

# Ambivalences around family care: The rhetoric of a family policy in Portugal

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## Introduction

This chapter focuses on family care provided at home by family members. Informal care refers to the unpaid care provided to older and dependent people by family members and friends (namely neighbours), either full-time or part-time, and which includes daily life activities related to health care and well-being (Comas-d'Argemir, 2019; Cès *et al.*, 2019).

Due to demographic changes and labour market demands, uncertainty about family care is expected to create a significant deficit of carers by 2060, leading to unmet care needs and a widening of the so-called 'caring gap' (OECD, 2014). The 'caring gap' describes the disproportion between the demographic growth of the older population, especially at advanced ages (> 80 years), and the reduction of future cohorts of potential carers, composed of younger generations (Bonnet *et al.*, 2021). This phenomenon raises the question, 'who will care for the older people?', a central issue for long-term care (LTC) policy.

Two dimensions should be considered to respond to this issue: the availability of potential informal carers and their willingness to provide care. According to the European Commission (2021a: 143), key variables affecting the future availability of potential informal carers are the future number of older people who have children who live near enough to provide care (i.e. co-residence or geographical proximity), and the future number of people living with their spouse. The second dimension is how the willingness to provide care will be affected by participation in the labour market (particularly that of women, who tend to be the main carers), as well as the ability/willingness to provide care. A third dimension is the citizens' right to receive formal care and to have easy access to institutional care. This preserves their right not to perform care, as well as the right to be protected by the state in the case of caring full-time for a family member (Comas-d'Argemir, 2019).

With the demographic changes we have been witnessing in Europe, care has emerged as an analytical concept (São José, 2016) and a political category (Casas-Cortes, 2019). This means that care today is understood as a broader category, seen not only as belonging to the private and domestic sphere but also to the public sphere. Care has gone public, becoming a matter of public and civic interest (Fine, 2007). This is expressed through the emergence of what some researchers have called a ‘care deficit’ (Hochschild, 1995). Care is conceived as a necessary social response to human frailty and vulnerability at different points in the life course. The form taken by the response, which we refer to as ‘care’, is not a fixed or self-sustaining autonomous practice. Rather, as Mary Daly has put it, ‘care is produced as an ethical commitment, a set of actions and increasingly as a policy good within complex economic, social and political contexts’ (Daly, 2002, cited by Fine, 2007: 144).

Care has become a new social risk covered by public social protection systems in several countries. However, it is also a social and moral construct shaped by social structures, ideologies, and contexts. The way care is constructed socially and politically has a significant impact on how it is provided and received (Weicht, 2015). When conceiving care as a social construct, the concept of care has become an object of sociological analysis (Weicht, 2015) and a political category (Casas-Cortes, 2019; Comas-d’Argemir, 2019; Soeiro and Araújo, 2020), passing through a process of birth, genesis, and legitimisation, through its institutionalisation. As an object of public intervention, the reconstitution of the process of institutionalisation of care brings us back to the concept of social construction (Berger and Luckman, 1985; Stiker, 1996). Henri-Jacques Stiker defines the concept of social construction as the way in which a society establishes and processes or handles a domain of life, a population, or a type of social relations, according to the representation it holds and the categories it uses. This representation and these categories are themselves dimensions of practices and cultural frameworks. Thus, all these notions are a constructed ‘result of antagonisms, struggles, categorisations and political strategies’ (Stiker, 1996: 311). Until the recognition of care as work (Pfau-Effinger, 2014; Frericks *et al.*, 2014; Dykstra, 2019), its institutionalisation goes through a process of politicisation, which means that care becomes a political struggle within the political system (Palonen, 2021).

An overview of the long-term care context in Portugal is given, and the new legal framework in force concerning informal care is presented to show how informal care has become the object of public policy, and, therefore, subject to a formalisation and regulatory process.

