Gulbenkian Home Care

Outcomes and impact
of the pilot phase

CALOUSTE GULBENKIAN
FOUNDATION

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Project “Sorrisos ao Domicílio”. © Absolutauge

Gulbenkian Home Care is an initiative focused on improving care for older people in their own homes. The initiative supports community-based projects that help individuals remain active and independent for longer through integrated care, tailored support plans, and continuous follow-up provided by skilled professionals while respecting the rights of older adults.

In line with the United Nations recommendations for the Decade of Healthy Ageing (2021–2030), the Gulbenkian Home Care initiative aims to tackle the unequal access to home care services for older people in Portugal.

The first phase of the Gulbenkian Home Care initiative supported the implementation of 15 pilot projects across mainland Portugal and the Autonomous Regions. Led by a diverse range of organisations, the projects received financial and technical support from the Calouste Gulbenkian Foundation, support and capacity-building from MAZE Impact, and evaluation by the Centre for Health Technology and Services Research (CINTESIS), through the School of Medicine and Biomedical Sciences of the University of Porto (ICBAS.UP).

The initiative is currently in its second phase – Gulbenkian Home Care 2.0 – continuing to invest in local networks and in care models adapted to the needs of people and their communities, now with greater involvement from the health sector.

More than 250 professionals and around 150 lead and partner organisations are contributing to Gulbenkian Home Care 2.0, all playing an essential role in implementing 17 projects across mainland Portugal and the Autonomous Regions. Fourteen of these projects are led by private charities (IPSS - *Instituições Particulares de Solidariedade Social*), with the remaining three coordinated by Local Healthcare Units (ULS - *Unidades Locais de Saúde*).

In this phase of the initiative, MAZE Impact is supporting participating organisations through a capacity-building programme, while RISE-Health/University of Porto is conducting the external evaluation of both the projects and the initiative as a whole.

The outcomes and impact of Gulbenkian Home Care will be shared in October 2027.

This booklet collates some of the most relevant findings and insights from the initiative’s final and follow-up external evaluation reports, carried out by CINTESIS/ICBAS.UP (team: Constança Paúl, Soraia Teles, Sara Guerra, Oscar Ribeiro and Sofia Medeiros; scientific support from Matilde Jóia), as well as from the technical and financial implementation reports submitted to Calouste Gulbenkian Foundation by the projects. More information about the project participants and the outcomes of the initiative can be found in the publication *Gulbenkian Home Care: Innovation in Home Care Services for Older People*.

New models of care in an ageing Europe: local actions, national responsibilities, global challenges[1]

Alexandra Lopes

Rute Lemos

Introduction

This text offers a background for the discussion on new models of home care in the context of long-term care, in Portugal, taking as its starting point the Gulbenkian Homecare Meeting (December 2025). Although the tone of the session was celebratory, marked by the presentation of innovative projects, the event served as a moment of reflection on the challenges of caring for older people with social and health needs. Although focused on the national reality, the projects presented reflect risks and pressures common to several European countries. In this text we identify and address some of those risks and pressures.

1 This text has been produced as part of research carried out by the LeTs-Care consortium: Learning from Long-Term Care Practices for the European Care Strategy, funded by the European Union under the Horizon Europe Programme and through Contract No. 101132701. Its aim is to study effective and replicable long-term care solutions, bringing together teams from seven European countries.

Growing care needs in an ageing Europe

Europe has been ageing, although at different rates and intensities across countries. This phenomenon is linked to increased longevity which accounts for the steady growth of the absolute number of older people. Estimates suggest that in the European Union (EU), the 26.6 million people aged 80 or over in 2020 will rise to 49.9 million in 2050 (Source: Eurostat, Population projections database). These data are relevant in view of the clear age gradient in the distribution of people with functional limitations due to health and frailty. In other words, the growth in the absolute number of older people will tend to be accompanied by an increase in social support and healthcare needs. The magnitude of this phenomenon will depend largely on the ability to prolong years of life in good health. In this area, Portugal faces significant challenges: in 2022, life expectancy at age 65 was around 21 years, of which only about 8 were expected to be lived in good health (Eurostat, 2022, hlth_hlye). This gives an idea of the foreseeable burden of care needs that will result from the growth in the absolute number of older people. This line of argument then leads us to ask how these support needs are being met. We will address this in the next section of this text.

