



**European Network of Economic
Policy Research Institutes**

ANCIEN

Assessing Needs of Care in European Nations

THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN POLAND

STANISŁAWA GOLINOWSKA

ENEPRI RESEARCH REPORT NO. 83

JUNE 2010



ENEPRI Research Reports present the findings and conclusions of research undertaken in the context of research projects carried out by a consortium of ENEPRI member institutes. This report was produced by the ANCIEN project, which focuses on the future of long-term care for the elderly in Europe. Funding for the project is received from the European Commission under the 7th Framework Programme (FP7 Health-2007-3.2.2, Grant no. 223483). See the back page for more information. The views expressed are attributable only to the authors in a personal capacity and not to any institution with which they are associated. This report has also been published as CASE Network Studies and Analyses No. 416, by the Center for Social and Economic Research (CASE), Warsaw, 2010.

ISBN 978-94-6138-025-8

Available for free downloading from the CEPS website (www.ceps.eu) and
ANCIEN website (<http://www.ancien-longtermcare.eu/node/27>)

© Copyright 2010 Stanisława Golinowska.

Contents

1.	Poland's system for long-term care	1
1.1	Overview and philosophy of the system.....	1
1.2	LTC needs assessment.....	3
1.3	Available LTC services	3
1.4	Eligibility	6
1.5	Management and organization (roles of different actors/stakeholders).....	6
1.6	Integration of LTC.....	8
2.	Funding	8
3.	Demand and supply of LTC.....	13
3.1	The need for LTC (including demographic characteristics).....	13
3.2	The role of informal and formal care in the LTC system (including the role of cash benefits)	13
3.3	Demand and supply of informal care.....	14
3.4	Demand and supply of formal care.....	15
	3.4.1 Institutional care	16
	3.4.2 Home care	18
	3.4.3 Semi-institutional care	18
4.	LTC policy	18
4.1	Policy goals.....	19
4.2	Integration policy.....	19
4.3	Recent reforms and the current policy debate	19
4.4	Critical appraisal of the LTC system	20
	Abbreviations	22
	References.....	23

List of Tables

Table 1.	Regulations concerning LTC functions.....	2
Table 2.	Share of older persons in different types of social welfare homes.....	4
Table 3.	Actors and their responsibilities in organizing and providing LTC.....	7
Table 4.	Public funding of LTC functions in the health and social assistance sectors – Estimations (% and PLN million).....	9
Table 5.	Types of co-payments made by care recipients for care services, by source of care and financing.....	10
Table 6.	Benefits in cash for the elderly aimed at covering nursing and care needs at home (PLN million).....	12
Table 7.	Structure of the population by age and life expectancy at birth, indicators.....	13
Table 8.	Projections.....	13
Table 9.	Development of residential home care in the social assistance sector provided by <i>powiat</i> self-government (districts).....	16
Table 10.	Number of facilities (homes) and beds for LTC in the health care system.....	17

The Long-Term Care System for the Elderly in Poland

ENEPRI Research Report No. 83/June 2010

Stanisława Golinowska*

1. Poland's system for long-term care

1.1 Overview and philosophy of the system

In Poland's long-term care (LTC) system, the family is still identified as the main caregiver for elderly persons with limitations in the activities needed for daily living. Two indicators describe the relatively significant role families play in the care system: the 'co-residence' index (elderly parents residing with their children) and the index of 'non-working women aged 55-64'. The levels of both indicators put Poland in an extremely high position in terms of family commitment (Reimat, 2009). In the field of social protection, Poland belongs to the EU group of countries with a family-based welfare model. The development of formalized, non-family LTC is in the initial stages and is similar in both sectors: medical and social. The health care system reform of 1999 provided an opportunity for the development of public LTC institutions that are separate from hospitals. As a result, hospital departments were transformed into nursing and care institutions. Institutional care is simultaneously provided in the social sector. Residential and daycare homes are administered as a part of the social assistance (welfare) scheme. They care for the elderly whose daily living activities are limited, and who do not have families or need institutional care for other reasons, such as poverty.

At the present stage of LTC development, there is no specific regulation that comprehensively covers the issues of care services for the elderly, the institutions providing these services, the rules of access to them or the ways of financing them. The LTC category is used exclusively by experts in the health sector and the National Health Fund (NFZ – established in 2003), which, in its plans and reporting, has begun to separate contracts for nursing and care services in the out-of-hospital system. In such a situation, it is understandable that LTC in the health sector has a medical character: "Long-term care designates help and services for chronically ill or functionally impaired persons, including frail elderly, provided for an indeterminate period of time" (Bień and Doroszkiewicz, 2006). In the social sector category, LTC is used very rarely because the concept of social assistance (1991) emphasizes assistance that allows individuals to remain independent. In the social assistance sector, however, practice is often different from theory and legal assumption. In social welfare homes, the majority of residents are dependent with a wide range of LTC needs.

The issues concerning LTC can be found in several regulations, which are separate for the health care system and the social sector. They are presented in the comparison shown in Table 1.

* Stanisława Golinowska is a Professor of Economics and Director of the Institute of Public Health, Jagiellonian University Medical College in Kraków. This report has also been published as CASE Network Studies and Analyses No. 416, by the Center for Social and Economic Research (CASE), in Warsaw. For more information on CASE, see the penultimate page of this study.

Table 1. Regulations concerning LTC functions

Regulation	Subject of regulation	Comments
Health sector		
Law on health care units (1991, amended many times, most recently in 2006)	This law concerned the possibility of the functioning of two kinds of residential LTC units: care and treatment facilities (ZOL), and nursing and care facilities (ZPO).	Because of ten changes to the law and numerous regulations by the Ministry of Health to the subsequent versions of the law, the legal situation of health care providers is not sufficiently clear (Dercz and Rek, 2007).
Law on health care benefits financed from public sources (2004, amended 2009)	This law addressed the possibilities of providing LTC services at home.	In the law and regulation of the law by the minister of health, LTC services in patients' homes were specified to be provided by the environmental nurse or the nursing unit on the basis of the performance contract with the National Health Fund (NFZ).
Law on the nursing and midwifery professions (1996)	Nurses have the right to professional independence and can sign separate contracts with clients.	There are requirements in the law concerning nurses having their own rooms for care, which limits the development of home-based environmental care.
Social sector		
Law on social assistance (1990, significantly changed in 2004)	The amended law widened the benefit options for social assistance and specified the responsibilities of the particular units providing them.	The regulations for the law specify the income criteria for access to benefits, however the criteria are different for social assistance benefits (lower income levels) from those for family benefits.
Law on income of territorial self-governments (2003)	The sources of income for self-governments were defined in this law at each level as well as their financial responsibility for social matters.	According to the law, the territorial self-government receives from the state budget, apart from the general subvention, resources for grants-in-aid. These are allocated to the specified social goals, including maintenance of the care homes.
Law on family benefits (2003)	This law regulated anew the catalogue of the kinds of family allowances available and who has access to them. Among them are the nursing allowances and nursing benefits for ill, disabled and older persons and their caretakers.	For the first time, this law defined the benefits for family members when they move away from professional work in order to care for a disabled child or elderly person.
Law on old-age pension and disability pension from the Social Insurance Fund (1998, amended in 2009)	The law retained the universal extra payment to the disability pension and old-age pension – the care allowance – for persons aged 75 or older.	This law also specified the level of the care allowance and the rules of its indexation – as in the case of old-age and disability benefits.

Source: Author's compilation.

Territorial governments, which were established a few years ago (through the decentralization reform of 1999), are responsible for the evaluation of LTC needs and the coordination of LTC. They have not been able to fulfil all of their obligations so far.

1.2 LTC needs assessment

LTC needs are not adequately assessed in the planning/programming documents at the governmental level (either by the Ministry of Labour and Social Affairs or the Ministry of Health). Nevertheless, regional governments (*voivodships*) provide planning documents (according to regulations concerning territorial self-government obligations) with an assessment of social and health needs and *inter alia* with LTC needs in a given territory. These documents are not standardized and users cannot receive the appropriate information for the whole country.