## (In)formal care: complementarities

Researchers have theorised care in various disciplines involving new forms of employment and different mixes of paid and unpaid care, reflecting deeper processes of social and economic change. Michael Fine identifies three elements in the care concept:

First, care entails *a disposition, a concern for others or another*. This element is the intangible, mental aspect of care that involves a cognitive, rational and emotional concern for the wellbeing of others. Second, care is given expression as a form of work that takes place as the activity of providing practical assistance to another. These actions involve the physical provision of support to another over time, and demand competence of practitioners. (...) The third element acknowledges care as a social and personal relationship, concerned essentially with interpersonal support. (...) Care must be understood as a fluid and variable expression of the most intense forms of social support. (Fine, 2007: 143–144)

The concept of care has been replaced by another concept, care work, which a group of feminists proposed in the late 1980s and early 1990s (Guberman *et al.*, 1992; Twigg and Atkin, 1994). This broke away from the concept of care as an essentially female practice. This movement drew attention to how essential care is a process involving an organisational system, resources, and skills. Care is analytically broken down into formal care (paid) and informal care (unpaid). The unpaid care of carers is conceived as *a burden* in the domestic context (Pearlin *et al.*, 1990), and the care debate increasingly came to focus on the work conditions and career development in the field of paid care (Ungerson, 1990).

The complexity and the interdependences in care arrangements require a conceptual approach, such as formal and informal care, or familialisation/defamilialisation. These concepts derive from feminist work (Lister, 1994), although they are now present in comparative welfare state studies:

While it has different usages, through a feminist lens, the concept seeks to theorise the role of social policy in affecting women's dependence on the family, on the one hand, and the state's construction of family responsibilities and roles, on the other. (Daly and León, 2022: 24)

Policies that support extrafamilial care are categorised as defamilialising, aiming to promote gender equality, and policies that promote informal care provision by relatives are categorised as familialising, placing these policies in logics that fall into one extreme or the other (Eggers *et al.*, 2020). Saraceno and Keck (2010) distinguish three patterns in familialisation of care: *option familialism*, *supported familialism*, and *defamilialisation*. The concept *option familialism* is based on the understanding that caring preferences do not need to conflict with policies lowering the burden of care. In *option familialism*, families can choose between provision of services and cash for home care,

whereas *supported familialism* allows access to services and public support for leaves. *Defamilialisation* implies good access to institutional care for older people through different actors: public, third sector services, and the market.

Some authors have stressed the increased blurring of boundaries in welfare regimes: 'The rise in a varied mix of care which includes a plurality of care providers, from public services to private profit services and subsidised third-sector services and unpaid and paid informal caregivers' (Naldini *et al.*, 2013: 173). In order to understand diversity in care arrangements, Daly and Lewis (2000) propose the concept of social care to overcome the dichotomies that have fragmented the concept of care, such as public-private, informal-formal, and paid-unpaid. Care is an activity and set of relations at the intersection of state, market, and family (and voluntary sector) relations, including three dimensions:

care as labour/work, a form of work that is carried out under certain conditions; care as an activity located within a normative framework of obligation and responsibility; and care as an activity with costs, both financial and emotional, which cross the public/private boundaries. (Daly and Lewis, 2000)

In his turn, Fine proposes a broader perspective, which he has termed the 'social division of care' (Fine, 2007). The concept is based on the recognition of care as a form of work, which includes: (1) the relationship between paid and unpaid care (2) the relationship between different forms of paid care staff, and (3) the relationship between care staff and care recipients, this last relationship as an active subject, not simply as the object of care. According to Fine, the concept is intended to provide a simple framework for the study of care as an increasingly complex form of work, drawing attention to how responsibility for different aspects and stages of care processes is being reapportioned between different social actors through the development of innovative hybridised forms of practices and responsibilities (Fine, 2007: 138). One such development that has significantly blurred the boundaries between paid and unpaid care in the informal sphere in several countries is the introduction of direct payments to family carers for the work they undertake. There is a need for more detailed and extensive research that explores the impact of these policies on families.