How are social care systems organised in Europe?

Long-term care systems in the EU vary in terms of funding, how they are organised and the types of care available. This diversity reflects different historical trajectories and different views on collective responsibilities in supporting those in need: Who pays? Who is entitled? How are responsibilities shared?

We have systems based on strong public provision of services with universal access dependent solely on the existence of a need and without payments by the user (or with very low co-payments) (e.g. Denmark). We have systems where public provision is combined with cash transfers, in particular through the use of personal budgets (e.g. the Netherlands). We also have systems financed by compulsory social insurance, of a contributory nature, designed to ensure the State's financial capacity to pay for care (e.g. Germany). At the service provision level, there is also a diverse range of configurations. While in the Nordic countries there is a strong public presence in service provision, in conjunction with local authorities, in Southern Europe we have a model of partnership between the public sector (which provides funding) and the social solidarity sector (which provides the service). In countries where care systems are still limited in coverage, informal provision (by family members) and commercial provision end up playing an important role (e.g. Portugal, Italy, and Lithuania). This mix also extends to the range of care services. Some countries opt to award monetary subsidies (e.g. dependency allowances, subsidies for carers, personal budgets), transferring the organisation of care to the individual, which tends to boost the commodification of the sector. Others opt for the direct provision of services, with varying degrees of institutionalisation and integration between personal and health care. In other words, a diversity of models that gives rise to a fragmented Europe in terms of both the capacity to respond to needs and the type of responses.

We have EU countries at different speeds and at different stages of maturity in their long-term care systems. A first group faces a problem of quantity - with low utilisation and likely pressures for rapid expansion of capacity. These are countries with a structural dependence on informal care, and which have expanded formal care more recently, mostly in the form of institutional care within the social assistance framework (e.g. Portugal). A second group has higher utilisation rates and less recourse to institutionalisation, typical of more mature community-oriented care systems. There is an emerging third group that combines high utilisation with signs of re-institutionalisation, possibly associated with an increase in dementia (e.g. France, Denmark and Finland). Given this fragmented institutional landscape, it is essential to identify common elements that will enable progress to be made on the agenda of promoting accessible, high-quality care for all, a theme that frames the recent developments in European public policy discussed in the following section.

Principles and commitments of a European vision for social support systems for dependent older people

The European political discussion on long-term care systems for older people has developed within the typical framework of soft policy, an expression used to designate an area in which the EU has no binding powers, with Member States remaining responsible for policy design and implementation. The role of the European institutions focuses on producing strategic guidelines, promoting common principles and mobilising technical and financial support instruments. Over the years, there have been numerous reports and calls for attention from European institutions, but only now are we beginning to see a clearer action plan emerging at EU level, with objectives and resources for its implementation. These initiatives make it possible to identify the underlying trends that will ultimately influence national agendas for the expansion and reform of care systems.

The Covid-19 pandemic has given a boost to this whole process by exposing structural weaknesses in care systems across Europe. Article 18 of the European Pillar of Social Rights enshrines the right of access to quality and affordable care, a principle reinforced by the European Care Strategy (2022). This strategy presents an integrated vision of the organisation of care and is accompanied by initiatives and instruments to support the desired transformation and reform: flagships for technical support, partnerships for knowledge and transformation, dedicated funding lines, whether under the structural funds or the social fund.

The elements of the European vision are discussed as fundamental principles, which are intended to be incorporated into national systems, naturally taking into account local specificities, but in any case, recognising and preserving essential matters to which these principles refer.

- Prevention is a critical aspect to consider both for the financial sustainability of the systems and for the continued residence of people in the community. Investment in early adaptations to living environments, individualised interventions and rehabilitation have proven effective in some countries, in contrast to systems that are overly focused on replacing lost intrinsic abilities. Our National Network for Integrated Continuing Care was created with this spirit in mind, which should be further developed and expanded.

- Another area requiring reform is needs assessment. Within the framework of European guidelines, two aspects of the process stand out as disruptive in relation to established practices in many national contexts: assessment must be person-centred to leverage individual support plans and must be carried out by bodies independent of the direct service provider.

