An Overview of In-Home Care for Older People in Portugal: An Empirical Study About the Customers

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Background: *The Portuguese in-home care services have never been adequately studied or identified. This is because of the lack of classification of variables related to the care receiver and to the demographic and organizational context in which it is inserted.*

Methods: *The 126 organizations in the central region of Portugal were categorized into four groups depending on whether they were located in a rural or urban environment and on whether they were large or small organizations. To obtain information, the In-Home Care Protocol (ProSAD), Elderly Assessment System (EASYcare), and the Center for Epidemiologic Studies–Depression (CES-D) scale were applied to 48 customers (6 randomly chosen customers of in-home care services of each of the 8 randomly selected organizations, 2 per group of variables).*

Results: *The rural context denoted a lack of diversity of services and the number of organizations available is reduced, which implies less time spent with the customers. The more dependent customers at the time of registration (Kruskal–Wallis test [KW] = 12.79; $p < .05$) in large organizations (Mann–Whitney [U] = 190.5; $p < .05$) benefit more from the services.*

Conclusions: *In-home care services are underused and are oriented to treat those that have a family caregiver. Overall, in-home care in Portugal still has much to achieve when compared with other European countries.*

Keywords: in-home care; social services; older adults; informal caregiver

The availability of formal care services for dependent older people in the community varies substantially across nations (Larson, Silverstein, & Thourslund, 2005). Specifically in Europe, in-home care services are very different from one country to another (Ranci & Pavolini, 2007).

The empirical studies and publications that focus on in-home care services are recent. Currently, there are extensive articles that evaluate in-home care in countries like Spain (Tornero, 2000), articles that analyze in-home care from the point of view of consistencies/inconsistencies (e.g., Sharkey, Larsen, & Milton, 2003), and articles that consist of reviews focusing on effectiveness in a specific country like Japan (Ogawa, 2006). There are no studies about in-home care in Portugal, but these services are nonetheless important.

The in-home care service in Portugal is a social response that facilitates access to basic services for persons in dependency situations. Examples of these activities of daily living (ADLs) supportive services are meals-on-wheels, personal care (e.g., daily hygiene and comfort procedures), housekeeping services, accompaniment to the outside (e.g., medical appointments, shopping), and assistance in other areas such as control of the medication intake. Organizations can also provide physiotherapy services at home, primary health care, and entertainment, considered as specific answers to the older adults who live at home (Bonfim & Veiga, 1996). Nevertheless, by definition, medical and nursing care are not included in basic services that are typically provided (Santana, Dias, Souza, & Roch, 2007).

The definition of the care plan is based on the balance among the apparent needs of the older adult, that person's ability to contribute (part of service is paid by customer taking into account the analysis of income), the consumer interest (services that the older adult agrees to receive), and responsiveness of the organization. Assessing case eligibility depends on eligibility criteria established by Social Security and others that can be defined by the organization if it is appropriate. These criteria include the risk of isolation, social emergency situation, geographic proximity, lack of informal caregiver, or the lack of nearby response that better addresses the older adult's needs. Referral to these services may be made by the older persons, their relatives or significant others, community, and other organizations such as health services.

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The definition of the care plan is based on the balance among the apparent needs of the older adults, that person's ability to contribute (part of service is paid by customer taking into account the analysis of income), the consumer interest (services that the older adult agrees to receive), and responsiveness of the organization.

In-home care services as well as, basically, the entire social sector activities in Portugal, are normally performed by nonprofit organizations and financed almost exclusively by the state (Franco, Sokolowski, Hairel, & Salamon, 2005). There are no official figures about how much the Portuguese state spends on in-home care, but it is possible to estimate an amount. Approximately 77,353 older people receive these services, and each one costs the state €224.56 (US$350.30 for only one or more services provided in in-home care) per month (Ministry of Labour and Social Security, 2006). Therefore, we can infer that the approximate total monthly cost is €17,370,389 (US$27,099,544). In the Portuguese context at the time of the study, the state financed the organizations equally, paying per customer of in-home care rather than per provided services. In 2005, 4.12 older adults (of 65 years of age or older) in every 100 received in-home care services (Martin, Neves, Pires, & Portugal, 2006). The coverage rate is low compared to Nordic countries such as Denmark (24.60%), Finland (10.70%), Iceland (18.90%), Norway (15.70%), and Sweden (8.20%; Nordic Social-Statistical Committee, 2002), but it is higher than the rate in Spain (3.14%; Ministry of Labour and Social Security, 2006).