## Processes of familialising and gendering care through the lens of the Portuguese case

### 1. *Who provides care to older people in Portugal?*

A longer life expectancy and low fertility rates are among Europe's most significant issues raised by demographic ageing. In 2013, 5% of the

Portuguese population were 80+, and demographic projections suggest a significant growth in people over 80 by 2060 to reach 16% (EU, 12%). The increase in people aged 80 and older and the projected increase in life expectancy (Eurostat, 2015) suggest that more older people will require care. In Portugal, the projected 'support ratio', i.e. the ratio of women aged 45–64 years old per person aged 80 years and older, has already diminished in the period 1990–2030 from five to two caregivers (Hoffmann and Rodrigues, 2010: 5).

The reduction in this ratio was also confirmed by the European study Felicie (Gaymu *et al.*, 2007), in which nine European countries participated, including Portugal. This study had the objective of analysing the availability of family care for older people in a situation of dependency based on demographic projections until 2030. The study concluded that with the closeness of life expectancy between men and women, women might rely more in the future on the presence of a spouse. This trend is particularly strong among Europeans over 85 years old since the presence of a spouse will be three times more frequent in 2030 than in 2000 (22% compared with 9%). It means that if the Portuguese population continues to age and the birth-rate falls, family care for older people will not seriously decline. However, care will be provided by other older people (a rise from 7% to 16% in 2030), which also increases the need for paid and formal care.

On average, across OECD countries, around 13% of people aged 50 and over reported providing informal care at least weekly in 2019. According to data from the Survey of Health, Ageing and Retirement in Europe (SHARE), 2.3 carers in Europe care for older parents or spouses, and as the age of the carer increases, more time is spent in caring. Two patterns of carers were identified: (1) younger carers (50–65 years) caring for older parents, usually daughters (gender differences are exacerbated); (2) older carers (above 65 years) caring for a spouse, who provide more intensive care (round-the-clock care). In this last pattern, gender differences are reduced (OECD, 2020). The proportion of the Portuguese population aged 50 and over providing informal care was 9%, 8% for those who provide care daily, and 1% every week (OECD, 2020). According to SHARE, 70% of informal care in Portugal is provided daily by women over 50 years old (OECD, 2020).

A survey of 846 families who provided care to older people in Portugal revealed that the direct family (spouses, both men and women) and daughters were the main sources of support whenever illness and disability arose (Gil, 2010). Although women were the dominant figures, the survey also uncovered the role of male carers (in old age and retired), revealing men's contribution to the family sphere. In this survey, sons (5.7%), extended

family members, neighbours, and friends, irrespective of gender, had relatively minor importance.

The two patterns of care across OECD countries are also in line with the Portuguese Time Use Survey (Perista *et al.*, 2016), which concluded that the gender gap is smaller in the older population (of advanced age and with chronic illness). Although the patterns of participation of women and men in the labour market have been progressively convergent, they still show significant asymmetries and a greater feminisation in care (Perista *et al.*, 2016). Women tend to be the main providers of informal care, and a large part of care is provided by unpaid women who are fully or partly pulled out of the labour market to provide care to relatives (Gil, 2010; Carvalho *et al.*, 2021). Gender inequality emerges as the central issue in paid and unpaid care and a central axis for public policies.

COVID-19 further aggravated the situation of many Portuguese carers, isolating them and negatively affecting their performance (Henriques *et al.*, 2022) regarding the number of hours of caring, physical and mental health, social isolation, and employment. In addition, access to services in the community (home-based services and day centres) was denied to many families (Carvalho *et al.*, 2021).