The Central Statistical Office (GUS) provides statistical information on disability, which can be used to approximate data on LTC needs. On the basis of the national census data (NSP) collected by the GUS in 2002, it has been established that the number of disabled persons with an officially determined disability (defined as the inability to work) amounts to 14% of the entire population in Poland (GUS, 2003). Almost 60% of those with disabilities are aged over 60/65.¹ The percentage of disabled persons in the subsequent age brackets as well as the level of disability increases and at the age of 75 or older, almost half of the population has an officially determined disability (provided either by insurance institutions or by territorial self-government offices). This rate is only 1.4% higher for elderly women than for elderly men (48.8% and 47.4% respectively).

While conducting the national census in 2002 and during special research undertaken in 2004 and 2006, GUS also gathered information on self-perception of fitness and disability among the elderly. This data reveals that the feeling of being disabled more widespread in old age than it appears from the statistics of official records on occupational disability. As much as 20% of the elderly who are not legally deemed disabled feel they have functional limitations, whereas this is only 4% for the total population. Moreover, more elderly women categorized themselves as disabled than men (over 25% more) (GUS, 2006).

The number of persons with a significant degree of disability increases with age, which is not surprising. Yet the growth rate of this most profound type of disability was very high in Poland during the 1990s and in the beginning of the new decade. This tendency grew in parallel with improvements in the average life expectancy (after years of stagnation during 1960–90).

1.3 Available LTC services

Institutional care

Residential LTC in Poland is situated in the health care system as well as in the social sector (social assistance system). Earlier it was located only in the health care system.

LTC within the health care system

The following kinds of residential LTC are provided by the health care system:

- care and treatment facilities (*zakład opiekuńczo – leczniczy, ZOL*)
- nursing and care facilities (*zakład pielęgnacyjno – opiekuńczy, ZPO*)
- palliative care homes.

¹ Polish statistics also provide information on individuals at the so-called ‘non-productive age’, namely above age 60 for women and 65 for men.

These facilities emerged as a result of the hospital restructuring processes (Act on Independence of Hospitals, 1991). The Ministry of Health accepted the hospitals' initiative and at the end of the 1990s, a development programme for residential care homes was elaborated and the standards for their functioning were defined. The territorial self-governments joined the process of establishing residential LTC homes and the National Health Fund (NFZ) contracted out the established homes.

LTC within the social system

Another form of residential care exists in the social sector, mainly in the social assistance (welfare) system. There are two kinds of social welfare homes: residential (DPS) and adult daycare homes (DDPS). The adult daycare homes are for persons living with a family, in which the members are not able to provide care for the older person because of the professional activities of the family members (most often women: wives, daughters or daughters-in-law). In the working hours of family members, i.e. 5 days a week for no more than 12 hours a day, the dependent person can go to an adult daycare centre that provides all the necessary living and care services.

A residential social welfare home is defined as an institution that provides round-the-clock living conditions and protection as well as supportive and educational services at the level of current standards. In the residential care homes, there are those who never leave institutional care. In Poland there are several kinds of residential homes, separated according to the kind of person receiving care, i.e. those who are

- older
- chronically ill
- mentally ill
- intellectually disabled adults
- intellectually disabled children and youth
- physically disabled.

Apart from the existence of special care homes for the elderly, most individuals in other homes are also elderly, except in homes for the intellectually disabled. For example, in homes for the chronically ill, 80% of persons are over age 60, and in homes for the physically disabled, about 60% are over age 60 (Table 2; see also Szczerbińska, 2006).

Table 2. Share of older persons in different types of social welfare homes

Type of social assistance home	Share of persons aged 60+ (%)	Share of persons aged 75+ (%)
Disabled	55	32
Mentally ill	39	12
Chronically ill	80	56
Elderly	92	62

Source: Szczerbińska (2006).

Private residential LTC

Private residential LTC in Poland already existed during communist times, and was mostly administered by religious organizations. In the 1990s, other types of private residential homes were established by both non-profit and for-profit organizations based on the economic law that granted people the freedom to create their own businesses. Specific regulations for LTC regarding private ownership of facilities were established later. The new Social Assistance Act (2004) confirms that there are no legal obstacles to establishing private and profit-making residential homes and it regulates the functioning of private residential homes that provide care services for the elderly and/or chronically ill. Still, every residential home must have permission from the *voivoda* (i.e. a governmental representative at the regional level from the territory where a home is located) and it has to be registered every year. The basic conditions for obtaining permission are adjusting to the required standards. The current standard of services is defined by the directive concerning residential homes issued on the basis of the regulations of the new Social Assistance Act mentioned above. This Act entitles a *voivoda* to control residential care institutions as far as the living standards and observance of the residents' rights are concerned. Fees and other financial conditions of stay are based on an agreement between the organization and the client, not on the basis of an administrative decision issued by the relevant authority (as in the case of public residential homes). Private LTC homes, which operate in line with the legal regulations regarding LTC in the health sector, can compete for a contract with the public one from the statutory insurance (NFZ).

Home care

In the Polish tradition, the family has always fulfilled the bulk of the care functions for the elderly, handicapped or chronically ill. Although recent years have brought significant changes, families still take care of dependent family members. Assistance for families is rather limited. Care services may be granted to individuals who require help from others in cases where there is no family or if the family is unable to ensure such help.

In recent years, as a result of the health care reform (1999) together with the development of primary care and the institution of the family doctor, the institution of the 'environmental nurse' began to develop. This kind of nurse arranges for his or her own contracts with the NFZ for care in the patient's home.

Apart from formal nursing care, in every community the local centre of social services provides care services in cooperation with the appropriate non-governmental, non-profit organizations or even with for-profit organizations. Such home care services are fully provided and financed by local authorities.

Services offered

Some facilities of the health sector provide LTC services of a similar range, but which differ in terms of the accessibility and scope of medical and nursing care services. The main kinds of services in particular units are specified below:

- hospital departments for LTC and palliative services, which provide medical treatment and nursing;
- ZOL (care and treatment facilities), which provide nursing, rehabilitation and pharmacological treatment (previously provided during hospital treatment) for patients who do not need further hospitalization, but who are dependent and suffer from a partial or advanced disability and therefore need nursing and medical rehabilitation as a first priority. The services are provided on a 24-hour basis mainly by nurses and physiotherapists;

- ZPO (nursing homes), which offer nursing and 24-hour care, including appropriate feeding, depending on the health status and health literacy of a client. Moreover, ZPO offers the services of physiotherapists and psychologists;
- hospices and palliative facilities, which provide nursing and pharmacological treatment, physiotherapy, psychological and religious services; and
- environmental nurses, who offer nursing and care assistance in patients' homes.

In the social assistance homes (DPS), the LTC services are in addition to other services for the patient. Apart from accommodation and nutrition, the patients can receive the following services: nursing, care assistance, physiotherapy, occupational therapy, social work, health education, psychological work and religious services. Additionally, social assistance homes provide cultural and integration programmes and activities. The LTC services are provided by an environmental nurse (nursing team) or nurse employed by the DPS (a so-called 'own nurse').

1.4 Eligibility

The intention behind the creation of LTC institutions within the health care system followed the government programme (part of the health care reform of 1999) to take some of the workload off hospitals in terms of health care provided to dependent persons who no longer require medical care. Yet they often need the continued monitoring of pharmacological treatment administered in hospital, a certain range of medical rehabilitation as well as constant nursing care. The Barthel test is used for the assessment of care needs.² This test is used to evaluate a person's level of independence in ten basic, everyday life activities: 1) feeding, 2) transfer, 3) grooming, 4) toilet use, 5) bathing, 6) mobility, 7) stairs, 8) dressing, 9) bowels, and 10) bladder. For each activity, a maximum of 10 points is granted if it can be done independently and 0 if it cannot be done at all. Since 2008, a person must have 40 points in the Barthel index to qualify for LTC services, which in practice is a relatively high level of dependence. This low index level significantly restricts access to LTC financed from the national health insurance.