This study aims to analyze the most important aspects of the in-home care services that exist in Portugal by using a carefully developed sample and by controlling the factors that can influence care services beforehand. Firstly, the results review the profile of the receivers of care and of the informal caregivers; secondly, they review services from the customers' perspective, such as the time spent caring for each one.

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METHODOLOGY

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Sample and Procedures

The sample was collected to be representative of the diversity of in-home care services developed in Portugal. According to Spanish studies, there are two variables that can have an influence on the type of services that customers of in-home care can profit from. These variables are the total number of customers who each service is capable of caring for and whether the context is urban or rural. Both variants were simultaneously controlled in this study (Institute for Migration and Social Services, 1998).

A list of all in-home care services available and of the number of customers in each service was obtained from the Ministry of Labour and Social Affairs (2005). The sample was collected from 126 organizations located in the Centre of Portugal. The average number of customers was 25. Therefore, in this study, those services with 25 customers or more were considered large organizations, and those with less than 25 customers were considered small organizations.

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The database of National Statistical Institute (Statistics Portugal, 2006) classified the in-home care organizations depending on whether they were situated in an urban or rural environment.

The data were categorized into four groups, classified by size and setting: Group I—large and urban organizations (52 organizations); Group II—small and urban organizations (65 organizations); Group III—large and rural organizations (2 organizations); and Group IV—small and rural organizations (7 organizations). For study purposes, 2 organizations were randomly chosen from each group.

In the management model of in-home care services, each organization is responsible for responding to a specific geographic area. Thus, it is important to determine which environment is covered by the organization and what implications this has on the provided services.

This study with data collection from social services does not require approval by an ethics committee. The project was approved by the Health Department of the University of Aveiro (Escola Superior de Saúde da Universidade de Aveiro [ESSUA]) and by the Research and EWAS requested from each organization. The protocol was applied to 6 randomly chosen customers of in-home care services from each of the 8 included. It was therefore applied to 48 customers ($N = 48$). All selected customers agreed to participate voluntarily in the study after being informed of the procedures for data collection.

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After contacting each organization and randomly selecting the customers, the information required was gathered in the customers' homes, guaranteeing their confidentiality.

Assessment Tools

In-Home Care Protocol. This study took into account specifically the methodologies described by Doyle (1991) to evaluate care services for older people. A protocol that gathered three

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different methodologies was developed. Thus, the data collection was guaranteed through (a) a structured assessment protocol, (b) a criterion-guided assessment (composed by a list of criteria that define the aspects of care that are important), and (c) selected key indicators, which are assumed to reflect the level of quality of care found in other unmeasured areas (a compilation of the different items that pertain to the in-home care services). The protocol was named In-Home Care Protocol (ProSAD; Martin, Oliveira, & Cunha, 2006) and was applied by two researchers who have been subjected to two training sessions on implementation of the survey. This training aimed to homogenization of the data collection. The characteristics of the customers and of their informal caregivers as well as the type of services available for these customers (Table 1) are some examples of the items that were identified. The protocol is exclusively composed of items requiring a direct answer by older adults and their caregivers.

The protocol was developed to be applied with Elderly Assessment System (EASYcare) for the evaluation of functional capacity, and the Center for Epidemiologic Studies–Depression (CES-D) scale for the evaluation of depressive symptoms, which will subsequently be explained. The data derived from an application of the CES-D were not analyzed in this study.