- Another issue that causes discomfort in some national contexts is deinstitutionalisation. The European framework affirms the right to live in the community, prioritising the expansion of local services that promote inclusion and social participation. It is urgent to rethink not only the models of care services provision that involve institutionalisation but, more importantly, the cultures of care typical of this organisational model.

- Another buzzword present in almost all guidance documents is integration. The integration of health and personal/social support domains is particularly challenging, requiring reforms in financing, needs assessment, professional profiles, quality and information management.

- Then there is the issue of technology and its use to enhance the coverage and quality of care, especially in less populated regions or in contexts of greater clinical complexity where regular (remote) monitoring can facilitate the organisation of visits, increase user safety, aid rehabilitation and autonomy, and facilitate information management processes.

- There is consensus on the need to ensure quality care, but what is quality? No Member State has a formal definition of what constitutes good quality care, which translates into diverse and inconsistent quality measurement tools. There is some consensus on the importance of using outcome indicators related to a person's quality of life, but also indicators that reflect the principles of person-centred care (e.g. self-determination, autonomy, freedom of choice, privacy, safety). The development of comparable indicators, including so-called soft indicators, is under discussion within the EC's Social Protection Committee. The desire to produce regular data is welcome, not least because it has the potential to highlight trends that force Member States to move in the desired direction.

- A particularly sensitive issue is that of dementia, given the insufficient preparedness of current systems to respond adequately. There are signs of re-institutionalisation in countries that had previously promoted deinstitutionalisation, a phenomenon associated with the increase in the number of people with dementia. This dynamic highlights the need for holistic approaches to care systems that promote the development of dementia-friendly communities.

- Then there is the issue of end-of-life care. Despite the widespread preference for dying at home, there has been an increase in deaths in institutional settings. This is a challenge, but it is certainly a consensual guiding principle that should also be included in the guiding charter for the reform of care systems.

- Finally, a mention of the commitment to support informal carers. There is much discussion about the economic value of informal care, as well as the costs of informal care (addressed mainly in the context of the labour market). Any change in the responsiveness of informal care will have an impact on the demand for formal care. It is therefore necessary to look at informal care more seriously: financial compensation, training, support, respite for carers, integration, quality assessment.

This is a demanding, ambitious framework, focused on people, their quality of life and their fundamental rights. It is a framework that confronts us with challenges that are common to the whole of Europe, but which are particularly complex and demanding in some countries. This is the case in our country. We will address these challenges from a national perspective in the last section of this text.

The major challenges for ensuring equity in access to quality care for all older people in a Europe for all and with all

Firstly, we highlight the challenge of quantity: increasing coverage, reaching everyone, avoiding territorial inequalities, and ensuring equity in access. The field of long-term care for older people continues to present coverage difficulties, often pushing people to purchase services on the commercial market. Access to care provision in the private market will encounter more and greater barriers to access for financial reasons. Across Europe, financial reasons remain the main reason for non-use or under-use of home care services. This means that there is unmet demand and a need to increase response capacity.

However, it is not just a question of expanding in terms of quantity; we also face the challenge of quality. Expansion should not be based on standardised formats that favour quick responses, particularly through institutionalisation. The aim is to promote quality care, focused on the community and the individual, based on their life contexts. This is precisely the relevance of the meeting promoted by the Calouste Gulbenkian Foundation, which gave rise to this publication. Care focused on the individual's home environment should be the priority.

But quantity and quality cannot be achieved without a workforce that is sufficient in number and qualified. In 2020, around 6 million people worked in the care sector in the EU, representing approximately 3% of the workforce, mostly women, often in demanding conditions, with low recognition and poor career prospects. Reinventing care work, valuing it, dignifying it and rewarding it is a fundamental pillar for attracting professionals and ensuring a return on investment in training. This process will require an increase in public investment, leading to the challenge of financial sustainability.

There is significant diversity across Europe in the mobilisation of public resources, with countries such as Portugal having expenditure levels well below the average. Growth in quantity and quality will require greater investment and a serious discussion on financing mechanisms in order to ensure adequate coverage and equity. The picture that emerges is demanding and requires political courage, clarity in public debate and the building of broad consensus beyond government cycles. Change will be marked by tensions and resistance associated with vested interests and entrenched practices, but it is possible, as demonstrated by the projects presented at the Gulbenkian Homecare Meeting.