The period of stay at an LTC institution has been defined by regulation in principle as "up to 6 months" but it can be extended and even defined as permanent stay. Such a possibility was introduced by provisions in 2005 upon doctor's orders and if the payer expresses consent for this.

In the DPS, eligibility is connected with the income (means tested) and family situation of applicants, such as living alone. In the social welfare home, nurses are employed as social and nursing caregivers paid by the local self-government. If a resident of a DPS needs more comprehensive and medically-oriented nursing care, he or she can obtain it from the environmental nurse. The Barthel test is also used by the environmental nurse to grant services in the social welfare home.

1.5 Management and organization (roles of different actors/stakeholders)

Responsibility for the development, organization, financing and management of LTC in Poland is divided among four groups of actors/stakeholders: the central government, the governmental health agency (health sector), governmental labour and social agency (social sector) and territorial self-government. These actors have unequal levels of power and their boundaries of

² The Barthel index is used i.a. in other European countries, e.g. in the UK, from where the method came. In the Barthel test the criterion of the time for supportive activities by a caretaker is not taken into account, as it is in Germany. Research indicates that the Barthel test is very useful in Poland (Kuźmicz, Bzostek & Górkiewicz, 2008).

power are not yet fixed. On paper, the territorial self-government has a lot of autonomy and a lot of room for decision-making. In reality, regional and local autonomy is still weak owing to low levels of capacity and resources. Table 3 indicates the formal responsibilities of each of the four actors.

Table 3. Actors and their responsibilities in organizing and providing LTC

Actors	Responsibility	Type of responsibility
Central government	General	General regulations: strategy, standards, education of professionals, regulation of payments, means for territorial self-governments
Health sector	Residential LTC, home-based nursing	Regulation of access and funding (health insurance)
Social sector	Residential social and health assistance, support for home care	Regulation of access and co-funding of services
Territorial self-government	Both sectors	Assessment of needs, participation in the management of LTC facilities, responsibility for development of the LTC infrastructure and financing or co-financing home care
Non-governmental organizations	Social initiatives promoted by the appropriate level of territorial self-government if they are unique and provide the services not covered by public institutions	Development of good standards, response to specific needs

Source: Author's compilation.

In both in the health sector and in the social sector, LTC services are provided by the economic units, whose founding institution and supervisory bodies are the appropriate levels of territorial self-government. According to the Social Assistance Act (an amendment in 2004), both the development and management of an infrastructure of residential homes with LTC services is one of the duties of the territorial self-governments. So each self-government makes decisions about setting up or liquidating units and has an impact on the choice of manager. Depending on their range, there are local (*gmina*) residential homes (run by local self-governments), *powiat* residential homes (run by *powiat* self-governments) and regional or specialized care homes (run by *voivodship* self-governments). The services are provided in the specific units of the health sector and are financed on the basis of the contract with the National Health Fund (NFZ) and the services of the social assistance sector – from the self-governments' resources.

Territorial authorities finance or co-finance LTC services in the form of a subsidy targeted at the realization of defined tasks. Subsidies may be given to non-governmental organizations as well as to individuals and organizational units, which work on the basis of the agreement between the state and the Catholic Church in the Republic of Poland, and the state's relation to other churches and religious associations. Thus, residential homes can be run by the Catholic Church, other churches, religious associations, social organizations, foundations, associations, other legal units or even an individual person.

The chief organizers of home care services are the local self-governments (*gmina*). At the same time, environmental nurses work on the basis of contracts with the national health insurance (NFZ). The scope of their contracts is defined in the form of specific, individualized care plans and financed according to the task (not per capita).

All organizations and owners (self-governmental, non-governmental and private) running residential homes are obliged to have the permission of the *voivoda* to provide LTC services for individuals with functional limitations.

1.6 Integration of LTC

Integration within the LTC system

The integration of LTC services faces two kinds of problems: i) problems in the integration of institutions that operate on the margins of the health care system with institutions that operate within the social assistance scheme, and ii) the integration of residential care and home care. Special intervention in both sectors and additional resources are needed to link the two institutional settings of the health care and social assistance systems. Expanding the contracting of medical and nursing services under health insurance for the social assistance homes is limited because of the scarce financial resources in the health sector and insufficient personnel in the residential care sector. On the other hand, residential care institutions in the health sector, such as ZOL and ZPO, use very restrictive independence tests for admission (less than 40% of the Barthel index) and do not take into account the person's living conditions (such as the degree of poverty) when deciding upon access to LTC. As a result, LTC units in the health sector have to obtain some means to cover the costs of stay of their clients from the social assistance system if clients are unable to cover these costs by themselves. This is not always easy given the complexity of administrative procedures and the limitations of financial resources in both sectors. These are just several examples to illustrate some of the restrictions and everyday problems of the integration. These internal barriers to integration additionally hamper the availability of LTC services.

Integration with health and social services

As described above, the social and medical functions of LTC are separate in the case of Poland. According to the creators and legislators of the social and health policy systems established after 1990, local governments coordinate the two systems for their clients. Such coordination is not always efficient, however. The main causes of the inefficiencies are limited financial resources and managerial constraints. Restrictions in the availability of nursing personnel in both the social assistance and health care sectors also pose a significant constraint to integration.

2. Funding

The LTC systems in Poland are funded on a public–private basis. Within the public sector, there are two sources: health insurance (LTC services in the health sector) and general taxation (social assistance homes). The division of public resources allocated for LTC services in both sectors is difficult to determine. In the health sector, a large share is still born by hospitals (mainly the units for the chronically ill, rehabilitation units, etc.). This share can only be estimated, taking into account that about 30% of persons over age 65 use hospital services. Among this group about 10% will stay significantly longer than twice the average period of stay in the hospital (average length of stay indicator – 6.2 days, 2007).

The relation between the costs for LTC in the hospital and the costs in the special LTC units are moving towards decreasing the hospital costs and increasing the LTC units (Table 4). It seems that in 2007 the relation became balanced and since that year the separate LTC costs have been predominant (MZ, Zespół ds. przygotowania Zielonej Księgi, 2009).

The estimation of costs for LTC services in the social assistance sector is based on information about the age of persons staying in DPS facilities. It seems that it can be assumed that older

persons (older than 75), who make up over 50% of clients in DPS facilities, generally need LTC services,³ to a lesser or greater extent, due to their physical limitations (Szczerbińska, 2006).

Recent regulation caused the costs of LTC services to shift to the health sector, and consequently to financing from health insurance. In the health care system, a patient's payment is nowadays less than it is in the social assistance system (which is further explained in the next paragraph). Moreover, health sector employees have started to limit their engagement in the social sector as a result of the lower salaries offered by the territorial self-governments in comparison with the salaries financed by the National Health Fund (NFZ). In recent years there have been increases in the salaries of physicians and nurses.

Table 4. Public funding of LTC functions in the health and social assistance sectors – Estimations (% and PLN million)

Payer for LTC	2006	2008	Structure 2008 (%)
Health insurance; NFZ			56,6; 43,0
hospitals	0,800	0,700	
LTC	0,599	0,970	
General taxation;	1,200	1,280	43,4
social assistance*			57,0
Total – without hospitals	1,799	2,250	100
Total – with hospitals	2,599	2,950	100
As a % of GDP	0,17	0,18	–
	0,25	0,23	

* Only the expenses for welfare homes with LTC services have been included – in a proper share as a component of all social assistance expenses targeted at elderly persons with functional limitations.

Source: Author's estimations.

To sum up, public expenditures on LTC services constitute only 25% of GDP in Poland. They are provided in two sectors of the economy: the health sector and social assistance sector. Despite efforts to 'extract' LTC services from hospitals, which began after the reform of the health care system in 1999, there is still pressure to use hospital services. Access to outpatient LTC services in the health sector is limited by the sharp criterion of independence (below 40% of the Barthel index). In fact, only bedridden persons are eligible to receive care.