## 2. Portuguese long-term care system

There are several studies (Hespanha, 1995; Adão e Silva, 2002; Soeiro and Araújo, 2020) on the integration of Portugal into a familistic regime. The arguments put forward include the late creation of a welfare state, the role of Catholicism's social doctrine, and the role of the *welfare society* (Hespanha, 1995). Portugal had a rudimentary social assistance system until the creation of a corporative welfare model, of Bismarckian inspiration, in 1935. The few institutions were public, and the situation in the 1960s until the early 1970s was chaotic. The living conditions in these asylums were inhuman, with cohabitation of older people, beggars, children, and prostitutes in the same space. It was in the 1970s that the Portuguese government began to show some concern for improving the living conditions of these institutions. This concern was framed in a European context, namely France and England, with the studies by Peter Townsend and Marcel Drulhe, who criticised the asylum institutions which explicitly contributed to the stigmatisation and isolation of individuals (Gil, 1998).

The process of modernising economic structures came about very late (in the late 1970s) when the fascist regime ended, and the fragility of the social sector and its underdevelopment made it unavoidable to resort to informal support systems. According to Hespanha (1995: 211), the vitality of the

*welfare society* is a social force compensating for the deficits in services coverage, where the family, mainly women, have historically played a central role in care.

In recent decades, Portuguese public policies have been developed in the social sector through two fundamental axes (Lopes, 2017). The first concerns the direct monetary transfers from the state to families to promote family care and to support the care recipient, as in the case of the ‘attendance allowance’ (for disabled people) and the ‘dependency pension complement’ (‘complemento por dependência’) <sup>1</sup> (i.e. the first generation of LTC policies for older people). The second pillar is based on the provision of care by public services (the National Health Service), particularly in primary health care and community care teams, and by the non-profit sector, led by the Private Institutions of Social Solidarity (IPSS) (83% of care services are part of the non-profit sector). They are non-profit, oriented towards social solidarity, and are recognised by the state, to which they may apply for funding (cooperation agreements). The services and facilities for older adults are included in a social network (*Rede de Serviços e Equipamentos Sociais* – RSES) (GEP, 2019).

From 2000 to 2019, there was an 84% increase in the number of users of nursing homes (from 55,523 to 101,919 (GEP, 2019)) included in this social network. In 2019, there were 11,500 facilities for older people (GEP, 2019), and the number of users also increased in home care services (112,272 users, and 64,338 were integrated into day centres). The capacity of these services in 2018 was 93% full in the residential facilities for older people, 70% in home care services, and 64% in day centres (GEP, 2019).

This Social Response Network (RSES) is distinguished from the National Network of Integrated Continuous Care (RNCCI) (which serves mainly convalescence, medium-term, and rehabilitation units), with services that are more health-oriented. In 2018, 48,677 users were assisted in the RNCCI, 4.6% more than in 2017, and 9.6% more than in 2015. The typology according to which most users were assisted in 2018 was integrated continued care teams, followed by long-term maintenance and medium-term rehabilitation units (National Health Service, 2019).

In 2019, only 1.9% of people aged 65 and over received formal LTC (from RNCCI) in Portugal (OECD, 2020), of which 1.2% received care in an institution and 0.6% received care at home. The low capacity of the Portuguese long-term care system is confirmed by the estimates from the European Institute for Gender Equality (EIGE, 2019). In the European Union, 29% of households reported unmet needs for professional home care services. Some of the most common reasons reported were affordability and lack of available care services (EIGE, 2019: 8). For example, among the

member states, this figure ranges from 12% in Sweden to 86% in Portugal. According to the European Commission (2021b), 39% of the population over 65 years old that needs long-term care in Portugal does not have access to it. The low number of people aged 65 and over receiving formal LTC may be linked to the shortage of LTC workers (OECD, 2020). Numbers are much lower in Portugal (less than one worker per 100 people over 65), leading to waiting lists for access to care and insufficient capacity to meet needs (OECD, 2020; Gil, 2021).

