

Answer to Questionnaire
On
Health and Long Term Care for the Elderly

Portugal

2002

1 Access

1.1 Health Cares

1.1.1.Mechanisms to guarantee the access

The Constitution of the Portuguese Republic, in Article 64th regarding the Chapter on the Rights and Duties, in accordance to text set forth by its 5th. revision of 2001, determines that all citizens have the right to health protection, being the State incumbent on the correlative duty of guaranteeing that right throughout the National Health Service (NHS).

The NHS is characterised, in Constitutional terms, by being general, universal and tendentious free of cost.

In order to ensure the right to the safeguarding of health, the State has a primary duty to:

- a) guarantee the access of all citizens, regardless of their economic circumstances, to both preventive and remedial medical care;
- b) guarantee a national and efficient coverage of human resources and health units throughout the whole Country;
- c) direct its action towards the socialisation of the costs of medical and medicinal cares;
- d) regulate and supervise the enterprise and private forms of medicine in the health institutions, in order to guarantee adequate standards of efficiency and quality;
- e) regulate and supervise the production, distribution, marketing and utilisation of chemical, biological and pharmaceutical products and other methods of treatment and diagnosis;
- f) establish policies for the prevention and treatment of drug abuse;

The NHS, which comprises all the national territory and all its citizens is managed in a non-centralised and participated way, comprising all types of health cares, which are paid for, taking into consideration the economic conditions of the citizens.

The Law of Bases of Health (Law no. 48/90, August 24) determines that:

- a) the Health System be constituted by the NHS and by all the public entities which develop promoting, preventing and treatment activities in the health area, as well as by all the private entities and by all the independent professionals who wish to establish with the NHS the rendering of all or of some of those activities.
- b) The NHS may dispose of self status;
- c) The NHS may comprise all the institutions and official services providing health care dependent and under the dependency of the Ministry of Health.

The Law of Bases particularises the determinations of the Constitution of the Portuguese Republic and confirms that the NHS is characterised by:

- a) being universal in relation to the population covered;
- b) providing or ensuring that it be guaranteed, in an integrated manner, global cares;
- c) being tendentious free for the citizens, bearing in mind their economic and social conditions;
- d) guaranteeing the equity in the access, with the objective of attenuating the effects of the economic, geographic inequalities and what ever other asymmetries;
- e) being organised at regional level and having a non-centralised and participated management.

Besides all the Portuguese citizens, the other benefactors of the NHS are:

- a) national citizens of the Member States of the European Union;
- b) displaced people residing in Portugal;
- c) Immigrants with residence visa;
- d) Foreign citizens residing in Portugal in reciprocated conditions;

The financing of the NHS is guaranteed by the General Budget of the State.

The access to the provision of NHS health care rendering is subject to the payment of Moderate Rates, being in force the regime approved by Decree-Law no. 54/92, April 11, in which the amounts to be paid are set forth by Regulation no. 338/92, April 11.

According to the terms of Article 2nd. Of Decree-Law no. 54/92, situations of exemption regarding the Payment of Moderate Rates are foreseen and contemplate:

- a) pregnant women and expectant mothers;
- b) children up to the age of 12, included;
- c) benefactors of complementary grants to children and handicapped young people;
- d) benefactors of lifetime monthly grants;
- e) pensioners whether or not receiving a pension below the national minimum salary, their consorts and minor children, provided that they are dependent;
- f) unemployed registered in the employment centres, their consorts and minor children, provided they are dependent;
- g) benefactors of eventual character provisions due to situations of need, paid by official services, as well as their consorts and minor children;
- h) children and young people deprived of normal family circle, boarded in homes;
- i) workers working for others receiving a monthly revenue not higher than the national minimum salary, as well as their consorts and minor children, provided that they are dependent;
- j) benefactors due to professional illness, with a degree of global permanent incapacity not inferior to 50%;