Elderly Assessment System. The EASYcare was developed to evaluate each older individual's awareness of personal social and health needs (Philp, 1997). It was adapted by 15 countries of the European Union. The instrument was validated in Portugal by Sousa and Figueiredo in 2000. EASYcare consists of nine subscales to characterize the older person, namely (a) physical disability (4 items), (b) the customer's perception of quality of life (3 items), (c) functional dimension (6 items), (d) mobility (6 items), (e) personal care (3 items), (f) bowel and bladder control (2 items),

TABLE 1. Characteristics of the Parameters Evaluated in the In-Home Care Protocol

Evaluation of the Client				
Sociodemographic				
Sex	Marital Status	Residence	Age	Education
Social support network				
Number of children	With whom does client live?	How close is the relationship?		
Economic situation				
Profession	Income			
Housing situation				
House	Room	Bathroom		
Dependency level when in-home care began				
Characterization of In-Home Care				
General information regarding the service				
Time of use of the service	Reason for the request			
Services provided to aid in activities of daily living				
Periodicity	Number of daily hours			
Characterization of health services				
Medical services	Nursing services			
Characterization of other services				
Telealarme system	Technical aids	Training for informal caregivers	Housing adjustment	
Characterization of the Primary Caregiver				
Biographical data				
Sex	Age	Marital Status	Education	
Social/economic situation				
Employment situation	Earnings	Individuals that are part of the household		
Characterization of the care				
Number of people that caregiver cares for	Type of care	Periodicity		
Relationship between the older adult and the caregiver				
Kinship	Proximity of residence	Social contact		

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Nevertheless, the absence of a cutoff point for each construct defined in EASYcare led to the need to adopt a simple strategy to establish the median observed in the sample as the cutoff point.

(g) disability (16 items), (h) depression (4 items of the Geriatric Depression Scale), and (i) cognitive impairment test (6 items).

From the subscale 1 to 6 (comprising 24 items), the maximum score is 100 points; the higher scores indicate greater disability. In subscale 7, 1 point is assigned for each symptom of depression, and a score of 1 point or more suggests the need for a better evaluation of the construct. In the test of cognitive impairment (maximum score of 28 points), a final score between 11 and 28 points indicates a moderate or severe decrease in cognitive ability.

In Portugal, EASYcare has been useful to develop various studies dealing with the older adult population (Sousa, Galante, & Figueiredo, 2002, 2003). It was considered a reliable tool (Sousa et al., 2003). Nevertheless, the absence of a cutoff point for each construct defined in EASYcare led to the need to adopt a simple strategy to establish the median observed in the sample as the cutoff point.

Center for Epidemiologic Studies–Depression Scale. The CES-D was developed by Radloff (1977) and is normally used in epidemiological studies about symptoms of depression in the general population. The success rate in evaluating symptoms of depression has been remarkable in diverse samples of the community (Knight, Williams, Mcgee, & Olaman, 1997), especially to evaluate possible symptoms of depression in informal caregivers (e.g., Neundorfer, McClendon, Smyth, Strauss, & McCallum, 2006). Fagulha and Gonçalves (2001) adapted a version of this scale for Portugal. This study followed the cutoff point proposed by the cited researchers (Fagulha & Gonçalves, 2001).

Methodology of Analysis

To prepare for the current analysis, all data were exported to Statistical Package for the Social Sciences (SPSS; SPSS, Inc., 2008), band encoded in the same database. A grid that added data from the three instruments was developed for the data analysis, and different variables were defined. These were the description of the type of care received by customers, the presence or absence of a caregiver (to identify if there was a link between the formal caregiving of in-home care and informal care giving), and the type of services provided by in-home care analyzed in relation to the different variables of context (rural vs. urban or large organizations vs. small organizations) and the characteristics of the receivers of care and their informal caregivers. The variable used was divided according to the services available, namely food services and others. This division also exists in other European countries such as Sweden (Larson et al., 2005) and in some areas of Spain where these services are independent (Institute for Migration and Social Services, 2007).

