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THE SYSTEM OF LONG-TERM CARE IN POLAND

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Abbreviations:

ALOS	Average Length of Stay Indicator
AZER	Labour Force, Education and Family Activities Survey (Aktywność Zawodowa, Edukacyjna i Rodzinna)
CBOS	Public Opinion Research Centre (Cenrum Badań Opinii Społecznej)
DDPS	Daily homes of social assistance (dzienne domy pomocy społecznej)
DPS	Social welfare (assistance) homes (domy pomocy społecznej)
GUS	Central Statistical Office (Główny Urząd Statystyczny)
IPiSS	Institute of Labour and Social Studies (Instytut Pracy i Spraw Socjalnych)
LTC	Long-term care (opieka długoterminowa)
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)
NGO	Non-Governmental Organization
NIK	National Control Chamber (Najwyższa Izba Kontroli)
NSP	National Census (Narodowy Spis Powszechny)
ZOL	Care and treatment facilities (Zakład opiekuńczo – leczniczy)
ZPO	Nursing and care facilities (Zakład pielęgnacyjno – opiekuńczy)
ZUS	Social Insurance Institution (Zakład Ubezpieczeń Społecznych)

1. Poland's System of 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 people with limitations on 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 'non-working women aged 55-64' index. The levels of both indicators situate 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 the family-based welfare model. The development of a formalized non-family LTC is in initial stages and is similar in both sectors: medical and social. Only recently did the health care system reform of 1999 provide 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. Stationary and semi-stationary 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, and the ways of financing them. The LTC category is used exclusively by the experts of 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, Doroszkiewicz 2006). In the social sector category, LTC is used very rarely because the new concept of social assistance (1991) emphasizes assistance that allows people to be independent. However in the social assistance sector, practice is often different from theory and legal assumption. In social welfare homes, the majority of residents are dependant people with a wide scope of LTC needs.

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

Comparison 1: Regulation concerning LTC functions

Regulation	Subject of regulation	Comments
HEALTH SECTOR		
Law on health care units (1991, amended many times, most recently in 2006)	Possibility of functioning of two kinds of stationary LTC units: ZOL and ZPO	Because of 10 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, Rek 2007)
Law on health care benefits financed from public sources (2004, amended 2009)	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 the environmental care.
SOCIAL SECTOR		
Law on social assistance (1990, significantly changed in 2004)	The amended law widened the benefits options for social assistance and specified the responsibilities of the particular units providing them	The regulations to the law specify the income criteria for access to benefits however the criteria are different for social assistance benefits (lower income levels) than for family benefits.
Law on income of territorial self-governments (2003)	The sources of income for self-governments were defined in this law on each level as well as their financial responsibility for social matters.	The territorial self-government according to the law receives from the state budget, apart from the general subvention, also resources for the grants-in-aid allocated for 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 people and their caretakers.	For the first time, this law defined the benefits for family members when they resign 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 called care allowance for people aged 75 or more	The 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.

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 the LTC. They have not been able to fulfill 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). However 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 people 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 people with disabilities are people aged over 60/65¹. The percentage of disabled people 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 elderly people's self-perception of fitness and disability. This data reveals that the feeling of being disabled is stronger 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 people with a significant degree of disability increases with age, which is not surprising. However, 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 in the period of 1960-1990).

¹ Polish statistics also provide information on people of the so-called non-productive age, namely above 60 years of age for women and above 65 years of age for men.

1.3. Available LTC services

Institutional Care

Residential LTC in Poland is located 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 located in the health care system:

- Care and treatment facilities (zakład opiekuńczo – leczniczy ZOL)
- Nursing and care facilities (zakład pielęgnacyjno – opiekuńczy ZPO)
- Palliative care homes

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, and a development program of residential care homes was elaborated and the standards for its 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 type 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 day care homes (DDPS). The adult day care homes are for persons living with family, in which the members are not able to provide care for the older person because of 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 dependant person can go to an adult day care center, which provides all the necessary living and care services.