- k) cancer patients, chronic kidney insufficiency, congestive cardiac insufficiency; cardiopathy; obstructive chronic lung disease; diabetes; hepatic cirrhosis with grave symptomatology; haemophilia; Parkinson disease; disabled arthritis, ankylosis spondylitis, dermatitis, multiple sclerosis, lupus, paraplegia; grave myasthenia , demyelination disease; neuroma disease motor;
- l) patients with genetic disease with grave clinical manifestations;
- m) patients with active chronic hepatitis;
- n) seropositive patients and with AIDS;
- o) patients with lung tuberculosis and with Hansen disease;
- p) patients with chronic mental disease;
- q) chronic alcoholics;
- r) drug-dependent individuals when put in recuperating programmes within the official services;
- s) benevolent blood donors;

Besides the State, and in accordance with the terms of Decree-law no. 11/93, which approves the Statute of the NHS, the following are accountable for the incumbency of health care provision services rendered:

- a) the non beneficial users and the benefactors with what is entitled to them, bearing in mind their economic and social conditions;
- b) the health subsystems and private institutions of social solidarity.

With the publication of Decree-law no. 118/92, of July 25, a special regime of co-participation of medicines was created and which covers, only, those holding a pension similar or below the national minimum salary. They will be entitled to a co-participation from the State of 15% relatively to what is set forth for the general regime.

As for the medicines prescribed to patients with esophagitis of reflux, paramyloidosis, lupus, haemophilia, hemoglobinopathy, fibrosis cystic, multiple sclerosis, amyotrophic lateral sclerosis, VIH, deficiency of the growth hormone and the syndrome of Turner, they are, still, fully co-participated by the State.

1.1.2. Assessment

So far, there exists in this Country waiting lists for the provision of health care. Therefore, there are tools available which enable us to know the no. of people waiting for surgery, by pathologies, by hospitals or by time of waiting. However, As for the waiting list concerning the provision of health care by ambulatory services, it is ,still, not well known.

In what respects the inequalities regarding the access to the provision of health care, it should be pointed out that the more differentiated technological equipment in the context of diagnosis and therapeutics as, being the case, for instance, with radiotherapy, hemodynamic, nuclear medicine and magnetic resonance, are concentrated in Lisbon, Oporto and Coimbra, the three more populated cities in the Country. Thus causing regional inequality concerning the access to this type of resources. The concentration movement of human

resources in the big centres and along the coast of the Country has also a tendency of accentuating the regional asymmetries, afflicting the populations with lower income residing inland. Big efforts of decentralisation are currently being developed.

Being the chronic patients and those suffering from big disabilities users of the health services, among which, the elderly people, it is noticed that, in the face of this reality, there is a lack of services, which may adequately respond to their specific needs. Above all, at the domicile and hospitalisation levels, for short and long term duration stays. On the other hand, the intersectional co-operation has not sufficiently been followed up, phenomena such as urbanisation, rural decentralisation and demographic ageing. Thus, making the access difficult to cares, namely those of the elderly.

1.1.3.Challenges

It is considered as being main challenges within this area:

- a) the need of adjusting the answers to the health services according to the current demographic and epidemiological trends, such as urbanisation and consequent rural isolation, the increase of the elderly population and the high prevalence of chronic diseases as well as the social changes, behaviour and biologic, as is the case, for example: the increase of sedentary life, the resistance to antibiotics and other medicines, drug abuse, civilian and domestic violence and the new and re-emerging communicable diseases;
- b) the fight against inequalities respecting the access of the users to health cares provided within the NHS;
- c) the fight against the rising increase of health expenses, through the controlled introduction of the principle of competition, along with the maintenance of the principle of solidarity;
- d) the development contract model with the social and private sectors, throughout the partnership with the State, for the provision of long term health care in the social context;

1.1.4. Foreseen Political Changes

It is considered as main foreseen political changes:

- a) the definition of main support sectors to the big and small risks in terms of health and social protection, limiting the respective areas of responsibility and of acting in relation to the NHS. The private and social sectors may be contracted or agreed upon with the State;
- b) the progressive development of the enterprising management scheme concerning the healthcare units, taking into consideration the relation production/quality;
- c) the re-orientation of the health centres regarding the practice of community health and of health promotion, through a wider investment in health education, school health, oral health, as well in the identification and programmed and periodical surveillance of those bearing additional risks.

This according to plans, programmes and priorities defined at national levels;

- d) the availability of health care resources within the generalist and family area on a 24 hour round basis, through contract /agreement with the social and private sectors and professional groups.