Nonparametric tests were employed to analyze in-home care in terms of type of services received, time spent in direct service delivery, and the period for which the older adults keep in-home care services. These have a similar distribution between the context conditions where service takes place (compared to care context variables, functional variables, and social network variables). Mann–Whitney (U) for the analysis of continuous variables or the Kruskal–Wallis test (KW) for the analysis of variables with more than two levels, such as the variable "level dependency," were applied to analyze the statistical relationship between two independent variables. Nonetheless, for the analysis of correlation between nominal variables (e.g., the type of provided services and functional variables), the chi-square test (χ^2) was applied. These comparison relations were analyzed with a criterion of $p = .05$ to determine potential significant effects.

RESULTS

Characterization of the Receivers of In-Home Care and of the Informal Caregivers

Most older adults who receive in-home care are male (33 out of 48 customers = 68.8%). Fewer females have a caregiver. The average age is high ($\dot{X} = 78.8$, DP = 9.8); but in the case where a caregiver is available, the average age decreases ($\dot{X} = 76.7$, DP = 8.2). The number of married customers ($N = 48$, $n = 18$, 37.5%) and widowers ($N = 48$, $n = 17$, 35.4%) is significant. Most has low literacy levels (62.5% and have spent less than 4 years at school; Table 2).

The primary caregiver of the sample ($N = 48$, $n = 19$) is mainly female ($N = 19$, $n = 11$, 57.9%), married ($N = 19$, $n = 11$, 57.9%), and their average age is high ($\dot{X} = 64.38$, DP = 13.59). Of the total number of caregivers, 11 completed fourth grade (57.9%).

who receive in-home care normally maintain family relationships with their children ($n = 6$, 31.6%) and spouses/partners ($n = 5$, 26.3%). A significant number of caregivers previously lived ($n = 13$, 68.4%) or presently live ($n = 14$, 73.7%) with the older adult they take care of.

More than half of caregivers ($n = 14$, 73.7%) spend more than 5 hr a day taking care of the older adult. This becomes a big burden, and most ($n = 13$, 68.4%) emphasizes the need for the assistance of a secondary caregiver. At the time of evaluation of depression symptoms among the informal caregivers ($n = 15$), only one presented risk of depression (CES-D ≥20).

The older adults seek in-home care especially when they suffer from a physical disability/dependency ($n = 23$, 52.3%).

TABLE 2. Sociodemographic Characterization of the Receivers of Care ($N = 48$)

	Total		Presence of Caregiver		Absence of Caregiver	
Sociodemographic Variables	*n*	%	*n*	%	*n*	%
Sex						
Male	33	68.8	19	57.6	14	42.4
Female	15	31.3	6	40.0	9	60.0
Age X (DP)	78.8 (9.8)		80.6 (10.6)		76.7 (8.2)	
Marital status						
Single	8	16.7	4	50.0	4	50.0
Married	18	37.5	10	55.6	8	44.4
Widow	17	35.4	9	52.9	8	47.1
Divorced	5	10.4	2	40.0	3	60.0
Level of education						
Primary school incomplete[a]	30	62.5	16	53.3	14	46.7
Primary school[b]	15	31.3	7	46.7	8	53.3
Preparatory school[c]	1	2.1	1	100.0	0	0.0
Vocational education[d]	1	2.1	0	0.0	1	100.0
University education[e]	1	2.1	1	100.0	0	0.0
Geographical mobility						
Birth place = Residence	40	83.3	20	50.0	20	50.0
Birth place ≠ Residence	8	16.7	5	62.5	3	37.5

[a]Less than 4 years of school.
[b]4 years of school.
[c]6 years of school.
[d]Up to 12 years of school.
[e]More than 12 years of school.

This percentage increases among those who have a primary caregiver (73.9%).

People also seek these services because they are not capable of preparing their own meals ($n = 12$, 27.3%). The percentage increases among those who do not have a caregiver (83.3%).