Conclusions

Debates such as the Gulbenkian Homecare Meeting show that the transformation of the sector depends not only on quantitative expansion, but also on a redefinition of care work, an emphasis on prevention and rehabilitation, and deinstitutionalisation. The integration of health and social care, investment in new technologies and the recognition of the role of informal carers are key elements in this process. However, the path ahead will not be easy: it will require political will, structural reforms, increased public funding and, above all, a cultural change that involves society as a whole.

It is with great anticipation that we accept to participate in discussions such as this Gulbenkian HomeCare Meeting, where the voices of people who have in-depth knowledge of these issues in their daily lives and difficulties are heard, and who can help us imagine ways to develop the social support system for the elderly. This is our commitment to building a more inclusive and sustainable future for all, promoting dialogue between the parties involved and facilitating the implementation of public policies that turn the European vision into reality.

Project “Cuid@r+”. © Absolutauge

Outcomes and impact of the pilot phase

Gulbenkian Home Care (GHC) is an initiative of the Calouste Gulbenkian Foundation (CGF) dedicated to reshaping the way care is provided to older people in Portugal, by improving and strengthening home care services[1].

By promoting multidisciplinary and integrated care that connects the social and health sectors, the initiative aims to support innovative, evidence-based solutions focused on making a tangible difference in the lives of older people and responding to their real needs. Another key focus of GHC is helping social organisations integrate technological solutions into the delivery and management of home care services, supporting their digital transformation.

GHC builds on the experience gathered through previous CGF initiatives that promoted ageing in place and within the community, helping create the conditions for people to grow older close to the people and places that matter to them, while preserving autonomy, dignity and quality of life. The initiative is closely aligned with both global and national goals for ageing, while also contributing to the Sustainable Development Goals (SDGs) of the 2030 Agenda.

During the pilot phase, 15 projects were supported across mainland Portugal and the Autonomous Regions, reaching coastal and inland areas, rural and urban communities, and bringing together social organisations from different sectors and diverse levels of experience in providing home care. The goal was to strengthen the skills of professionals and improve the quality and specialisation of care, while helping social organisations modernise their methodologies, intervention practices, and home care services management, monitoring and evaluation tools.

1 Learn more on the Calouste Gulbenkian Foundation website.

A pioneering initiative

GHC introduced an innovative model of financial and non-financial support within the Portuguese philanthropic landscape[2], helping professionals and social organisations strengthen their capacities while supporting the long-term sustainability of the projects. In addition to the technical and scientific guidance provided by the Foundation, the non-financial support gave projects access to specialised consultancy and independent impact evaluation carried out by external organisations. Beyond thematic training provided to all project teams, the specialised consultancy offered personalised support tailored to the needs and realities of each organisation, helping to foster organisational transformation.

Calouste Gulbenkian Foundation also helped promote the projects through the production of video stories and the organisation of the Gulbenkian Home Care Conference: Innovation in Home Care Services for Older People, held on 10 December 2024. The conference presented the initiative's main outcomes and brought together stakeholders from across different sectors of society.

2 Source: Final external evaluation report of the GHC initiative, prepared by a team of researchers from CINTESIS/ICBAS.UP.

Project "Sorrisos ao Domicílio". © Absolutauge

Project "My SAD". © Absolutauge

Supporting older people and informal carers

Who benefited and what activities were carried out?

Older people receiving care

1065

Informal carers

196

Projects

15

The activities delivered through the 15 projects directly benefited 1,065 older people receiving care and 196 informal carers. When joining the projects, participants' social, health and sociodemographic profiles were assessed.

Profile of older people receiving care

SOCIODEMOGRAPHIC PROFILE

62%
were women

80,4
average age

63%
were married or living with a partner

50.4%
completed primary education (Year 4), 9% never attended school

39%
lived alone

HEALTH AND QUALITY OF LIFE

66%
had health issues

37%
were dissatisfied with their health

45%
felt that physical pain limited their ability to do what they needed to do

30%
had difficulty seeing, even when wearing glasses

36%
had difficulty hearing, even when using hearing aids

40%
were unable to walk for at least 10 minutes a day

63%
reported memory problems

35%
frequently experienced negative feelings

80%
of men and 72% of women showed muscle weakness

29%
needed help organising or taking medication

65%
had not received any type of therapy before joining the projects

SOCIAL RELATIONSHIPS

29%
frequently felt lonely

56%
rarely took part in activities with other people

Although most participants were already receiving home care services, most did not have access to specialised support at home.