Co-payment

The public service provision of LTC requires a co-payment by the care recipient (Table 5). LTC care recipients in the residential facilities of the health sector pay only the cost of accommodation and board. Medical treatment and nursing are financed by health insurance. The monthly payments by care recipients are established at the level of 25% of the lowest pension, but this fee cannot be higher than an amount equivalent to 70% of the monthly individual income of the care recipient. When the NFZ funds LTC services by providers at a scale lower than the real number of care recipients, the providers offer places at commercial prices with a promise to lower the price following the acquisition of funds from the NFZ. The commercial

³ This assumption is also present in the regulations concerning the rules for granting general nursing benefits. Special studies on family care and economic activity confirm this assumption; in the group of persons aged 75 and older, care needs increase dramatically (AZER – Wóycicka and Rurarz, 2007).

price is usually 2–2.5 times higher than the fee that takes into account the NFZ's financial contribution. The poorest patients must rely on support from the social assistance system.

Table 5. Types of co-payments made by care recipients for care services, by source of care and financing

LTC institution	Public source	Co-payment
Wards in general hospitals: specific (for chronically ill) and non-specific	Health insurance	Informal
Care nursing units of the health sector (ZOL and ZPO)	Health insurance	Formal – for part of the costs (accommodation costs) but no more than 70% of the own income of the caretaker
Hospice care – Home – Facility	Health insurance and/or social resources (fund-raising and sponsoring) and local self-government units	Free of charge, but one can sponsor the unit
Care homes: residential	Self-government budgets for the share pertaining to social assistance – subventions plus the self-government's own resources	Formal, with the cost division as follows: 1) governmental subvention, 2) care recipient (70% of own income, 3) family (if their income is higher than the threshold of the social intervention), 4) local self-government from its own resources
Day's stay		Free of charge, but sponsoring involved
Home-based environmental care	Health insurance (NFZ) and the budgets of local self-governments	Free of charge; there are informal payments
Religion and church organization	Social resources	Voluntary
Non-governmental organizations – non- and for-profit organizations	Grant from self-governments and social resources	Free of charge or voluntary payments

Source: Author's compilation.

In the case of the LTC services provided within the social assistance system, payment is regulated on a general basis according to the amended Social Assistance Act (2004). This act divided the costs of the residential stay in social assistance homes into four parts, financed by different payers: 1) state subvention (according to the estimation, accounting for 75% of the cost of welfare homes), 2) care recipients (70% of individual income), 3) their families (depending on family income) and 4) the local social budget.

To test family income, an income threshold was introduced (as it is generally in the social assistance system); monthly income per capita in the family can be no more than 316 PLN (which amounts to about 10% of the average earnings in the economy). In practice this means that when an income does not exceed 316 PLN per capita (at the OECD equivalence scale), services are provided without family payment, and when the income ceiling is exceeded, the family of the resident must pay a certain percentage of the cost of the service.

Introducing family (spouse and/or children) co-payments for care home services was seen as a ‘revolution’ in the Polish social system. It was clearly stated that the family shares responsibility, according to the subsidiarity principle.

The economic slowdown brought changes to the division of financial responsibilities at the end of the 1990s. State subvention continued to decrease, and as a consequence the share of the payment financed by territorial self-governments should increase. But the territorial self-governments generally do not have many funds at their disposal and welfare homes are having financial troubles at the moment, which has led to urgent requests for a larger share of the costs to be covered by the family.

As the income threshold for social intervention is set rather low, less well-off families have also faced necessary payments (several hundred PLN) for the care of their family members in social welfare homes. To avoid this, some families have tried to move their relatives to the LTC units in the health care sector, where family payments have not been introduced. As a result, the queues for the social welfare homes have decreased and queues increased at the LTC homes in the health sector.

Income support for care recipients and family caregivers

The main care-related benefits in Poland are called ‘care allowances’. These payments are in addition to the old-age pension and disability pension. Individuals aged over 75 receive an extra permanent allowance, the care allowance, which is the same amount each month on top of their old-age or disability pension. It is supposed to cover the attendance care costs. This is a universal allowance, regardless of the degree of dependency. The value of this allowance (173.1 PLN) is symbolic in comparison with the actual costs of care (which are 10-20 times higher according to the commercial prices of LTC institutions). At the same time, contrary to the name, this is an unjustified expenditure in the case of fit persons. The care allowance is used by almost 2 million persons. If an elderly person does not receive an old-age or disability pension, s/he does not receive the extra payment either. The person can, however, gain a slightly lower nursing allowance in the frame of family benefits. Notably, persons needing care staying in any public place or residential care home financed from public sources are entitled to neither to the extra payment nor the allowance.

In 2003 nursing benefits were introduced for the family caregiver (parent, child, sibling or other legal guardian) of the disabled or elderly dependent person, if s/he had resigned from professional work in order to devote him or herself to care. Access to this benefit is limited by the income criterion, which is obligatory in the family benefit system (part of social assistance). It is used mainly by parents of disabled children, and to a lesser extent by caretakers of the elderly.

The expenditures on all of the financial benefits on individual income support earmarked for nursing needs at home are listed in Table 6.

Table 6. Benefits in cash for the elderly aimed at covering nursing and care needs at home (PLN million)

Benefits in cash	Comments	2006	2008
Extra care benefit for pensioners (<i>dodatek pielęgnacyjny</i>)	Universal allowance for persons aged 75 and older or for younger disabled dependent persons; the amount is 173.1 PLN (per month), financed by social insurance	3,345.5*	3,589.6*
Nursing benefit (<i>zasilek pielęgnacyjny</i>)	For disabled persons and the elderly aged 75 and older, who do not receive the extra benefit for pensioners; the amount is 153 PLN per month, financed by local self-government	1,209.5	1,416.1
Nursing allowance for caregivers (<i>świadczenie pielęgnacyjne</i>)	For caregivers in poor families, who have given up jobs to care for elderly family members, inter alia for persons aged 75 and older; the amount is 520 PLN per month (2009)	357.4**	336.5**
Total		4,912.4	5,342.2

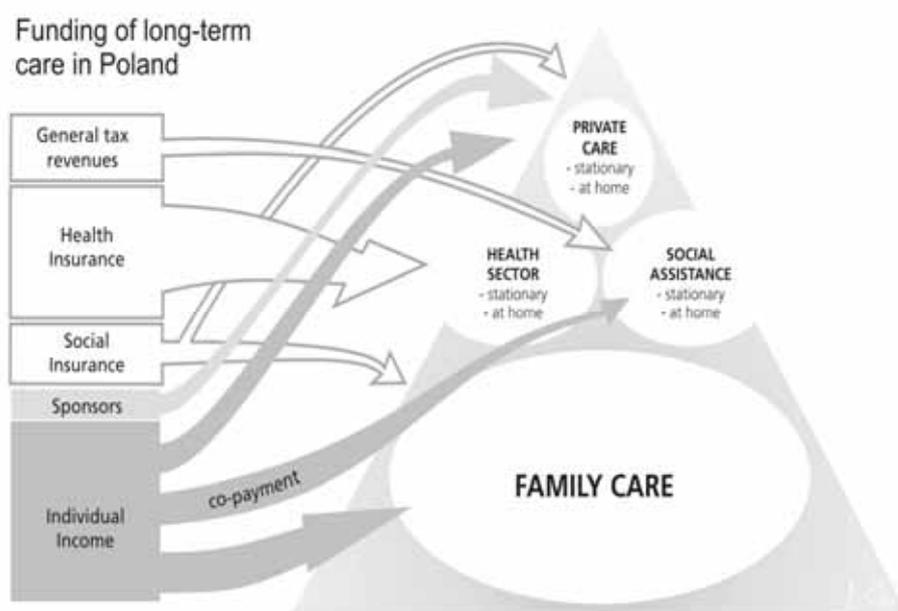
* Only for ZUS pensioners (without KRUS)

** Also covers benefits for caregivers of children with disabilities

Sources: Based on GUS (2007 and 2009) (*Rocznik Statystyczny* [Statistical Yearbook]) and ZUS (from the Statistical Department).