1.2 Long Term Cares

1.2.1 Access to the long term cares

The provision of the social action systems which cover long term health cares of social nature to elderly people, is defined by:

- a) pecuniary instalments, on a eventual basis and under exceptional conditions;
- b) instalments in goods;
- c) utilisation of the non-profit network of services and social equipment through a fee granted by the users or their families based on their profits per capita. This network is set up by the State, beneficiaries, local administration and non-lucrative private organisations with which the State established protocols and programmes of co-operation;

The elderly population has been the goal of a significant state investment at the level of setting up answers to long-term health care within the social ambit;

The evolution of political measures has been effectuating. Above all, through social answers, which try to privilege the stay of the elderly person within the family circle, bearing in mind the specific characteristics of this age group. The social political measures regarding the equipment and services embody, respectively, the social security sector level and the activities developed at the health sector level.

1.2.2. Assessment

Of the equipment which provide long term health care to elderly people within the social ambit, the 'day centres'¹, 'homes'², the 'social centres'³ and the 'domicile support services'⁴ are those which exhibit a wider coverage within the National Continent. In 2000, it was set up, as a new answer, in terms of long-term care, 'the temporary emergency shelter centre', on account of being recent, still displays a low coverage rate.

By Ministerial Joint Resolution no. 407/98, integrated answers were established regarding the follow up cares (long term cares within the social and care scope), aimed at the population on a dependent condition, in which the elderly are very often contemplated. It guarantees the articulated and integrated intervention within the health and social sectors, namely the services of 'integrated domicile

¹ In 2000, there were 1542 Day Centres in the Country

² In 2000, there were 1407 Homes in the Country

³ In 2000, there were 447 Society Centres

⁴ In 2000, there were 1581 Domicile Support Services

support' (DSS) and 'the integrated support units' (ISU). These two answers, still with low coverage, register over-occupation, which is the proof of the need of this type of care

1.2.3. Challenges

Currently, the following challenges within this area are as follows:

- a) the need to create integrated answers between the health and social sectors, whether in ambulatory, domicile or rehabilitation regimes, in order to cover the exponential increase in the number of people carrying chronic diseases, with inexorable course for the deficiency and for the disadvantage and for the incapacity. Among these, there is a significant percentage of elderly people included who show additional needs of social support without reducing the need of health care;
- b) the need to counterpart, by means of answers and efficacious solutions, the current occupation of hospital beds, directed for acute patients with chronic diseases, which need long and medium term cares rather than high diagnosed technology and hospital therapeutic;
- c) the need to promote and improve the provision of health care and of integrated social support to elderly people, centred in multidisciplinary teams that have human resources, duly trained, and centralising their performance within a rehabilitation and follow up component. Thus, it is carried out through medium and long-term treatments. They are indispensable to a health system, which one wants to be adequate in giving answers to the needs of a population, which is ageing.

1.2.4. Foreseen Political Changes

The implementation of a National Plan of Integrated Continuous Cares⁵ is foreseen.

This Plan aims at the establishment and organisation of a diversified network of integrated answers to the needs within the medium and long term cares, so as to respond to the complex health needs and social support of people suffering from loss of self-autonomy and/or suffering from chronic diseases.

This Plan will be based on a structure comprised by a national network of integrated answers between the health and social sectors, as well as by a set of organised local networks, preferably within the geographic areas of hospital influence of the NHS.

These local networks foresee the following topology of complementary answers situated between the level represented by the central and general hospitals and the health centres and integrated within the setting up of an intermediate level, which may meet with the general needs of a certain geographic territory of the Country:

⁵The setting up of this Plan is under the responsibility of Ministry of Health and of the Ministry of Social Security and Work and is based on the Resolution of the Cabinet Council no. 59/2002

Mobile teams of 'integrated domicile support' that on a 24-hour on-going basis, during the seven days of the week, provide medical, nursing, social and rehabilitation cares;

- a) 'Transitory integrated support' units – hospitalisation and day areas for medium duration (up to 30 days), for acute chronic conditions that do not require high hospital technology. They should be located within the orbit of the hospitals for the acute cases, in order to provide advantages for diagnostic and therapeutic resources;
- b) 'Long-term integrated' support units – hospitalisation and day areas for long duration (up to 180 days, on an average), for disabled chronic conditions to people on a dependent condition who require global rehabilitation with the goal of achieving the maximum possible autonomy;
- c) 'Permanent integrated' units – hospitalisation on a permanent basis for people on a dependent condition who require permanent cares which are not possible to be carried out at home.