Profile of informal carers

SOCIODEMOGRAPHIC PROFILE

70%
were women

67
average age, 25% aged between 76 and 85

76%
were married or living with a partner

23%
completed secondary education (Year 12), while 21% completed higher education

37%
remained professionally active

48%
were retired

49%
were spouses or partners of the person receiving care, and 39% were their children

CARE PROVIDED

74%
lived with the person receiving care

45
hours, of care provided per week (median)

45%
received no support in their caregiving role

51%
felt uncertain about the care they provided

80%
expressed no intention of institutionalising the person receiving care

HEALTH AND WELL-BEING

36%
reported significant levels of caregiver burden

33%
were dissatisfied with their sleep quality

31%
were dissatisfied with their health

82%
had not benefited from any support services before taking part in these projects

SOCIAL RELATIONSHIPS

31%
frequently felt lonely

56%
felt they had few opportunities for leisure

Around one quarter of carers were themselves older people, many of whom likely to need care and support of their own. Despite the significant burden associated with caregiving, most carers wanted the person they cared for to continue living at home. Most carers had not benefited from any support services before participating in these projects, and in 84% of cases the person receiving care also benefited from the GHC projects.

Included in the activities carried out by the projects were a broad range of health interventions focused particularly on physiotherapy, occupational therapy and psychomotricity, as well as individual and group psychological support for both older people receiving care and informal carers. Also noteworthy were the activities developed to encourage social engagement, meaningful occupation and reduce loneliness among older people. The projects also included training and awareness-raising initiatives designed for older people, carers and the wider community.

Overall, the interventions planned and implemented through the projects responded closely to the health and social profiles of older people receiving care and of informal carers, highlighting the need for innovative, integrated and multidisciplinary responses that bring together the different actors involved in home care.

Main activities carried out

4,598
physiotherapy, occupational therapy and psychomotor therapy sessions

3,139
individual and group psychological support sessions

1,234
individual and group sessions involving other therapies

645
nursing care services

535
instances of support for medical examinations and access to healthcare

3,139
telecare calls (received and made)

1,125
individual sessions dedicated to social engagement and meaningful occupation

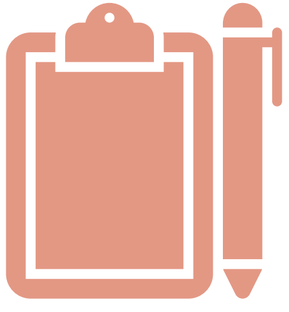
1,365
social support consultations

692
cultural, engagement and socialisation activities

197
training initiatives for older people, carers and the wider community

109
educational multimedia resources developed

131
assistive devices acquired



Wokforce development and optimising home care services management

What activities were carried out?

Professionals received training	Training initiatives	Specialised consultancy
227	138	75
Thematic training sessions	**Organisations recruited**	**Volunteers**
8	12	77

Alongside the recruitment of specialised professionals, the projects and MAZE (CGF's partner for capacity-building and specialised consultancy) carried out activities aimed at enhancing the skills of home care services professionals. These initiatives were designed based on a needs assessment that considered the digital and organisational maturity of each institution.

Workforce development

227
professionals received training and supervision through the projects

138
training initiatives for professionals (technical staff and direct care assistants) were carried out by the projects

75
individual specialised consultancy sessions were provided with Calouste Gulbenkian Foundation support, each team benefiting from five to six sessions

8
thematic training sessions focused on key topics for project success (Calouste Gulbenkian Foundation support)[3]

12
organisations recruited specialised professionals for the projects[4]

77
volunteers joined the projects

Digital transformation

14
projects adopted home care services management software and/or technological solutions to support older people in their daily care

112
health monitoring and telecare technologies acquired

GHC encouraged organisations to invest in digital tools for managing and coordinating home care services, as well as in technologies that help monitor and support older people, including telecare devices. These solutions were aimed at modernising organisational processes, improving service efficiency and enhancing the quality of support provided to older people in their own homes.