Public expenditures allocated for LTC services are almost twice as much as expenditures on the residential care in that field. They constitute about 0.5% of GDP. The number of beneficiaries is growing as well, with the tendency towards the progressive ageing of the population. In 2010–15, the number of persons aged over 75 will increase by almost 500,000, as the total population of the country decreases (GUS, 2009). Figure 1 gives a full picture of Polish LTC funding.

Figure 1. LTC funding in Poland



3. Demand and supply of LTC

3.1 The need for LTC (including demographic characteristics)

Demographic statistical data and projections show that the share of the elderly in the total Polish population has had a tendency to grow dynamically (Table 7). In 25 years, the share of persons in the total population aged 65 and older will be almost 25% and those aged 80 and older will be about 7% (Table 8).

Table 7. Structure of the population by age and life expectancy at birth, indicators

Population by age	1990	1995	2000	2002	2003	2004	2005	2006	2007	2008
Share aged 65+	10.2	11.3	12.4	12.8	13.0	13.1	13.3	13.4	13.5	13.5
Share aged 80+	1.9	2.0	2.0	2.2	2.4	2.5	2.7	2.8	3.0	–
Life expectancy at birth										
Men	66.5	67.6	69.7	70.4	70.5	70.7	70.8	70.9	71.0	–
Women	75.5	76.4	78.0	78.8	78.9	79.2	79.4	79.6	79.7	–

Source: GUS (2009).

Table 8. Projections

Population by age	2009	2010	2015	2020	2025	2030	2035
Share aged 65+	13.5	13.5	15.6	18.4	21.0	22.3	23.2
Share aged 80+	3.3	3.5	3.9	4.1	4.1	5.4	7.2

Source: GUS (2009).

It is estimated that approximately 50% of the population aged 65+ (which constitutes over 5 million persons) will need care and nursing owing to considerable limitations in activities (Szukalski, 2004). According to a national medical consultant, approximately 1 million persons suffer limitations in daily living activities, to a degree that renders independence at less than 40% of the Barthel scale (NFZ, 2007 and 2008).

3.2 The role of informal and formal care in the LTC system (including the role of cash benefits)

Families, namely spouses and children, are the main providers of care to the elderly who are not self-sufficient. According to the AZER survey (GUS et al., 2007), more than 80% of households with adults in need of care provide services based on unpaid family work. In the countryside, this percentage is even higher, at almost 90%. This result confirms other research results that were based on individual assessment. In the well-known public opinion poll in Poland by CBOS (Public Opinion Research Centre), when the elderly were asked from whom they receive care in case of illness and disability, 80% pointed to their children as the main providers of care (CSIOZ, 2004 based on CBOS).

Public institutional care in both the health and social sectors is provided only in marginal, dramatic situations of high levels of dependency and only for the poor and for persons with no relatives. Therefore, the public supply of institutional care is very limited. The number of beds

available in residential care is decreasing, along with financing from the local government budgets. Well-equipped, public LTC institutions with a sufficient number of personnel offer their services on a commercial basis.

There is greater income support for the elderly, although the widespread extra nursing payment is relatively low. Still, the very widely paid *Giesskanne prinzip* constitutes a significant budget position. Public expenditures on extra nursing benefits with the intention of allocating them for LTC services are almost twice as high as expenditures on the residential care services in that field (respectively 0.5% and 0.24% of GDP).

3.3 Demand and supply of informal care

Care within the family

Care of the elderly in Poland takes place mainly within the family. According to the representative statistical data, about 80% of those aged 65+ do not use any institutional care or home care provided by a third party (AZER study, GUS et al., 2007). This indicator is probably slightly overrated as in more well-off households caregivers are employed informally, which is not reflected in the statistics, but it reduces the indicator by only a few percentage points. Taking this into consideration, the indicator is still the highest among the EU countries. European studies confirm the major role of the Polish family in the provision of care services. In a questionnaire on the attitude towards the family care of older persons, 59% of Polish respondents in the sample answered that it should be done by children (as a moral obligation). This indicator for the remaining 27 EU member states was on average 30%. In the Czech Republic and Hungary it was 36%. In Germany it was 25% and in Holland it was only 4% (Eurobarometer, 2007).

A large share of the family care for the elderly is a result of both the strong ties in big families (cultural conditioning and the specific phase of economic development) and limited possibilities for care outside the family. In the traditional model of family care, care is performed by a woman (daughter or daughter-in-law), who leaves the labour market much earlier than her husband to provide care within the family, for both grandchildren and elderly parents. The surveys on family care for the elderly, the results of which were presented in the reports of two projects – Eurofamcare (Błędowski and Pedich, 2004) and the AZER study (Wóycicka and Rurarz, 2007) – show that women are the main caretakers of the elderly. The female family caregiver is often someone who also receives an old-age or disability pension. In 2008, the average age of women granted an old-age pension was 56.2 years (ZUS, 2009), while the official women's retirement age was 60 years. For men it was respectively 61.1 and 65 years. Women also leave the labour market earlier mainly as a result of being granted a disability pension. The average age of women granted a disability pension in 2008 was 47.3 years (for men the figure was 50.2 years). GUS research on the plans concerning retirement confirms the conviction about the need for women to leave the labour market earlier, significantly earlier than at age 60. This does not concern women who have completed higher education (GUS, 2007). In such a situation it is no wonder that proposals to make the retirement age equal for men and women and extend it to an older age have been met with strong social objections for many years. A typical female caregiver in a family has completed secondary school (in the city) or elementary school (in the country). Most of these women have not been trained for performing care, apart from possibly the cases of Alzheimer's disease.

The AZER study results note an additional factor related to family caregivers, namely to the participation of family members from the extended family (younger brothers and sisters, cousins, and grandchildren) in unpaid care. In the case of grandchildren, it is very often connected with a promise to inherit their grandparents' house or dwelling.

This tendency to provide care within the family is unlikely to continue in the future, for demographic and social development reasons, and the tendency towards regulating the labour market and social protection. Demographers have shown that the so-called ‘indicator of nursing potential’, i.e. the share of women aged 45-65 with reference to the population aged 75+ or 80+, is sharply decreasing (it will be halved in 20 years); individuals who need care will outnumber the potential number of women who could act as caregivers (Szukalski, 2009). Moreover, women aged 45-65 in the nearest future will not leave the labour market as early as they are doing so now, because the level of education and employability of the current generation of women will be much higher. Additionally, new labour market changes (lower labour supply) and pension reforms (the introduction of the defined benefit system) will incentivize women to work longer than in previous periods of the country’s development.

Care outside the family

Informal care for the elderly outside the family covers both care in the home by persons employed in the household without work permits and residential care in private care homes, which operate without the proper permission. Neither of these is rare, although in recent years a lot has been done to facilitate the legalization of both activities.

In households where an elderly person is cared for by an employee, the employees are mainly women from abroad, most often Ukrainians. Information on that comes from high-quality research on immigration to Poland (Domaradzka, 2007). According to this research, the demand for this kind of employment exists primarily in large cities and the engagement takes place through a rather close network of contacts.

As far as the care homes are concerned, whether functioning informally or not fully formally, the information comes from control research of the Supreme Chamber of Control (NIK), and recently from the monitoring of *voivods* (2009). As a result there have been attempts to legalize the activities of the private care homes.

It is very difficult to assess expenditures on informal care. It seems that the number of persons receiving care informally is the same as those receiving formal care. Even so, the expenditures on informal care may be less, as the costs in the gray zone are lower than the unit costs of care in the formal sectors. Its quality is significantly lower, as the care activities are performed by persons with much lower qualifications.