The organisation of these answers will be based on the competitiveness principle and developed based on the principles that inform the concept of the continuity of cares, to be contemplated in a National Plan for Integrated Continuous Cares.

2. Quality

2.1. Health Cares

2.1.1. Norms

The NHS comprises norms within the quality area, according to the nature or care coverage, among which are: technical guidance, normative circulars, books on good practices, strategic plans and Intervention programmes.

It is referred, as an example, the following normalised areas in the health area: child and juvenile health, reproductive health, family planning, pregnancy, communicable diseases, oral health in maternal and child health, vaccination, tuberculosis, pain, cancer, asthma, cardiovascular diseases, diabetes, fracture of the femur, pressure ulcers and medical assistance of high specialisation abroad.

Also, the visits to hospitalised patients and the patients' rights and duties are normalised.

2.1.2. Assessment

The health services develop their activity based on annual plans, which are subject to assessment. There exist specific norms that determine the frequency, the contents and outline of the respective reports.

The assessment of the provision of health cares is inferred from the scope of the objectives and goals of the national and regional plans and programmes, of

performance protocols or of existing norms, which provide standards and assessment criteria.

There is, still, a specific evaluation model of the hospital and nursing cares.

2.1.3. Promoting the Improvement of Quality

As a reinforcement of the awareness of providing better attention to the citizen, as health care user, a social-conscientiousness has been promoted between the patients in general and, between those who integrate vulnerable groups, in particular. For this purpose, the dissemination of information that may prepare and enable them to have the capacity to manage, in a more independent way, their disease process was put into practice. This strategy has shown positive results in what regards their adhesion to treatment and self-alertness to diseases with manageable course.

Through an effort of effective decentralisation, which may approximate the health system to the patient, conditions have also been established in order that they may progressively lead the patients to having a more active role in decision-making and in the planning of the cares, which are provided to them. Thematic areas have also set up orientations for good professional practices. They are based on national and international scientific consensus and guarantee of the respective scientific societies, in order to normalise activities and improve the quality of the cares provided.

With the definition of a health strategy, one tried to bring about the definition of gains in health to be obtained within the main health problems of the Portuguese population.

Although the qualitative evolution of the health system is becoming notorious, the model of care provision is still based, essentially, on a pathogenic practice.

Nevertheless, real health gains have been obtained, namely in what regards the decrease of the incidence of communicable diseases, in the decrease of mortality and even in some chronic diseases.

The gains obtained, for instance, in the area of maternal-child health, demonstrate the effectiveness of strategic programmes of action and sustain the need of its replication in other areas.

On the other hand, the progresses verified in the areas where the influence of intrinsic factors prevail have proven to be insufficient, such as: attitudes and harmful behaviour, imprudent and aggressive procedures, e.g., as the cases with accidents, especially those pertaining to domestic and road accidents, the various forms of violence, chemical substance dependency and the infection by VIH. These factors will incite to a progressive re-orientation of the health services for the practices based on more healthful and centripetal qualitative models.

2.1.4. Challenges

Considered as being main areas of challenges in this area:

- a) the implementation of the cycles of the improvement of quality;
- b) the improvement of the information system;
- c) the improvement of the professional performance;
- d) the increase of production;
- e) the rationalisation of costs;

2.1.5 Foreseen Political Changes

The following measures have been planned or are already in progress:

- a) more participation of the social and private performers;
- b) more follow up, surveillance and more effective assessment of results;
- c) examining carefully the innovative experiences of management;
- d) more valorisation of health resources based on the competencies; on the technical differentiation, on the continuous training and on the professionals status.

2.2. Long term Cares

2.2.1. Norms

Taking into account the assurance and promotion of the population's well-being, with priority to the people who, due to their physical, psychological or social characteristics, are in a situation of special vulnerability or with limited autonomy (being the case of many elderly people), a legal cadre was set up within the social sector. This permits and promotes qualitative answers and inhibits those who do not have it.