As a result, most of the 15 supported projects introduced or expanded the use of home care services management software and technological devices to support their work with older people.

3 Seven sessions led by MAZE covering project management, change management, case management tools, data structuring, digital tools and financial sustainability. One session led by CINTESIS/ICBAS.UP on outcomes evaluation.
4 Including physiotherapists, occupational therapists, psychomotricists, nurses, psychologists, social workers and sociocultural animators, among other professionals.

Professionals involved in project implementation

SOCIODEMOGRAPHIC PROFILE

97%
were women

43 years
average age

39%
completed higher education, while 12% of direct care assistants had the second cycle of basic education" (grades 5–6) or below

57%
worked as direct care assistants and 35% held technical roles

79%
had permanent contracts

WORKPLACE WELL-BEING

85%
frequently expressed satisfaction with their work

92%
felt confident in carrying out their roles

90%
considered their work important

24%
frequently experienced work-related anxiety

27%
considered their work to be undervalued

At the start of the projects, professionals described several challenges in their day-to-day work, including the high turnover of direct care assistants, which increased pressure, workload and feelings of demotivation. They also highlighted difficulties managing time and resources, physical fatigue, and emotional exhaustion caused by demanding workloads and long hours, continuous exposure to the vulnerability of the people they cared for, and limited access to ongoing training. The challenges raised by professionals reflected the need for the activities developed through GHC to strengthen the workforce and improve home care services management.

What were the outcomes?

For older people receiving care and informal carers

Across the projects, participation led to positive and meaningful improvements in the health and social well-being of both older people receiving care and informal carers[5]. Older people receiving care showed improvements in overall and physical quality of life and mobility, alongside a reduction in negative feelings. Greater opportunities for leisure and social participation were observed among both older people receiving care and informal carers.

For older people receiving care, one of the most meaningful improvements was the reduction of isolation and unwanted loneliness[6].

Participants spoke positively about the support received and expressed the desire to continue benefiting from the activities provided through the projects.

5 Health and social outcomes were assessed using protocols specifically developed for GHC. The evaluation followed a quasi-experimental study design, with participants assessed both when joining the projects and after receiving support through the interventions. The findings presented are based on the evaluation of 310 older people receiving care and 57 informal carers.
6 Based on telephone interviews carried out with a sample of project beneficiaries.

Changes in health and social indicators

40%
of older people felt their overall quality of life had improved

53%
of older people reported improvements in their physical quality of life

27%
said they were walking more often (for at least 10 minutes)

51%
showed improved respiratory performance[7]

30%
of older people were more satisfied with their sleep quality

30%
reported experiencing negative feelings less often

32%
of older people and 27% of informal carers said they had more opportunities for leisure and social engagement

58%
of older people felt that their overall well-being had improved[8]

SATISFACTION

97%
of older people said they were satisfied with the projects

88%
said they would like to continue benefiting from the support provided

7 Assessed using the peak expiratory flow test.
8 Based on a telephone survey carried out with a random sample of participants.

What older people said

"I couldn't walk before. But now, with my walker, I can walk a little."

"Physiotherapy has been wonderful. Since I started, I've been feeling better every day."

"I don't know what would happen to me if I lost this support [...] without it, everything would change. I feel like everything would go backwards [...] I'd be back using the walker and falling again."

"He [the psychologist] does incredible work [...]. I'm so much better now; before, I just couldn't cope..."

"I love everything about it! I never used to go out anywhere and now [...] The other day we went on a picnic. I hadn't been back to my hometown in 50 years. And they took me there on my birthday.

I never used to go on outings, and now I go on so many. I even have photographs!"

Professionals' perspectives on the impact of the activities on people receiving care

From the perspective of professionals, GHC had a positive impact on the physical and mental health and overall well-being of older people. These improvements were mainly associated with care that was better tailored to individual needs, greater access to specialised support, and the availability of assistive equipment and support products.

Professionals also highlighted the diversity of activities offered to respond to different interests and needs, more humanized and holistic approaches to care, and more personalised and effective care management with closer follow-up. Health monitoring and preventive care were also seen as key factors behind these positive changes.

“An intervention that goes beyond traditional home care services shows us that having a regular multidisciplinary presence in people’s homes can make a real difference to their quality of life and physical and mental health.”