Lopes (2017) underlines that although Portugal has seen some convergence towards the EU average in coverage rates for formal care provision, it should be noted that coverage rates alone do not necessarily correspond to an appropriate coverage. Some factors are pointed out in the formal care sector: 'excessive workloads and long working hours', 'poor working conditions are coupled with high rotation of staff', and 'poorly trained and remunerated staff members (Gil, 2021). Lopes considers that 'the non-profit sector itself, either because it operates as a monopoly or because of ideological orientations towards care, is still very embedded in the Christian doctrine of charity and assistance and not in a culture of social rights' (Lopes, 2017: 71).

Despite public investments in the long-term care system, in the last decades, Portugal allocated 0.9% of its gross domestic product to the public provision of LTC, less than the average across OECD countries (1.5%) in 2019 (OECD, 2020) and, therefore, considered a limited state intervention model (Pavolini, 2021).

A number of consequences emerged from the inadequate coverage of LTC, such as the reliance on an informal care work market, the increase in unlicensed homes, and a higher responsabilisation of the family, particularly of women (Gil, 2019), as well as continued demand for domestic and care workers, mostly immigrants. This unqualified work, which includes mainly domestic work, cleaning services, and social care for the older population, is performed by African (Cape Verde, Angola) and Brazilian immigrant groups (Oliveira, 2022). In recent decades, there has been a segmentation of the labour market in Portugal, including a segregated immigrant labour force, particularly in the least qualified professional groups, with precarious jobs, more exposure to instability in the labour relationship, lower pay, and a higher incidence of labour accidents (Oliveira, 2022). Immigrant carers work mainly in the informal market, often as live-in carers in private households or non-licensed private nursing homes. Sometimes they are vulnerable to exploitation, discrimination, and abuse (Figueiredo *et al.*, 2018, cited by Gil, 2021: 6) due to the insecurity surrounding their immigration status. Thus, they are exposed to the vulnerability of their unqualified work and also to racial inequalities related to their immigration status.

### 3. (Re)familialisation: a policy to support informal carers

#### *The visibility of informal carers in the public arena*

Some studies (Soeiro and Araújo, 2020; Canha, 2020) were conducted to understand the context and the conditions that allowed the issue of informal care to enter the political agenda between 2016 and 2019, which led to the entry into force of the Law of Informal Care in Portugal.

The first carers' meeting was held at the Catholic University in 2016, at which some public figures from left-wing parties were present. After the first National Meeting of carers in June 2016, there was a clear motivation to bring attention to their cause in the public arena, using two key mediation channels for this purpose: the media and the political authorities. The media space contributed to bringing into the public sphere the biographical narratives of carers and their needs. In this process, different political parties (especially the left-wing political parties) and civil society actors (the Portuguese Association of Family and Friends of Alzheimer's Patients and associations for disabled people) reflected different political-ideological perspectives on the role of informal care in society. The main goal of this social movement was to remove this reality from invisibility, socially and legally. This demand was articulated through claims that, in essence, relied on the categories of Nancy Fraser (2008), the *struggle for recognition and the struggle for redistribution*:

The struggle for recognition of a segment of the population whose work was not identified as such and which, until then, did not have access to forms of collective representation of their interests as carers. The struggle for redistribution, that is, social policies capable of valuing informal care and making it a platform for access to rights and social protection. (Soeiro and Araújo, 2020: 58)

The informal carers' movement included carers of all ages (such as disabled and old people and carers for young children with health problems), which triggered political and public attention, providing an opportunity for legislative regulation. With public and political pressure to recognise an informal care policy in the face of demographic ageing and changes in family structures, care emerged as an object of public policy. One of the public figures who supported this movement was the Portuguese President. According to Marcelo de Sousa, 'the law signified the possible consensus to follow up a great movement of the Portuguese society, in some cases related to some principles, in others going further in terms of implementation' (Jornal de Notícias, 2022). The pandemic of COVID-19, he added, made the process difficult, but in any case, a 'historic step' was taken, the result of the 'merit of those who fought for the law, coming from the base', i.e. 'informal carers,

but also some protagonists', such as the BE Marisa Matias (member of the left-wing political party and member of the European Parliament). More than a simple object of public policy, care was the subject of a visible and debated process in the public arena (contested, negotiated, and emerging from struggles), which became relevant in the process of politicisation.