3.4 Demand and supply of formal care

Introduction

Demand for LTC services is influenced by demographic and epidemiological changes as well as by the developments and conditions of the labour market. The unfavourable labour market situation in Poland creates conditions for the early retirement of women, who take up the function of care providers for either their grandchildren or dependent parents/parents-in-law. In the near future this tendency is likely to decrease (see above) and demand for professional LTC services will rapidly increase. Johannes Koettl, a World Bank expert, has put forth the thesis that by 2020 the care needs of the elderly in Poland will increase so much that there will be a social shock (Koettl, 2009). Figuring out how to organize and finance LTC services will be the greatest social challenge for the country in the coming years.

3.4.1 Institutional care

According to the survey on household activities (AZER study, see GUS et al., 2007), only a small percentage of households use institutional care for adults needing care (and of children almost 20%).

Institutional care in the social sector

The network of residential homes (social welfare homes) in the social assistance sector is larger than the LTC homes within the health sector. There are approximately 800 homes (80,000 places) (MPiPS, 2008) in the social sector. In Table 9 we can see the development of the largest number of typical, social welfare homes provided at the district (*powiat*) level.

Table 9. Development of residential home care in the social assistance sector provided by powiat self-government (districts)

Number of homes/places	2004	2005	2006	2007
Homes	813	795	793	794
Places	80,633	80,226	78,918	78,337

Source: MPiPS (2008).

The number of social assistance homes increased in 1999, after a period of decrease during the 1990s. This stemmed from an administrative reform, which led to an increase in community ownership possibilities and the restructuring of property for social purposes. The number of residential care institutions increased by about 250 new institutions (25,000 places) compared with the period before the reform (1999). In 2005, the number of social assistance homes slightly fell again and then stabilized. The financial crisis at the end of the decade and changes in regulations connected with limitations in access to residential care in the social sector led to a lower demand for this kind of care. The waiting time for a place is shorter (Maciejczak, 2008); however, the waiting time for residential LTC is estimated to be approximately 2.5–3 months in the public setting.

Social welfare homes face problems in ensuring the appropriate quality of services, which were defined in 2001. The completion of adjustments to the quality of standards that were introduced was foreseen for 2009 (the deadline was postponed several times). A *voivod*, i.e. the representative of government administration in a region (*voivodship*), supervises the quality of care homes. According to a report by the Supreme Chamber of Control (NIK), the control functions in this respect are not being fully performed (NIK, 2006) and the executive regulations for the law on social welfare that was amended in 2004 are being introduced rather slowly.

LTC services for recipients of care in welfare homes are performed by nurses employed there (the ‘own nurses’). About 8,200 nurses work in social assistance homes (DPS), thus for one social welfare home there are ten nurses on average.

According to the law on health care units, which was changed in 2006, it is possible to set up an entire primary health-care unit in the care home. The founding institution is the local self-government. So far, in the DPS facilities, only 17 health care units have been set up. The problem is how to finance them. The decision must be made by the National Health Fund, which has very limited resources.⁴

⁴ In Poland only 4% of GDP is allocated for health care. It is one of the lowest indicators in Europe (Eurostat, 2008).

LTC services in the social sector are less available for those in need of care because the criterion of income (income test) is obligatory. Those who are better off, but not very affluent, can use private LTC services or the services at the market price, which are also offered in the public care homes. This additionally increases the demand for non-public LTC services and induces growth in the supply of private home care and the development of private LTC institutions, while the development of public LTC institutions lags behind the demand.

The establishment of private, profit-making care and nursing homes has been relatively widespread and in some regions there are more of these homes than public ones or those run by social organizations. Not long ago, many of them had been functioning informally, since the regulations on having permission for running such a home and obligatory care standards were not clear as recently as 2006 (NIK, 2006). The monitoring by the *voivods*, done at the beginning of 2008, showed that there are over 228 profit-making care homes in Poland (of which 25% are public) and only half of them have legalized status (Maciejczak, 2008).

Institutional care in the health care sector

The development of institutional care in the health system, which began in 1999 thanks to the health care and decentralization reforms, is still underway. At the beginning there were more than 100 such homes in operation with more than 9,000 beds; now there are more than 420,000 beds (Table 10).

Table 10. Number of facilities (homes) and beds for LTC in the health care system

Type of care	1999	2000	2001	2002	2003	2004	2005	2006	2007
Care and treatment ZOL									
- Facilities	95	126	149	174	190	227	251	300	–
- Beds	8,521	9,633	10,195	11,623	13,387	13,439	14,726	16,099	–
Nursing and care ZPO									
- Facilities	20	49	85	100	104	119	128	119	–
- Beds	861	1,800	3,146	3,642	3,863	4,595	5,165	4,847	–
Palliative care									
- Facilities	–	–	–	–	412	431	477	514	524
- Beds					691	747	851	841	971
Total (without palliative)									
- Facilities	115	175	234	274	294	346	379	419	–
- Beds	9,382	11,433	13,341	15,265	17,250	18,034	19,891	20,946	–

Source: GUS (Central Statistical Office) (2008).

The capacity of the LTC homes in the health sector is estimated at 4.2 places per 10,000 inhabitants. An increase in the capacity of LTC homes is planned to 14 places per 10,000 inhabitants in the coming years. These indicators are approximately ten times lower than the EU-15 level (MPiPS, 2009).

3.4.2 Home care

According to the regulations, the local self-government is responsible for the care of older persons. Even if the local self-government properly recognizes the need for care, what it can offer the elderly depends more on the resources that the self-government (*gmina*) has at its disposal, than on the estimated and actual needs of its residents. This problem was raised in the special report of the Ombudsman in 2008 (Szatur-Jaworska, 2008). Only dramatically difficult cases are unquestionably included in the provision of home care services, which are provided by the environmental nurse, financed by the National Health Fund (NFZ).

Access to LTC at home depends on one's independence rating (Barthel test), which is obligatory in the health sector. The institution of the environmental nurse may be widened to a caregiver 'team', which would include visits by physicians, psychologists or even priests. This would then constitute a unit of home-based environmental care. The range of persons under care using the services of the environmental nurse is very limited. In 2008, the number of contracts with the NFZ (21,500) was reduced by a third as a result of a change in the criteria for care, namely the introduction of the Barthel test for home care at the 40% index level.

3.4.3 Semi-institutional care

Adult daycare centres (DDPS) for persons needing help, but who are more independent than those in residential homes, are developing slowly, but systematically.

The basis for the DDPS is the concept of so-called 'supporting centres', as stated in the Law on Social Assistance of 2004, although centres of this type were functioning earlier. The DDPS are available to the elderly on the basis of a diagnosis performed by a social employee concerning the elderly person's disability (physical or mental) and a difficult living condition (poverty) qualifying for social assistance. The DDPS are mainly used by persons who are intellectually disabled and who have mental disorders, and elderly persons with mild psychophysical disorders. There is care for persons suffering from comas or Alzheimer's disease in some homes. The services of the DDPS cover meals, workshops on occupational therapy, social activities and sometimes physiotherapy and psychotherapy. Each home has its own statute and can change the range of the services provided. The services are provided free of charge on the basis of an application submitted to the centre for social assistance.

In Poland there are 250 such homes, and about 20,000 persons use them. The current financial crisis has slowed the development of these units. Moreover, increased usage of daycare homes puts pressure on the issue of transporting the care recipient. It is bothersome for the elderly person, for the family and for the local self-government responsible for the state of the roads and local infrastructure. In many regions of the country it would be a major problem.

4. LTC policy

The policy concerning LTC for the elderly in Poland is defined mainly in the health sector. In the period 2006–07, the Ministry of Health carried out work on the so-called 'nursing law', which aimed not only at separating the LTC sector in the system of social protection and health protection, but also at planning a new form of insurance, based on the example of Germany, i.e. nursing insurance, to enable the financing of this care. A replacement of the nursing extra benefit for individuals older than 75 with a selective benefit for the poor in need of nursing care

was discussed at the same time. Later (2008–09), however, these efforts were given up. Nowadays, political interest in this problem is growing, but mainly among the experts. It is hard to predict what kinds of guidelines will be specified in the political sphere. Because of the financial crisis, all proposals connected with increasing public expenditures have been postponed for future consideration.