Professional involved in one of the projects

Reduced loneliness and social isolation, helping people strengthen social relationships and feel more connected to their communities;

Improved emotional well-being and mental health, with fewer feelings of anxiety and sadness and better ability to cope with difficult situations;

Maintenance, and in some cases improvement, of cognitive, motor and communication abilities, while helping prevent age-related decline, especially through activities such as occupational therapy and psychomotor stimulation;

Improved quality of life and greater autonomy through more active participation in community life. Assistive devices and rehabilitation strategies also helped older people become more socially engaged and connected;

Close relationships and a sense of security. Like the older people involved in the projects, the teams also recognised that the close relationships built between technical staff, volunteers and beneficiaries created a strong sense of security and comfort. Visits and activities became moments people looked forward to, helping strengthen trust in the support provided;

Prevention of the worsening of health conditions. Home nursing services, ongoing clinical follow-up and telecare helped teams monitor people’s health more closely, respond quickly in urgent situations and prevent health conditions from worsening. In some cases, this support even helped avoid visits to hospital emergency services;

Reduction of burden, increased rest and stress relief among informal carers. Support and training helped carers feel more prepared to deal with the challenges associated with dementia and other health conditions, strengthening their sense of confidence and competence. Psychosocial interventions also helped reduce stress and caregiving burden and provide carers with more opportunities to rest. Having a stronger support network also played an important role in improving family dynamics and helping carers develop better ways of coping with daily challenges.

For teams and social organisations

Professionals also recognised that the initiative had positive effects on both the teams involved and the organisations themselves. The projects helped strengthen teams through the integration of more specialised professionals. Training, capacity-building and supervision also played an important role in promoting stronger team cohesion, greater motivation and higher levels of professional satisfaction. The initiative helped organisations broaden the services they provide, encouraged new approaches to care and strengthened more human-centred care.

The introduction of new methodologies and digital tools, both to support older people directly, such as telecare systems, and to improve home care services management, also helped modernise services, improve operational efficiency and respond more effectively to beneficiaries' needs.

Many of these changes continued within the teams and organisations even after the projects had ended[9], suggesting that GHC helped create lasting capacity within the home care sector. Several of the activities introduced through GHC were also maintained after funding ended, especially specialised health interventions such as nursing and occupational therapy, supported through the continued hiring of specialised professionals.

The personalised capacity-building provided by MAZE, adapted to the needs of each team, together with the scientific evaluation and validation conducted by CINTESIS/ICBAS.UP (including outcome analysis and recommendations), were regarded by the supported teams as key elements in consolidating and improving their practices.

9 Conclusion based on a follow-up evaluation carried out by the CINTESIS external evaluation team six months after the projects ended.

Benefits for teams and organisations

Digitalisation and operational efficiency

The introduction of home care services digital platforms helped improve productivity and time management, strengthened internal communication, and made it easier to identify and respond more effectively to beneficiaries' needs.

Stronger and more specialised teams

The projects also enabled the recruitment of professionals who had already been identified as essential for delivering high-quality care and support. This reinforcement enhanced home care services and improved the organisations' ability to respond to people's needs.

Continuous training and professional development

Teams benefited from ongoing training, discussions with specialists, and supervision. According to professionals, these activities improved the quality of the services provided and supported more evidence-based approaches to care.

Cohesion, motivation and professional satisfaction

The working environment became more collaborative, interdisciplinary and motivating. Teams described higher levels of professional satisfaction, associated with better communication and management processes, more varied care routines, perceived improvements in the quality of care provided, and stronger interpersonal relationships.

Humanisation and quality of care

The projects helped promote more human-centred care and strengthened the emotional bonds between professional teams and the people receiving care. Technical support and external supervision were seen as essential in helping achieve these outcomes.

Stronger networks and greater recognition for organisations

The projects helped organisations strengthen their partnership networks and reinforce their role and positioning within the social sector. Social organisations also gained greater visibility and recognition, which in some cases led to increased demand for home care services.

Sustainability and organisational growth

In some cases, activities carried out through the projects became permanent services, helping organisations grow, expand their range of services, and strengthen their role in delivering home care.

What happened after funding ended?