### *The regulation of the Informal Carer Statute*

The recognition of the need for measures to support informal carers emerged following the Resolution of the Portuguese Parliament 129/2016. The Informal Carer Statute (ICS) was approved in July 2019 and regulated the rights and duties of carers (Ordinance 2/2020: 5).

The primary informal carer is a family member living in the same household as the person being cared for, providing care permanently without any salary. A secondary carer is a family member providing care on a regular but non-permanent basis, with or without compensation. There was a split in this policy, which resulted in the exclusion from the designation of all those who provide daily support, namely non-family members, friends, neighbours, and formal carers paid by families, who are also sometimes secondary carers (Ordinance 2/2020: 6). All family members, regardless of gender, who accompany and provide care regularly but not permanently, are excluded.

Before the institutionalisation of the support for family carers within the social security system was extended to the entire country, which took place in 2022, authorities had implemented pilot projects lasting for 12 months, from 1 April 2020 to May 2021, which covered 30 Portuguese municipalities (Ordinance 64/2020: 5). According to a national report, until June 2021, the status of the informal carer was recognised for 977 people in the 30 municipalities where the pilot project took place, with 83% of these being women, which shows a significant feminisation of care. The carer's allowance covered only 352 people in the country, with a monthly average below the poverty threshold (281.96 euros per month) (CAMAI, 2021).

In 2022, the Regulative Decree 1/2022 established the terms and conditions for recognising the status and the support measures for informal carers. In order to receive cash benefits for family care, care has to be provided by a family member (aged 18 years or older) who is either a spouse or unmarried partner, kin up to the fourth degree of the direct or collateral line of the person being cared for, and who lives in the same household. More precisely, there are strict eligibility restrictions with regard to specifying a family carer:

- a) living in the same household as the person cared for; b) providing care permanently; c) not having a paid professional activity or any other type of

activity incompatible with the provision of permanent (24/7) care to the person being cared for; d) not receiving unemployment benefits; e) not being remunerated for the care they provide to the person being cared for. (Regulative Decree 1/2022: Art. 6)

The family carer must qualify and attest through health services to his/her health status to become a family carer.

Generic and demagogic measures have been laid down, without any budgetary reinforcement to implement them, either in terms of access to services or in terms of hiring human resources. In Art. 11, the legal document stipulates that the assigned reference health professional is to be responsible, namely within the context of the health team centre, for advising, accompanying, empowering, and training the informal carer, to develop skills in caring for the person being cared for. Art. 13 regulates the Carer-Specific Intervention Plan, a document resulting from the diagnosis and person-centred planning needs in terms of health and social services. In Art. 15 participation in support groups and psychosocial support are regulated together with respite care for the carer following the diagnosis made by the reference professional, for a period of up to 30 days per year, due to the informal carer's need for respite and depending on the availability of a vacancy for respite care in the RNICC.

The informal carer support allowance ('Subsídio de apoio ao cuidador informal principal') is a cash benefit from the social security system. The allowance and the amount awarded depend on the income of the entire household of the informal carer (their income as well as the dependency benefits of the person being cared for), which means that household income must be less than 576.16 euros (1.2 times the value of the Social Support Index – IAS). The reference amount of the support allowance is 443.20 euros (month). In Portugal, this amount is meagre and below the poverty line since the income relates to the entire household (in Portugal, the minimum wage was 740.83 euros in 2022). The allowance cannot be received along with the following benefits: unemployment benefit, dependency pension complement, invalidity pension, and old age pension, except for early pensions (before retirement age). The primary informal carer can benefit from social security insurance for providing informal care – the Non-Compulsory Social Insurance Regime ('Seguro Social Voluntário') – by paying a contribution rate of 21.4% of the informal care allowance. Under this scheme, the protection covers invalidity, retirement, and death. This insurance, although voluntary, corresponds to the lowest contribution and can be considered the first recognition of family care as a form of work.

