decision-making, and promote the designation of trusted persons. Provide training for HCS teams on legal capacity, rights, and limits of family involvement, integrating these principles into quality, audit, and supervision frameworks.

6 – Strengthening upper management organizations capacity and recognise the value of care professionals

Objective: To professionalise care work by establishing structured career pathways and comprehensive training systems across all institutional levels (care assistants, technical teams, management, and executive leadership).

Measures: Standardise job titles, roles, and professional profiles in home care services, ensuring coherence across non-profit and for-profit sectors. Restructure career pathways with progression and remuneration aligned with job complexity. Guarantee labour rights, social protection, and measures to combat precarious employment. Define minimum qualification requirements and mandatory training in key care domains. Develop initial and continuous training programmes for all levels, including management, planning, and social-health integration. Strengthen regular technical supervision, ensuring dedicated time for team support and burnout prevention.

7 – Ensuring evaluation, audit, and quality systems are in place

Objective: To redesign evaluation, audit, and quality assurance systems through continuous monitoring and transparency, centred on the person and care continuity.

Measures: Define and implement quality systems for HCS based on person-centred standards and indicators. Establish regular evaluation and audit mechanisms, including outcome indicators, user satisfaction, continuity of care, and territorial equity. Use digital technologies for real-time monitoring, data recording, and transparency. Involve users, caregivers, and communities in service evaluation. Integrate quality assessment into licensing, contracting, and funding processes, rewarding performance and the adoption of evidence-based best practices.

8 – Diversify service provision and expand the use of technological innovation

Objective: To personalise and diversify services through the integration of technological innovation in HCS, enhancing comprehensive care, continuity, and reducing social and territorial inequalities.

Measures: Expand the range of services to include health care, psychosocial support, cognitive stimulation, social participation, and community engagement. Fund telecare, monitoring, digital communication, and record-keeping technologies. Develop a multidimensional assessment model for users. Promote the adoption of technology, particularly in rural and mixed territories and in the Autonomous Regions of Madeira and the Azores, as a complement to, not a substitute for, human care. Integrate technology into quality, transparency, and continuity systems. Ensure digital literacy training and data protection education for professionals, users, and caregivers. Promote pilot innovation projects with systematic evaluation for potential scaling.

Conclusion

Home Care Services constitute an essential response within long-term care policies for older people and other populations requiring continuous support. However, this study highlights the need for a profound transformation to address the diversity of user profiles and needs, territorial contexts, and the requirements of cohesion, sustainability, and quality.

The coexistence of multiple service models from conventional to highly differentiated structures demonstrate adaptability but also reveals inequalities that, in the absence of common standards, may exacerbate disparities in access and compromise minimum quality thresholds.

Portugal benefits from dedicated human resources, community-embedded organisations, and innovative practices that can be expanded. However, without a shared strategic vision, adequate financing aligned with care complexity, effective integration between health and social care, and robust monitoring and quality systems, the potential of HCS remains constrained. It is therefore necessary to establish a basic quality framework applicable to all services, ensuring dignified, safe, and needs-responsive care for older people regardless of location or sector.

This framework must simultaneously enable differentiation, innovation, and territorial adaptation, avoiding excessive standardisation while valuing diversity as a resource. Its implementation requires coordinated action across public, social, and for-profit sectors, not only in regulation but also in capacity-building, financing, and monitoring. Only through such an integrated approach can inequalities be reduced, care integration strengthened, and a person-centred system consolidated, one that recognises both formal and informal caregivers and supports older people in remaining in their homes and communities.

Reorganising home care thus represents a decisive step towards a more equitable, sustainable, and resilient long-term care model aligned with the country's demographic and social challenges. The future of HCS will depend on the collective capacity to translate evidence into action and to affirm consistently that dignity and autonomy in old age are foundational pillars of an inclusive society prepared for ageing and longevity.

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It should also be noted that preliminary findings of this study were publicly presented on 27 March at the Institute of Social and Political Sciences (ISCSP), in an event attended by approximately 450 registered entities. The study was also widely disseminated in the media, including Agência Lusa, RTP, TSF, and several national daily newspapers.

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