Ministerial Decree-Law no. 133-A/97, May 30, with the rectification introduced by normative Ministerial Dispatch no. 31/2000, June 21 and Ministerial Decree-Law no. 268/99, July 15, defines the licensed and supervision regimes respecting the provision of services, as well as that of the establishments where the activities of social support in the area of social security are carried out, and where the delivery of long term care to the elderly on a social basis is included.

The inspection and supervision of these establishments is under the Ministry of Social Security and Work's responsibility. The license of these establishments is titled by permit that is issued by the Social Security services within their location area and complies with a set of pre-defined requisites.

There is a normalisation of the ratifying regime, as well as of the administrative closing of the establishments, which are not in conditions of permitting the guarantee of quality in providing these services.

In accordance with the principle of the right to protest on behalf of the user and their family is established. The fulfilment of such principle acquires additional

importance in the locations where the attendance to people has a continuous nature and aims at the more vulnerable stratum of the population, as it is the case with the elderly people.

Recently, the 'attendance and formality centres' were set up, through the Ministerial Dispatch no. 7837/2002 (2nd series), with the objective of facilitating the procedures inherent to the issue of permits for 'homes' for the elderly people, closing down and adjustment of those homes.

Besides the regulating norms, previously mentioned, there exists a set of diplomas and technical guidance for each social answer, which rules the implementing conditions, localisation, installation and functioning of the institutions which provide long term cares of social nature, as well as the rights and duties of the users.

2.2.2. Control and Quality Promotion

March 16, of the Ministries of Economy and of Solidarity, Joint Dispatch no. 410/2000 set up a national plan entitled 'Grandfather Plan'. Its purpose is to promote the quality of the services provided and the daily humanisation of the 'homes' and 'residences' for elderly people. Of the several measures unchained by this plan, it should be underlined:

- a) The implementation of the ISO 9001:2000 Norm which defines standards of quality to the 'homes' for elderly people;
- b) The diagnostic assessment of the conditions of the installation and of the dynamics in relation to those 'homes';
- c) The analysis of the quality of the services provided to the residing elderly in the 'homes';
- d) The implementation of a process of certification of the 'homes'.

Programmes of Support with the view of improving the quality of the equipment and services for the elderly have also been established. To be referred, in particular, the Support Programme for Social Private Initiative. It aims at financing the establishments of the profitable network in what concerns the improvement of their infrastructures, promoting the training of their human resources and the Programme of Integrated Support to the Elderly⁶. This latter programme has, beyond the projects of domicile nature and of support to dependent elderly people which has it has financed, has promoted training to a set of formal providers, such as: family helpers and other informal professionals and providers, e.g., relatives, neighbours and volunteers rendering daily care to the elderly population. Likewise, and in fulfilment of the principle that the training of human resources who provide care to the elderly people is a fundamental condition for the offer of qualitative services, the family auxiliaries have been the target since 1989, within the ambit of social security, of initial and continuous training regarding theoretic and practical characteristics.

⁶ It is an inter-ministerial Programme which contemplates a set of projects at local development (DAS-Domicile support Services), SCD-Support Centre to Dependent/Pluri-disciplinary centre of Resources and HUMTR-Training of Human resources) and of central development (Tele-alarm service, Health and Senior Thermae and Social passes for Advanced Years

The implementation of a future national plan of integrated continuous cares, which may provide long term cares of social nature and of health cares, will, also, compel the demands of specific and continuous training. Its *curricula* and scientific contents will be normalised by the Institute of Employment and Professional Training and by the Directorates Generals of Health and Social Security. It will, still, incite to the assessment of the quality of the services provided. This evaluation, of a qualitative nature, should be based on the implementation of a continuous and systematic process of monitoring the performances in relation to explicit criteria of good practice. Therefore, two fields of evaluation will be considered:

- a) 'Management and performance area', having as criteria: the reference; the access; the explanation to users; the articulation of the answers and the dissemination and circulation of information.
- b) 'Area of answers', having as criteria: the reception of the user; the individual plans of intervention; the internal ruling; the plan of activities; the management of human resources. The contents of the clinical and social registries and the accomplishment of the admission and discharge criteria.