The law defines work-life balance policies for a non-primary informal carer as the following: parenting scheme, remote work regime, and measures

promoting reconciliation between professional activity and care, by agreement with the employer or by the provisions of the applicable collective labour regulation instrument. Other policies strengthening the labour protection of a non-primary informal carer include a scheme for absences: the right to 15 days of unpaid absence; leave (annual leave of five days, without pay, and the obligation to notify the employer ten days before the leave); organisation of work hours (flexible working hours, part-time work for up to four years); and legal protection in case of dismissal (Law 13/2023 of 3 April, which amends the Labour Code and the related legislation, within the scope of the Decent Work Agenda).

Measures to promote a return to the labour market after the main carer's work ends are also unclear. The law includes measures for an unemployed person, provided that he/she is enrolled in an employment centre. The only specific measure after the cessation of the provision of care is recognising and validating the carers' competencies through a Portuguese Entity ('Centro Qualifica'). This public recognition of the carer's skills and his/her certification through the national entities is an indirect way of forwarding carers to the formal care sector, which is characterised by a shortage of LTC workers (OECD, 2020; Gil, 2021).

#### *From contestation in the public arena to proposed regulatory change*

The movement of informal carers, after the legal regulation, has used different forms of collective action in civil society. The National Association of Informal Carers, as the representative body of its members, emerged from the social movement ('O movimento dos cuidadores informais'). Today, the association acts as a source of support and information on the rights of informal carers and, recently, the promoter of a citizens' legislative initiative.

The citizens' legislative initiative proposed in the Portuguese Parliament to change Law 100/2019 on the Statute of the Informal Carer and Regulative Decree 1/2022 is underway. This initiative, for which 20,000 signatures are needed (from Portuguese voters), is currently collecting signatures before it comes up before Parliament for discussion. The proposal was based on the following demands:

- Extending the recognition of the status of the informal carer to people who, not being a spouse, unmarried partner, relative or kin, demonstrate ties of affection and/or closeness with the person cared for and prove that they effectively exercise the role of informal carer.
- Extending the recognition of the status to children under the age of 18 who are caring for their parents, provided they are referred to as effective carers by the social or health services, even if they are not entitled to an informal carer's allowance.

- The recognition of the status no longer being dependent on the eligibility of the person being cared for to access the *dependency pension complement* or the *attendance allowance*.
- Changing the term ‘informal primary carer’ and ‘informal secondary carer’ to ‘full-time informal carer’ and ‘part-time informal carer’, respectively.
- Recognising the right to rest for the carer for no less than 58 days per year.
- Exempting the cared-for person from fees on admission to units within the RNCCI in cases where it is intended to ensure rest for the carer.
- The informal carer’s allowance no longer depending on the income of the entire family household of the informal carer.
- Increasing the informal carer support allowance, corresponding to 100% of the value of the contributions that fall into the first level of the Non-Compulsory Social Insurance Regime.
- Providing a labour regime that protects the informal carer, ensuring absences and leaves, regulating flexible working hours, and extending the parental leave of up to one year for holders of parental rights.

## Conclusion

Portugal has implemented policies to support informal carers to promote family care. The issue of informal care was politicised at the time of its legal regulation. However, the movement that surfaced in civil society has lost strength in terms of contestation in public space. The primary demand of this social movement was to remove the carers from social invisibility, but today there is a general dissatisfaction among informal carers (Gil, 2022, 2023). The *struggle for recognition* (Fraser, 2008), in the public arena, through the social movement turned into a struggle to change the law, mobilising civil society. This policy has been challenged for perpetuating the invisibility of care since many women are excluded from such recognition without any social protection mechanism.