The results are not surprising, considering the profiles of the receivers of care and of the informal caregivers. Nonetheless, the caregivers spend a great part of their day caring for the older adults, even when the latter have access to in-home care.

Characterization of the Type of In-Home Care Carried Out

Meals-on-wheels is the most requested service ($n = 21$, 43.8%) followed by personal hygiene ($n = 10$, 20.8%). Some customers do not receive any type of personal care (e.g., personal hygiene; $n = 6$, 12.5%). More than half of the receivers of care do not receive housekeeping ($n = 17$, 35.4%).

Nonetheless, the caregivers spend a great part of their day caring for the older adults, even when the latter have access to in-home care.

The customers who enjoy the most from personal care live in an urban context, are younger than 74 years of age (51.9%), are more dependent in terms of mobility and personal hygiene, or are considered completely disabled, which proves to be the reason that those who have a primary caregiver have a closer connection with in-home care services (Table 3).

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TABLE 3. Relationship Between the Type of Services of In-Home Care, the Time Spent and the Period in Which the Older Adult Keep In-Home Care Services With the Context of Care, the Functional Characteristics, and the Characteristics of the Social Network

	Type of Services[a]	Time Dispensed	Period[b]
Demographic context (Urban/rural)	$\chi^2 = 4.10$, $p = .04$ | Urban		$U = 136.00$, $p = .01$ | Urban
Institutional context (Large/small)		$U = 190.50$, $p = .04$ | Large	
Sociodemographic characteristics			
Gender			
Age	$\chi^2 = 7.25$, $p = .03$ | <75 years		
Marital status			
Level of education			
Income			
Functional characteristics			
I. Level of dependency when in-home care began (three levels)		KW = 12.79, $p = .002$ | 3rd > 2nd > 1st	
II. EASYcare			
Physical disability *(CP = 1)*			
Functional dimension *(CP = 10)*		$U = 166.5$, $p = .01$ Level 2[c]	
Mobility *(M = 9)*	$\chi^2 = 10.24$, $p = .003$ | Level 2	$U = 89.0$, $p = .00$ | Level 2	$U = 156.5$, $p = .05$ | Level 2
Personal care *(M = 6)*	$\chi^2 = 11.52$, $p = .001$ | Level 2	$U = 120.0$, $p = .00$ | Level 2	
Bowel and bladder control *(M = 0)*		$U = 134.5$, $p = .002$ | Level 2	
Complete disability *(M = 25.5)*	$\chi^2 = 10.24$, $p = .003$ | Level 2	$U = 125.5$, $p = .00$ | Level 2	
Geriatric depression scale *(M = 1)*			
Quality of life perceived *(M = 1)*			
Characteristics of the social network			
Lives alone			
Presence of a primary caregiver	$\chi^2 = 5.25$, $p = .02$ | Yes	$U = 175.0$, $p = .02$ | Yes	
Presence of a secondary caregiver			

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U = Matt–Whitney test statistic; KW = the Kruskal–Wallis test; EASYcare = Elderly Assessment System.
[a]Other types of care (with or without meals).
[b]In months.
[c]Level 1 means < dependency (score less than the median); level 2 means > dependency (score equal to or greater than the median).
M = the median value from which was emerged the cutoff point set for considering a nonproblematic or problematic situation.

An average of 2.44 hr a week are spent on household chores (DP = 2.3). This is insufficient when compared with other countries. Studies from England consider 11 hr/week to be inadequate (Netten & Forder, 2007); in Spain, the time spent in housekeeping is 3.9 hr/week (Ministry of Labour and Social Affairs, 2005).

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Customers who are enrolled in large organizations and are more dependent at the time of registration benefit more from the services. The greater the customer's dependency level (in terms of functionality), mobility, personal hygiene, bowel and bladder control, or in cases of total disability, the greater number of hours

The greater the customer's dependency level (in terms of functionality), mobility, personal hygiene, bowel and bladder control, or in cases of total disability, the greater number of hours spent caring for these customers.

spent caring for these customers. Those who have a primary caregiver benefit even more from in-home care.