13/15

organisations continued the differentiated activities and services created through the projects

> 50%

retained the professionals recruited for the projects

10

organisations continued using management software and other technologies

15

teams felt they had strengthened or developed new skills and competencies

New Home Care service model

Based on evidence and achieved outcomes

“By focusing on innovative and integrated approaches to home care services, combined with rigorous evaluation, capacity-building and digital transformation within social organisations, Gulbenkian Home Care has positioned itself as a pioneering initiative helping reshape the way care is provided to older people.”

The pilot phase of the GHC initiative was an important step forward in modernising home care services for older people in Portugal. The initiative broke new ground by testing innovative approaches, strengthening the skills of teams and accelerating digital transformation within social organisations, helping improve efficiency, sustainability and impact.

GHC also showed the value of a “Funder Plus” model that combines funding with technical and scientific support, specialised consultancy, capacity-building activities and systematic external evaluation of outcomes. This combination helped improve the quality of social intervention and encouraged a culture of continuous improvement grounded in evidence and learning.

The lessons from this phase highlight the importance of more multidisciplinary and person-centred home care, tailored to people’s real needs and expectations (whether physical, emotional or social and recreational) while supporting functionality, psychological well-being, self-determination and social engagement. The experience also underlined the importance of safeguarding the well-being of both care professionals (preventing psychosocial risks, recognition and skills development), and informal carers (managing caregiver burden, self-care, opportunities for rest and access to psychological support).

Strengthening in-home care solutions requires closer collaboration between the social sector, healthcare services and local authorities, together with more diverse services capable of responding to needs that are still not fully addressed. Although digital transformation brings technical and human challenges, it is essential for improving the quality and efficiency of care and support.

To consolidate and build on these outcomes, it will be important to validate and transfer the knowledge generated, share good practices, and invest in solutions that are sustainable, scalable and capable of being replicated in other contexts.

Ultimately, investing in home care services is a more human-centred and effective response to ageing, one that helps ensure dignified and active ageing by allowing more people to remain in their own homes with the support they need.

GULBENKIAN HOME CARE 2.0

The success of the GHC pilot phase led to the launch of a second phase, building on the lessons learned and the recommendations made by the external evaluators. The initiative continues to invest in local networks and in care models tailored to the needs of people and their communities.

Gulbenkian Home Care 2.0 is currently supporting 17 projects[10] led by IPSS charities and Local Healthcare Units. Because these organisations work closely with local communities, they are well placed to understand people’s needs and develop responses adapted to the realities identified in each region. This new approach to in-home care is rooted in the building and/or strengthening of local networks and collaboration between actors from the public, private and social sectors, while fostering broader partnerships, improving the use and efficient management of resources, and promoting best practices in person-centred care.

Gulbenkian Home Care 2.0 aims to test and validate new ways of delivering more personalised home care. The initiative pays particular attention to inequalities in access to care across different regions of the country, helping ensure that older people living at home can access appropriate support wherever they live, whether in urban or rural communities, coastal or inland areas, or places with higher or lower population density. The solutions implemented in each region will help identify which approaches work best in different contexts, recognising that older people living in different places need different types of support, not only because of their individual needs, but also because of the opportunities available in the communities where they live.

10 Learn more on the Calouste Gulbenkian Foundation website.

In this second phase of the initiative, collaboration agreements and formal partnerships with a wide range of organisations (including local authorities and healthcare providers such as Local Healthcare Units, Integrated Long-term Care Units, Family Health Units and Health Centres) aim to create better conditions for providing integrated multidisciplinary care and support the long-term sustainability of the projects. Local authorities can play a very important role in supporting in-home care, particularly through co-financing models and the sharing of resources with IPSS charities, helping ensure the future sustainability of these interventions. Public healthcare organisations can also provide forms of specialised care that IPSS charities often find difficult to deliver, but which are essential for supporting people living with multiple health conditions and complex chronic diseases requiring regular follow-up.

Many of the projects have also become more specialised in response to the growing number of older people living with dementia and cognitive impairment. At the same time, social isolation linked to geographic dispersion and low population density remains a major challenge in this new phase of the initiative, which will continue until October 2027, when the outcomes over the five-year period of implementation of Gulbenkian Home Care will be assessed.

Project “Home 360”. © Absolutauge

Colophon

Gulbenkian Home Care – Outcomes and impact of the pilot phase

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