4.1 Policy goals

The following five policy goals were formulated by government experts in the National Strategy on Social Protection and Social Inclusion of 2008–10, which was approved by the cabinet in December 2008:

- development of an LTC infrastructure that is responsive to the increasing demand for care;
- further education of professional LTC personnel, especially nurses and medical care providers;
- standardization of LTC services, including care provided at private LTC facilities;
- introduction of a more effective system of quality control of the LTC services; and
- creation and introduction of the information system on LTC.

The goals have been assigned to the Ministry of Health. Nevertheless, self-governments, according to their competences, should play a major role in their realization. They are responsible for the identification of the care needs, for the development of the LTC infrastructure and for information on the resources. To reach these goals, the self-governments need more capacity, especially know-how and financial resources.

4.2 Integration policy

So far, the policy of integrating the LTC services provided in two different sectors, the health care sector and the social assistance system, has not been the subject of debate. The responsibilities of the health sector are rapidly expanding. The activities of the national consultant on nursing⁵ are very significant. His/her yearly reports not only represent a source of information, but also set the activities. The health sector also proposed the introduction of LTC financing, namely nursing insurance.

4.3 Recent reforms and the current policy debate

Fundamental changes in the LTC system in Poland took place in the late 1990s when, together with the health care system reform, new, specialized residential care institutions providing LTC and nursing care came into existence. Following this, decisions about education and the qualifications of personnel were undertaken. A new specialization, namely the medical care provider, was introduced only in recent years (2006).

At the end of the decade, there were financial limitations in the health sector, which gave rise to limitations in access to LTC services. Medical professionals active in the LTC system have criticized the insufficient funding provided for services in ZOL and ZPO facilities. The National Health Insurance pays only half of the actual cost of the services (50 PLN per day compared

⁵ The institution of a so-called ‘medical consultant’ (national and regional) exists in every medical field in Poland. The consultant is a professional authority in a given medical specialty who comments on disputed issues, consults and gives opinions on administrative decisions as well as important developments in the medical field.

with the actual cost of 120-150 PLN per day). At the same time, it requires that a complete service is provided, as specified by the contract for care and nursing.⁶ As a result of insufficient funding, low quality services are provided, mainly because of a dereliction in nursing, which can be considered a violation of patients' rights. Such cases were reported to the Ombudsman and the General Sanitary Inspection in 2006. These incidents were the subject of discussion on the highly insufficient care within the LTC system in Poland. At the same time, the Barthel index level, which is used as an access criterion to residential care provision in the health sector, was lowered from 60 to 40%, which significantly reduced access to care and treatment (ZOL) and nursing and care (ZPO) facilities and to the district nurse services.

In the social sector, the significant changes that were favourable to the development of LTC services were introduced by the law on the social assistance (2004) and family benefits (2003). They widened the scope of care available at home and in adult daycare centres. Meanwhile, the rules on co-payment in the care homes changed, with payment from the family (not just from care recipients) being introduced. This slightly reduced the queue for DPS facilities. Generally, however, access to LTC services is now significantly limited.

The debate on LTC is dominated by the concern over insufficient resources in the circumstances of rapidly increasing needs, caused mainly by the demographic and labour market changes. This concern has been removed from the agenda because of necessary cuts to public expenditures owing to the financial crisis.

4.4 Critical appraisal of the LTC system

As a group, the elderly with functional limitations do not as yet constitute a significant health-care policy interest in Poland, although this group is becoming increasingly numerous. The number of the elderly (aged 65+) is currently estimated at about 3.2 million and the oldest among them (aged 80+) at about 1 million, with an expected increase by 50% and 100% respectively in the next 25 years (GUS, 2009). It is estimated that about 2 million persons will have functional limitations (Szukalski, 2004).

A change in the health care policy in relation to this group requires several simultaneous actions:

- increased education of doctors (particularly GPs and geriatricians) oriented towards the treatment of old-age illnesses;
- enhanced skills on the part of basic health care doctors (through appropriate life-long training) in the scope of health care, nursing care and social care within local communities;
- improved education and motivation of nurses to work with the elderly with functional limitations;
- development of occupational training and knowledge of integrated health and social protection, based on upper secondary vocational schools; university education should not be the sole way of obtaining nursing qualifications;
- verification of the Barthel index in order to estimate the appropriate level of needs for nursing and care;

⁶ This includes a national consultant on nursing for the chronically ill and disabled (2007) (www.mz.gov.pl).

- integration of the LTC services provided independently in two sectors, the health care sector and social assistance system, through the establishment of an extra body for this purpose at the territorial self-governmental level;
- development of the network of public and private (both non- and for-profit) LTC institutions with quality control and quality assurance of the standards and practices; and
- significant expansion of home care for the dependent elderly through targeted care benefits or nursing allowances for caregivers, based on the new definition of access – higher than 40% on the Barthel index.

Although there are still no prospects for the comprehensive regulation of LTC and its institutional separation (the situation has been exacerbated by the financial crisis), services for this type of care are advancing, mostly in the private and informal sector. In the formal sector, some access limitations have been introduced.

The dynamics of population ageing, accompanied by changes in family formation, labour market changes and pension reform have led to a lively expert and political debate on the future development of LTC services. Still, the current agenda is dominated by the financial crisis and promoting reforms in the public sector that reduce social expenditures.

Abbreviations

AZER	Labour Force, Education and Family Activities Survey (Aktywność Zawodowa, Edukacyjna i Rodzinna)
CBOS	Public Opinion Research Centre (Cenrum Badań Opinii Społecznej)
DDPS	Daycare homes of social assistance (<i>dzienne domy pomocy społecznej</i>)
DPS	Residential social welfare (assistance) homes (<i>domy pomocy społecznej</i>)
GUS	Central Statistical Office (Główny Urząd Statystyczny)
IPiSS	Institute of Labour and Social Studies (Instytut Pracy i Spraw Socjalnych)
LTC	Long-term care (<i>opieka długoterminowa</i>)
MPiPS	Ministry of Labour and Social Policy (Ministerstwo Pracy i Polityki Społecznej)
MZ	Ministry of Health (Ministerstwo Zdrowia)
NFZ	National Health Fund (Narodowy Fundusz Zdrowia)
NIK	Supreme Chamber of Control (Najwyższa Izba Kontroli)
NSP	National Census (Narodowy Spis Powszechny)
ZOL	Care and treatment facilities (<i>Zakład opiekuńczo – leczniczy</i>)
ZPO	Nursing and care facilities (<i>Zakład pielęgnacyjno – opiekuńczy</i>)
ZUS	Social Insurance Institution (Zakład Ubezpieczeń Społecznych)