AQ10 The average time that customers benefited from in-home care was 41.3 months (DP = 37.4). The highest average was when an informal caregiver was available ($\bar{X}$ = 44.6, DP = 40.0). The duration of in-home care is higher among people in the city and among those that are more dependent when it comes to mobility.

Customers primarily obtain personal care services, and only a small number has housekeeping services. Therefore, we can assume that most of the time is spent providing personal care.

DISCUSSION

Some of the most relevant characteristics about in-home care services in Portugal have emerged in the preparation of this article, which brings up new issues about the role of in-home care in a long-term care system.

It was verified from the variety of services available that very few are used appropriately (poor provision of services that would be important to meet the needs of the older adults), except for the meals-on-wheels service (n = 22, % = 45.8). Nursing care or, more specifically, services such as readapting to the physical environment, are scarcely requested. Hence, in-home care services are underused. The average time spent daily in caring services (M = 20 min; minimum = 5 min, maximum = 125 min) also reflects the low intensity of these services.

Three variables identify whether the in-home care services are provided appropriately. It depends on the customers' profile; the type of context, rural or urban; and the size of the organization.

Firstly, most of those who receive in-home care do not seem to have difficulties with their daily living activities currently or in the near future. When in-home care provides personal care services—such as hygiene, getting dressed, and mobilization—only the older adults with informal caregivers benefit from these services (ad hoc). The older adults with higher levels of dependency are normally supported by people that belong to their social network, even if they benefit from in-home care (Emlet, 1996), and the results of this article corroborate this fact.

Secondly, the customers who live in a rural context normally benefit only from the meals-on-wheels service. This can be explained because in-home care developed in a rural environment ends up being more expensive to carry out because of the distance among residences.

Thirdly, there is a relation between the size of the organization and the intensity of the average time spent on different services (M = 32.5 min in large organizations compared to M = 5.0 min in small organizations), possibly because large organizations have better conditions to treat older adults who are more dependent. Consequently, large organizations have more dependent older adults belonging to the list of the receivers of in-home care.

For the most part, in-home care is oriented to treat those that have a family caregiver. When older people do not have an informal caregiver, or are at a high stage of disability, they eventually end up in nursing homes. In 2006, 3.60% of the Portuguese older adults (65 years of age or older) lived in nursing homes (Ministry of Labour and Social Security, 2006). This is not a high average in comparison to other European countries (e.g., France with 6.70%), but it was considered high when compared to in-home care coverage levels (4.30% of in-home care). Moreover, the Portuguese and Spanish situation is similar because both countries have low coverage levels (3.77% in nursing homes, 3.14% in in-home care).

With a reduced sample, even though randomly chosen, and without other empirical studies to allow comparison of results, the development of new studies about this reality in Portugal becomes fundamental. Furthermore, it is difficult to understand the real performance of in-home care without the development of transversal studies to research more in depth the performance of other organizations, namely nursing homes.

Limitations

There are three main limitations in this study. The first is related to the reduced sample (random selection of organizations in the north region of Portugal). Although effort was made to ensure the randomness of the sample, the data (N = 48) ensured did not allow the use of statistical analysis initially set.

The second is related to the peculiarities of in-home care in Portugal, specifically in terms of funding of social responses, the types of services that are typically available, and the way they are made available to customers. This presentation of in-home care invalidates the comparability with external contexts. The third, although it is a fact that the organizations that provide in-home care select the older adults who will receive services, the study cannot explain in detail the reasons behind this scenario. Further studies are needed for a detailed analysis of factors affecting the provision of services.

The results of this study are important in the practice of care in responses such as in-home care to identify the strengths and weaknesses of the relationship among the dynamics of organizational

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management, the provision of services, and older adult's needs. This article alerts us of the failure in the profitability of social responses. Services such as in-home care often provide care not appropriate to the customer's needs, such as the time spent in care and daily monitoring.

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