First, one can wonder why only 11,080 carers (of which only 2,767 receive allowances) (CAMAI, 2021) benefit from official recognition, out of the presumed 827,000 Portuguese carers. It also merits reminding that 207,000 were estimated to work full-time (Eurocarers, 2017). Secondly, the idea of family obligation remains associated with the policies to support informal carers, based on the value of family solidarity and an absence of discussion around gender inequality. This law gives the family a central role in care, without this being matched by compensation for that care, particularly in terms of social transfers (Soeiro, 2022) or more accessible access to support services (i.e. domiciliary services with nursing care, medical assistance, respite care).

Formally, the Portuguese government has come to recognise that family care is work that can be stressful and needs support. However, it only gives minimal support to a selected group of carers. There is no real committed defamilialisation by the state. There is a rhetorical discourse on the status of the informal carer that does not coincide with practice, that is, with concrete measures that minimise costs associated with care.

The main characteristic of the Portuguese care regime is the prevalence of a *familistic model*, in which care is seen as a family obligation (mainly female) and not as a social right (Gil, 2021). The carers do not see their citizenship rights recognised for their work, and neither the carers nor the persons cared for benefit from formal care conceived as a social right related to citizenship. The support, at the level of monitoring, training, psychosocial support, and respite care proposed by the Regulative Decree 1/2022, can only be practical for carers with increased coverage in the formal sector. Despite an improvement in the availability of social services and facilities for older people, the social response network and the user capacity are insufficient to cover all those in need, and the formal support network has not kept pace with the demographic ageing of the Portuguese population. Since the 1990s, Portugal has seen an expansion in the coverage of services for older people, although far below the real needs emphasised by the accelerated ageing pattern of the Portuguese population. Furthermore, there are no vacancies in nursing homes in the non-profit sector because of the limited number of places available (RSES and RNCCI). For the (licensed) private sector, families cannot afford care home fees, which are outside the reach of the majority of the Portuguese population (Gil, 2019), and often employ African and Brazilian immigrant care workers in the informal market, often as live-in carers in private households (Gil, 2021) in precarious labour situations and without social protection.

The Informal Carer Statute was a great step in the recognition of family care. However, more responsibilities are assigned to carers under a discourse of support and recognition (Canha, 2020) without this discourse being accompanied by effective measures that minimise the impacts on carers. The way the care relationship is legally framed causes distinct contradictory interests within the family, i.e. the family carer is legally in a precarious position. Family carers only receive an allowance if they provide full-time care to a family member with severe care needs, and live in a cohabitation regime, and they cannot have a paid professional activity, or receive unemployment benefits or a pension.

Informal carers become an object of social policy in which there is a risk of perpetuating their burden and associated gender inequality. There is no explicit gender differentiation in the law, but informal care inevitably emerges from a family obligation, and a naturalisation process is attributed

to women. Rather than a universal policy that recognises the social rights of informal carers (Comas D'Argemir, 2019), it is a policy against poverty, reduced to an allowance limited to a social group in a vulnerable situation (Gil, 2023). Therefore, it cannot be said that families are relieved or less burdened than before or that the law can be considered a form of *supported familialism* (Saraceno and Keck, 2010) since the allowance only applies in situations of extreme poverty and depends on the household's resources. The low amounts of care allowances, which had created expectations in carers, have ended up not valuing and not providing real compensation for care. At the same time, these care allowances can lead to an early exit from the labour market or greater dependence on other family members. The value of informal care is recognised, but measures that can ease the burden, particularly in the context of work-life balance policies, remain to be defined. The effects of these measures are still weak regarding gender differences, age, education, and racial discrimination, which are still predominant.

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- 1 The dependency pension complement (‘Complemento por dependência’) is awarded to a person requiring permanent assistance from a third person to perform daily life activities. First degree: people who cannot perform, with autonomy, basic needs of daily life (acts related to nutrition, locomotion, or personal hygiene care) (106.96 euros); second degree: people who are bedridden or suffer from serious dementia (192.52 euros).

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