2.2.3. Challenges

The challenges which are set forth with more acuity in this area:

- a) The setting up of a continuous monitoring process, which may enable to ensure the assessment of providing health cares and social support to elderly people;
- b) The setting up and maintenance of an adequate information system;
- c) The setting up of a manual on the quality in health care and social support to the elderly people, with emphasis on the processes of: leadership; strategy; development of human resources; management of resources, satisfaction of the clients and collaborators; global performance of the organisation and impact on society.

2.2.4. Foreseen Political Changes

The foreseen changes in the context of long-term provision of cares of social nature and of health cares for elderly people are based upon:

- a) the implementation of a national plan of integrated continuous cares, which may cover the needs, territory-wide, both in long term cares of social nature and in health cares (at the domicile and at the medium-long term hospitalisation levels),
- b) in contracting the provision of this type of cares with the social and private sectors;
- c) in the accomplishment of the qualitative criteria of performance and of results, previously established, which will condition the renewing of the contracting.

3.Sustainability

3.1.Health Cares

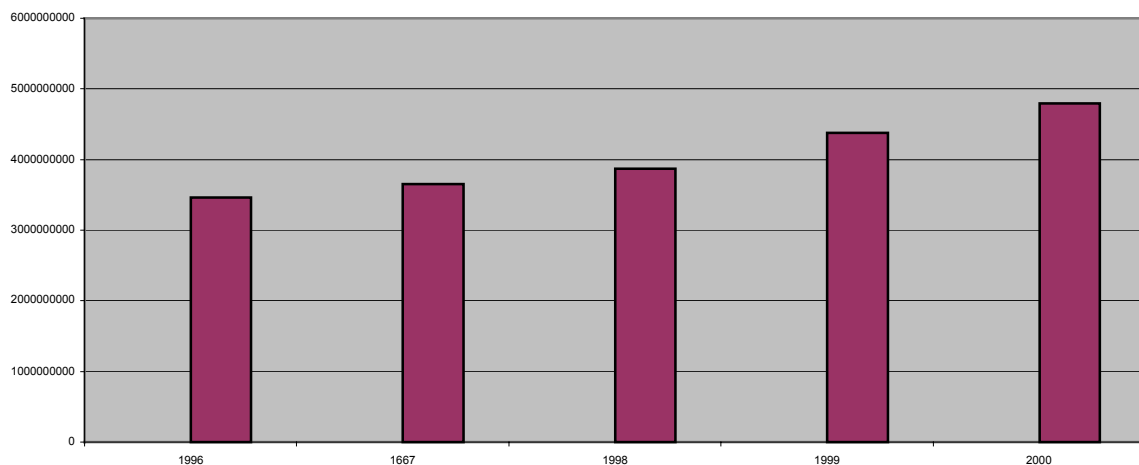
3.1.1.Expenditure and Financing

The expenditure with the NHS have increased during the last years, at the annual average rate of about 10%, having summed up to about 4.7 billions of Euros in 2000. The rise of the number of patients with chronic pathologies has, surely contributed for this growth Among those patients, elderly people are included due to the fact that it is estimated that these diseases and their incapable outcomes are responsible for the consumption of great part of the resources allocated to the health and social security systems.

Relating the NHS expenditure with the total expenses of the State (without investment) and with the Gross Internal Product, it is verified that the percentages, in the annual order of about, respectively, 16,5% and 4,2% have, practically, continued unchanged in the last years. The contribution of the NHS own revenues decreased and has been decreasing in the last years. What may contribute to this situation is the increasing responsibility of the State for the coverage of big risks, which are inherent to the provision of health cares.