A residential social welfare home (DPS) is defined as an institution which provides round-the-clock living conditions, protection as well as supportive and educational services at the level of current standards. In the residential care homes there are people who never leave the institutional care. In Poland there are several kinds of residential homes, separated according to the kind of persons under care, that is:

- older people
- chronically ill
- mentally ill

- intellectually disabled adults
- intellectually disabled children and youth
- physically disabled

Apart from the fact that there are special care homes for elderly people, most people in other homes are also elderly people; except the homes for the intellectually disabled. For example in homes for the chronically ill, 80% are persons over 60 years old, and in homes for the physically disabled, about 60% are over 60 years old (Szczerbińska 2006).

Table 1: Share of older people in different types of social welfare homes

Type of social assistance home	Share of people aged 60 +	Share of people 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 90s, other types of private residential homes were established by both non-for profit and for-profit organizations based on the economic law which 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 regulates the functioning of private residential homes which provide care services for elderly and/or chronically ill people. However every residential home must have permission from the voivoda (i.e. a governmental representative on the regional level from the territory where a home is placed) and it has to be registered every year. The basic conditions for getting 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 stationary care institutions as far as the living standards and obeying 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 legal regulations regarding the 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 care functions towards 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 people who require other people's help in the 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 National Health Fund (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 as well. Such home care services are fully provided and financed by local authorities.

Services offered

Some units of the health sector provide LTC services of a similar range, but which differ as far as accessibility and proportion of medical services to nursing care services are concerned. The main kinds of services in particular units are specified below:

- Hospital departments for LTC and palliative services: medical treatment and nursing
- ZOL (Care and Treatment Facilities): nursing, rehabilitation and pharmacological treatment (previously provided during hospital treatment) for patients who do not need further hospitalization, but 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 24 hours mainly by nurses and physiotherapists.
- ZPO (Nursing Homes): 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: nursing and pharmacological treatment, physiotherapy, psychological and religious services
- Environmental nurses: 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 in DPS (a so called ‘own nurse’)

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 workload off hospitals in terms of healthcare provided to dependent persons who no longer require medical care. However, they often need continued monitoring of pharmacological treatment administered in hospital, a certain scope 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 assess a person’s level of independence in 10 basic every day life activities: (1) feeding, (2), transfer, (3) grooming, (4) toilet use, (5) bathing, (6) mobility, (7) stairs, (8) dressing, (9) bowels, (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 social assistance institutions (DPS), eligibility is connected with the income (means testing) and family situation of applicants, such as living alone. In the social welfare home, nurses are employed as social and nursing care givers paid by the local self-government. If a resident of DPS needs more comprehensive and medical oriented nursing care, he or she can obtain it from the environmental nurse. The Barthel test is also used by the environmental nurse in order to grant services in the social welfare home.

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

1.4. Management and Organisation (roles of different actors/stakeholders)

Responsibility for the development, organisation, financing and management of LTC in Poland is divided between 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 power are not yet stable. On paper, the territorial self-government has a lot of autonomy and a lot of space for decision-making. In reality, regional and local autonomy is still weak due to low levels of capacity resources. The comparative table below indicates the formal responsibilities of each of the 4 actors.

Comparison 2: Actors and responsibilities in organizing and providing of 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 LTC infrastructure and financing or co- financing home care
NGOs	Social initiatives promoted by the appropriate level of territorial self-government if they are unique and respond to the uncovered services by public institutions	Development of good standards, response to specific needs

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 have an impact on the choice of manager. Depending on their range, there are local (gmina) residential homes (run

by local self-governments), poviats residential homes (run by poviat self-government) and regional or specialized care homes (run by voivodship self-government). 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-government 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 people and organizational units which work on the basis of the agreement between the state and the Catholic Church in the Republic of Poland, the state's relation to other churches and religious associations. So, 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-government (gmina). However 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 people with functional limitations.

1.5. Integration of LTC

Integration within the LTC system

The integration of LTC services faces two types of problems: (i) problems with 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 in order to link the two institutional settings of the health care and social assistance systems. Expanding the contracting of medical and nursing services to health insurance for the social assistance homes is limited due to 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 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 due to the complexity of administrative procedures and the limitations of financial resources in both sectors. These are just several examples to present some of the restrictions and every day 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. However, such coordination is not always efficient. The main reasons for these 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

LTC systems in Poland are funded on the 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 identify. In the health sector a large part is still born by hospitals (mainly the units for chronically ill, rehabilitation units, etc). This part can be only estimated, taking into account that about 30% of people over 65 use hospital services. Of this group about 10% will stay significantly longer than an average period of stay in the hospital doubled (indicator ALOS – 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. It seems that in 2007 the relation became even and since that year the separated LTC costs are 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. It seems that it can be assumed that older persons (more than 75 years old), who make up over 50% in DPS, generally need LTC services³, to a lesser or greater extent, due to their physical limitations (Szczerbińska 2006).