References

- Bień, B. and H. Doroszkiewicz (2006), *Opieka długoterminowa w geriatrici: dom czy zakład opieki?* [Long-term care in geriatrics: Home or care facility?], *Przewodnik Lekarza* Nr 6/2006.
- Błędowski, P. and W. Pędich (2004), *Services for Supporting Family Carers of Elderly People in Europe: Characteristics, Coverage and Usage*, National Background Report for Poland, Eurofamcare Project, Hamburg.
- Centrum Badań Opinii Społecznej (CBOS) (2009), *Polacy o hospicjach i opiece paliatywnej* [Poles in hospices and palliative care], CBOS, Warszawa.
- CSIOZ (2004), *Dostępność świadczeń zdrowotnych w opinii Polaków 1998–2003* [Health care Services Accessibility in the View of Polish citizens 1998–2003], CSIOZ, Warszawa.
- Domaradzka, E. (2004), *Popyt na pracę migrantów w Polsce. Wyniki badań empirycznych*, in S. Golinowska, *Popyt na pracę cudzoziemców. Polska i sąsiedzi* [Demand for work performed by foreigners: Poland and neighbours], IPiSS, Warszawa.
- Dercz, M. and T. Rek (2007), *Ustawa o zakładach opieki zdrowotnej – komentarz* [Act on Health Care Providers – Comment], Wolters Kluwer Polska ABC, Kraków.
- European Commission (2008), *Long-term care in the European Union*, European Commission, Brussels.
- Golinowska, S. and A. Koziarkiewicz (2008), *Quality in and Equality of Access to Healthcare Services, Country Report for Poland*, HealthQUEST Project, European Commission, Brussels.
- Golinowska, S. (ed.), B. Balcerzak-Paradowska and J. Krzyszkowski (2007), *In-depth country study on Social and Health Services of General Interest (SHSGI) in the EU: The Case of Poland*, European Commission, Brussels.
- GUS (2003), *Osoby niepełnosprawne oraz ich gospodarstwa domowe* [People with disabilities and their households], Narodowy Spis Powszechny, GUS, Warszawa.
- (2006), *Podstawowe dane z zakresu ochrony zdrowia w 2005r.* [Basic data on health care in 2005], GUS, Warszawa.
- (2008), *Podstawowe dane z zakresu ochrony zdrowia w 2007* [Basic data on health service and social welfare], *Statistical Information and Papers*, GUS, Warszawa (<http://www.stat.gov.pl/>).
- (2009), *Prognoza ludności na lata 2008–2035* [Population projections for Poland 2008–2035], GUS, Warszawa.
- GUS, IBnGR, SGH and UW (2007), *AZER (Aktywność Zawodowa, Edukacyjna i Rodzinna)* [Labour force, education and family activities survey], GUS, IBnGR, SGH and UW, Warszawa.
- Koettl, J. (2009), “Challenges of financing and provisioning of long-term care in Eastern Europe”, presentation at the “6th Health and Ageing Conference” of the Geneva Association, Warsaw, 26-27 November.

- Kozierkiewicz, A. and K. Szczerbińska (2007), *Opieka długoterminowa w Polsce: ocena stanu obecnego oraz rozwiązania na przyszłość* [LTC in Poland: Assessment of the current stage of development and future solutions], Wspólny Rynek Medyczny oraz Wydawnictwo Termedia, Warszawa.
- Kuzmicz, I., T. Brzostek and M. Górkiewicz (2008), Kwestionariusz Barthel jako narzędzie pomiaru zakresu samodzielności fizycznej osób w podeszłym wieku [Barthel Questionnaire as a Measurement Tool for the Physical Independence of Older Adults], *Studia Medyczne*, Nr 12/2008.
- Krzyszczkowski, J. (2003), "Social Care and Social Work in Poland since 1989: Evidence from Recent Research", *Social Work in Europe*, Vol. 10, No. 3/2003.
- (2005), "Labour Demand and Supply in the Care Sector: The Case of Poland", unpublished report for European Foundation of Improving Living and Working Conditions, Dublin.
- Maciejczak, R. (2008), Brak kontroli w domach pomocy społecznej, [Lack of supervision in social assistance homes], *Gazeta Samorządu i Administracji*, Nr 12, Warszawa.
- MPiPS (2008), *National Strategy Report on Social Protection and Social Inclusion*, MPiPS, Warsaw.
- (2009), *Raport o rynku pracy i zabezpieczeniu społecznym. Polska 2008* [Report on labour market and social security: Poland 2008], MPiPS, Warszawa.
- MZ (2007), *Informacja o stanie opieki długoterminowej w Polsce* [Information on the current situation of the LTC in Poland], Sprawozdanie z działalności konsultanta krajowego w dziedzinie pielęgniarstwa przewlekle chorych i niepełnosprawnych w 2007 r., MZ, Warszawa (<http://www.mz.gov.pl>).
- MZ, Zespół do przygotowania raportu: Finansowanie ochrony zdrowia w Polsce – Zielona Księga (2009), *Finansowanie ochrony zdrowia w Polsce* [Funding and financing of health care in Poland], Kraków: Wydawnictwo Vesalius.
- Najwyższa Izba Kontroli (NIK) (2006), Informacja o wynikach kontroli prawidłowości świadczenia usług przez domy pomocy społecznej, KPZ 41009 -05, Warszawa.
- Narodowy Fundusz Zdrowia (NFZ) (n.d.), Zarządzenia Prezesa w sprawie w sprawie określenia warunków zawierania i realizacji umów w rodzaju: opieka długoterminowa, 2007 and 2008 (<http://www.nfz.gov.pl>).
- Reimat, A. (2009), *Welfare regimes and long-term care for elderly people in Europe*, paper prepared for the IMPALLA-ESPAnet Conference, "The European Social Model in a Global Perspective", Luxembourg, 6-7 March.
- Szatur-Jaworska, B. (ed.) (2008), Stan przestrzegania praw osób starszych w Polsce. Analiza i rekomendacje działań, *Biuletyn RPO – Materiały*, nr 65, Warszawa.
- Szczerbińska, K. (ed.), (2006), *Dostępność opieki zdrowotnej i pomocy społecznej dla osób starszych w Polsce* [Access to health care and social assistance for the elderly in Poland], Wydawnictwo Uniwersytetu Jagiellońskiego, Kraków.
- Szukalski, P., (2004), Projekcja liczby niepełnosprawnych seniorów do 2030 r. [Projection of the number of disabled elderly persons to 2030], in J. Kowaleski and P. Szukalski (eds), *Nasze starzejące się społeczeństwo. Nadzieje i zagrożenia*, Wydawnictwa Uniwersytetu Łódzkiego, Łódź.

- (2009), Starzenie się ludności a publiczny kontrakt intergeneracyjny, in J. Kleer (ed.), *Konsekwencje ekonomiczne i społeczne starzenia się społeczeństwa*, PAN, Komitet Prognoz 'Polska 2000 Plus', Warszawa.
- Wóycicka, I. and R. Rurarz (2007), Zapotrzebowanie na opiekę [Demand for care], in I.E. Kotowska, U. Sztanderska and I. Wóycicka, *Aktywność zawodowa i edukacyjna a obowiązki rodzinne*, Wydawnictwo Naukowe Scholar, Warszawa.
- ZUS (2009), *Ważniejsze informacje z zakresu ubezpieczeń społecznych 2008 r.* [Most important information on social insurance in 2008], ZUS, Warszawa.

About the Centre for Social and Economic Research (CASE)

CASE is an independent, non-profit, economic and public policy research institution founded on the idea that evidence-based policy-making is vital to the economic welfare of societies. Established in 1991 in Warsaw, CASE scholars and researchers assisted policy-makers during the early years of transition, before turning their attention to the challenges inherent in the European Union enlargement process and then EU key policy challenges in the globalized world. While remaining focused on our five core thematic areas of 1) the European Neighbourhood Policy, enlargement, trade and economic integration, 2) labour markets, human capital and social policy, 3) innovation, competitiveness and entrepreneurship, 4) reforms, growth and poverty reduction in developing and transition countries, and 5) macroeconomics and public finance, we want to contribute to new debates facing Europe, including the economic impact of climate change mitigation policies and the economics of energy policy. In addition to consolidating our position in the European research market, we are also broadening our geographical horizons by going beyond our traditional countries of interests, i.e. the Western Balkans and the Commonwealth of Independent States. Starting in 2006, we became active in the Middle East and Africa, where we hope to strengthen our presence by competing for technical assistance projects. Networking and communication activities remain central to our organizational development. As CASE entered its 18th year of existence in 2008, we want to build on our relationships with our own internal network, associated organizations and membership in international and external networks, partnerships and alliances to make our research and expertise available and have a growing impact in the European policy debate. Reaching out to an increasing number of international experts is another of our priorities.

ANCIEN

Assessing Needs of Care in European Nations



FP7 HEALTH-2007-3.2-2

L launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

- 1) How will need, demand, supply and use of LTC develop?
- 2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (<http://www.ancien-longtermcare.eu>).