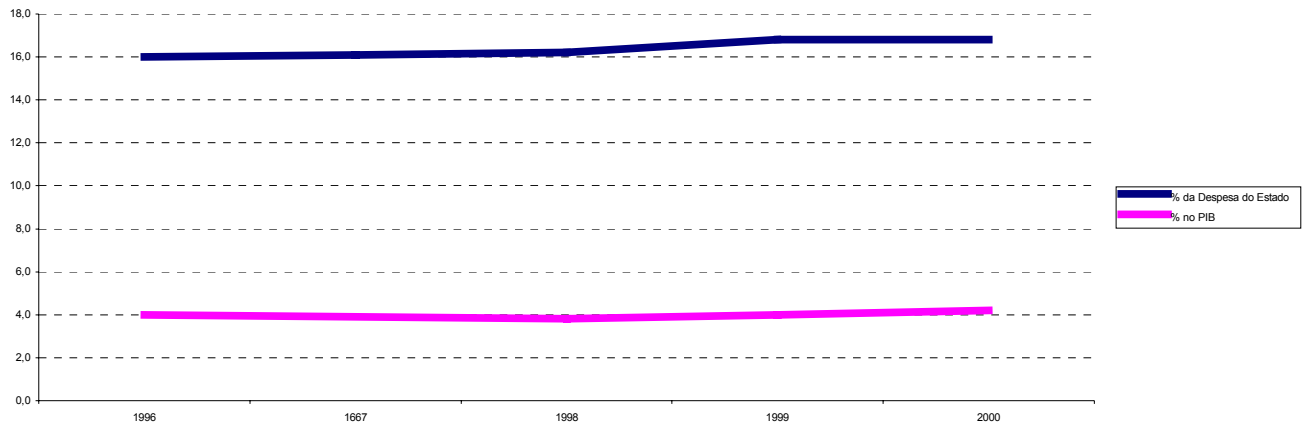
3.1.2. Trends in the area of expenditure

Figure V
Evolution of the NHS expenses
EUROS unit



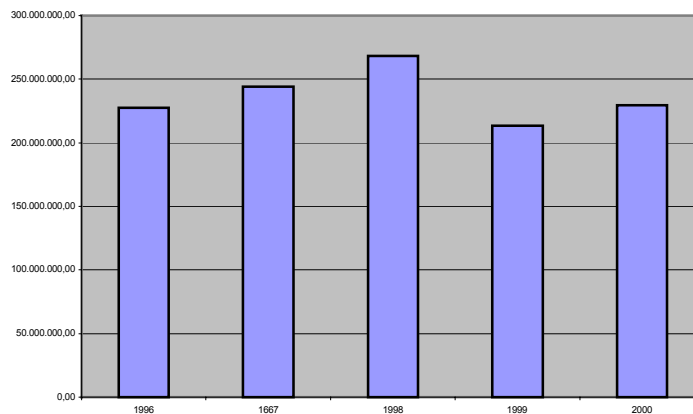
Source: Instituto de Gestão Informática e Financeira do Ministério da Saúde

Figure VI
Percentage evolution of the NHS



Source: Instituto de Gestão Informática e Financeira do Ministério da Saúde

Evolution of the NHS own receipts
EUROS unit



Source: Instituto de Gestão Informática e Financeira do Ministério da Saúde

3.1.3. Mechanisms for Cost Control

The implementation of new mechanisms for cost control derives from the restructure of the health and social security sectors and it implies, in the health sector, of an organisational and management change within the NHS.

The process of changing the traditional model from hospital management to the enterprising model is in progress. It will keep the hospitals in the public scope, although managed on a private basis. The application of this enterprising model enables an effective control of costs and incites to a new collective ruling of work, with the incentive of the professionals, which may easily adapt the remuneration in accordance with established types of tasks.

Thus, one intends to attribute resources to the services according to the effective provision of health cares.

It is, also, in progress the setting up of referral prices regarding the medicines, based upon the intersection for each active substance, among the running prices for the brands, the copies and the generics, with the participation of the State, based on those referral values.

3.1.4. Challenges

It is considered as being main challenge in this area, the adequate re-engineering of the NHS which may ensure its future sustainability, improving its access, equity, effectiveness and efficiency.

3.1.5. Foreseen Political Changes

It is considered as main political changes within this area:

- a) The general implementation of the principle of financing of the of services which provide health cares in accordance with the results obtained, both in qualitative and quantitative terms;
- b) The setting up of a national plan of integrated continuous cares;
- c) The setting up of a national plan for the health of the elderly people, which may define promoting strategies regarding healthy ageing throughout life time, of intervention in terms of adapting health cares to the elderly and the improvement of the professionals' practices in order to have an impact on the relation quality/cost;
- d) The continuation of the implementation of national programmes for prevention and control of the more prevalent and more incapacitating chronic diseases.