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

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 lower than in the social assistance system (which will be further explained in the next paragraph). Moreover, health sector employees started to limit their engagement in the social sector as a result of the lower salaries offered by the territorial self-governments in comparison to the salaries financed by the National Health Fund (NFZ). In recent years there were increases in physicians' and nurses' salaries.

Table 2: Public funding of LTC functions in the health and social assistance sectors, in PLN (millions) – estimations

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

Notes: * 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 people with functional limitations

Source: own estimations

To sum up – public expenses for LTC services constitute only ¼ % of GDP in Poland. They are provided in two sectors of the economy: the health sector and social assistance sector. Apart from 'extracting' LTC services from the hospital, which began after the reform of the health care system in 1999, there is still pressure to use hospital services. Access to out of hospital 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 services of LTC require a co-payment by the patient. Individual 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 payment of care recipients is established at the level of 250 % of the lowest pension. However this fee can not be higher than the amount equivalent to 70% of the monthly individual income of the care recipient. When NFZ funds LTC services for providers at a scale lower

than the real number of patients, the providers offer places at commercial prices with a promise to lower the price following the acquisition of funds from NFZ. The commercial price is usually 2 – 2.5 times higher than the fee that takes into account NFZ's financial contribution. The poorest patients must rely on support from the social assistance system sources.

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 cost of the residential stay in social assistance homes into 4 parts, financed by different payers: (1) state subvention (according to the estimation - 75% of the cost of welfare homes), (2) care receivers (70% of individual income), family (depending on family income) and (4) 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 about 10% of 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 price of the service.

Introducing family (spouse and/or children) co-payments into care homes was seen as a 'revolution' in the Polish social system. It was clearly stated that the family is co-responsible, according to the subsidiarity principle.

The economic slowdown brought changes to the financial responsibility at the end of the 1990s. State subvention has been decreasing, and, as a consequence, the share of payment by territorial self-government should increase. However, 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 bigger share of payment for the family.

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

Table 3: Types of co-payments people make to use care services according to the sources of financing

LTC institutions	Public sources	Co-payment
Wards in general hospitals: specific (for chronically ill) and non-specific	Health insurance	Informal
Care nursing units of the health sector (ZOL i ZOP)	Health insurance	Formal – part of the costs (hotel costs) – no more than 70% of own income of the caretaker
Hospices: · home · stationary	Health insurance or/and social resources (fund-raising and sponsoring) and local self-government units	Free of charge, but one can sponsor the unit
Care homes: stationary	Self-governments budgets in the part concerning the social assistance – subventions + self-government's own resources	Formal – cost division: (1) governmental subvention, (2) person under care (70 % of own income, (3) family (if its 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
Environmental care	Health insurance NFZ and budget of local self-governments	Free of charge. There are informal payments
Religion and church organization	Social resources	Voluntary
Non governmental organizations - non for profit organizations	Grants of self-governments and social resources	Free of charge or voluntary payments

Source: own comparison

Support of income of care receivers and family care-givers

The main benefits in Poland are called 'care allowances'. These are additional payments to the old-age pension and disability pension. Persons over 75 years of age receive an extra permanent allowance, a so called care allowance which is the same amount each month in addition to their old-age or disability pension. It is supposed to cover 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 to the actual costs of care (which are 10-20 times higher according to 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 mln persons. If an elderly person does not earn old-age and disability pension, he/she does not receive the extra payment either. The person can, however, gain a slightly lower nursing allowance in the frame of family benefits. Persons needing care staying in any public place or stationary care home financed from public sources are entitled to neither 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 he/she 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 the social assistance). It is used mainly by parents of disabled children, and to a lesser extent the caretakers of the elderly.

The expenditures for all the financial benefits on individual income support earmarked for nursing needs at home have been listed below.