3.2. Long Term Cares

3.2.1 Expenditure and Financing

With the functioning of the integrated responses to long-term cares of social nature to dependent persons, it is estimated that in the budget of the Social Security an amount of 1.592.502,07 Euros was spent within 1999-2000. Also, 2.795.373,15 Euros were spent in the investment of projects to be adjusted and in the construction of 'integrated support units' for elderly people

The specific financing of long term cares of social nature for dependent, namely the elderly is, currently, under the exclusive responsibility of the budget of the social security, through contracts-programme with non-profit institutions, on a basis of, families, non-profit institutions and State co-responsibility.

In what respects the budget of the health sector, it is not possible to account for the expenses or estimate costs concerning the provision of cares for the elderly, due to the fact that these dissolve in the rendering of general health cares of the

NHS. In fact, whether the provision of domicile cares or the provision of cares to the elderly during hospitalisation, on a budget basis it is not differentiated.

Nevertheless, one should underline, the scarcity of specific answers in what concerns the long-term cares, whether be it of domicile or hospitalisation natures. When existing in several areas of the Country, they originate from the health centres and the hospitals. However, It is not foreseen the possibility of its development taking place within the isolated context of the NHS. This due to the need of their institutions having to answer to all type of demands and to the limitations imposed by the legislation that rules, not only these institutions, but also the professional careers of those who work there. This fact incites, as already above mentioned the setting up of specific answers, integrated in other sectors.

3.2.2. Cost Control Mechanisms

The different answers regarding long term cares of social nature for the elderly have different and rising costs, according to the cares which are provided in the 'day centres', 'domicile support' or in the 'homes'.

On a yearly basis, plans of activities in the vector of investment and functioning of social answers, at regional and local levels, are set up. They are based upon the identification of the social needs of the more vulnerable groups of the population. Namely, the dependent elderly, through the social networks established in the Resolution of the Council of Ministers no. 197/97, November 18.

This planning meets with the criteria and priorities of sectorial and strategic policy defined by the Government and, once consolidated, it con-substantiates in the approval of annual programme-budgets, which constitute transfers of the State Budget to the social security budget.

By Ministerial Joint Resolution no. 407/98 of the Ministries of Health and Social Security, integrated answers in the area of long term cares to the population on a dependent condition were established. Therefore, it guarantees the articulation and integrated intervention of the health and social action sectors, with gains at the complementary level, avoiding superposition and enhancing the existing resources. The non existence of financial co-responsibility between the health and social security sectors, the insufficiency of the social security co-participation regarding expenses originated from the provision of long term cares, from not making contracts with health resources within the health area which may make up for the insufficiencies of the NHS, has made it difficult for the integrated provision of the cares and the effective functioning of those answers, as well as their implementation and Country-wide coverage.

3.2.3. Challenges

It is considered as being a new challenge in this area, the establishment of innovative answers, financed through a common budget established by the public sector (divided among the health, social security and autarchy sectors)

and private sector (insurance companies, employment sectors, fostered situations and families) on a complementary basis between the solidarity principle of the State and the competitiveness principle as generator of quality and reduction of costs.

These answers will focus on the coverage of the users' needs, among which are those of the elderly people regarding cares on a transitory, long term, and permanent, on hospitalisation, ambulatory and domicile basis with an emphasised rehabilitation vector.

3.2. 4. Foreseen Political Changes

The foreseen political changes are based upon the following fundamental principles, which comprehend the provision of health cares and social support to the elderly people:

- a) integration;
- b) solidarity;
- c) equity;
- d) access;
- e) quality;
- f) dignity of the users;
- g) dignity of the professionals;
- h) humanity.

These changes settle on, essentially, the re-structuring of the NHS and on the re-formulation of the Law of Bases of the Social Security, inciting to, in what regards the health sector:

- a) re-centre the hospitals of the public network in their diagnostic and therapeutic vocations concerning high technical and technological differentiation;
- b) re-centre the health centres in their health promotion, community intervention vocations providing medical cares of generalist ambit on a 24 hour round basis;
- c) set up contracted or settled upon services, destined to acutely chronic and dependent situations which need recuperation or long term maintenance, at the domicile or hospitalisation levels on a medium and long term duration, inserted in a national plan of continuous cares.