Table 4: Benefits in cash for the elderly with intention to cover nursing and care needs at home - in million PLN

Benefits in cash	Comments	2006	2008
Extra care benefit for pensioners (dodatek pielęgnacyjny)	Universal allowance for persons aged 75 and more or for younger disabled dependant persons – amount 173,1 PLN (monthly) financed by social insurance	3 345, 5*	3 589,6*
Nursing benefit (zasiłek pielęgnacyjny)	For persons with disabilities and elderly aged 75 and more, who don't receive extra benefit for pensioners, amount - 153 PLN monthly financed by local self-government	1209,5	1416,1
Nursing allowance for care givers (świadczenie pielęgnacyjne)	For care givers in poor families, who have given up jobs to care for elderly family members, interalia for person aged 75 and more – amount 520 PLN monthly (2009)	357,4**	336,5**
Total		4 912, 4	5 342,2

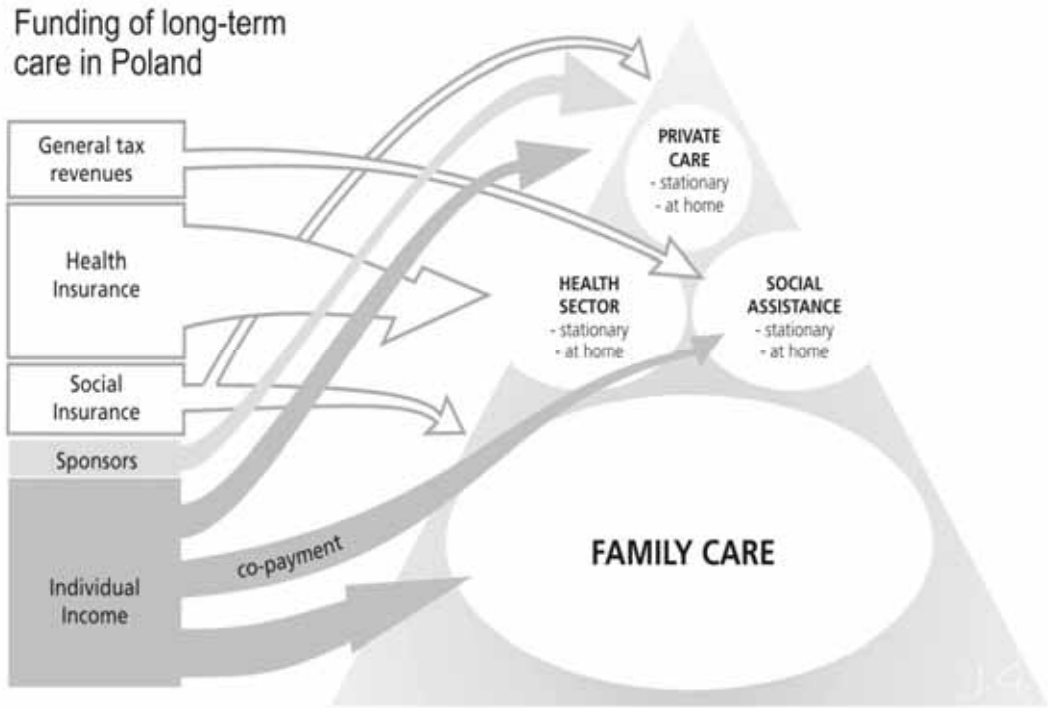
Notes: * only for ZUS pensioners (without KRUS), ** also covers benefits for care givers for children with disabilities

Sources: based on GUS 2007, 2009 (Rocznik Statystyczny- Statistical Yearbook) and ZUS (from Statistical Department)

Public expenditures allocated for the LTC services are almost twice as much as expenditures on the stationary services in that field. They constitute about 0.5% of GDP. The number of beneficiaries grows as well with the tendency towards the dynamic ageing of the

population. In 2010 – 2015 the number of people over 75 will increase by almost 500,000, as the total population of the country decreases (GUS 2009).

An entire picture of the 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 elderly in the total Polish population has a tendency to grow dynamically. In 25 years, the share of people in the total population aged 65 and more will be almost ¼ and the people aged 80 and more will be about 7%.

Table 5: Structure of the population by age and life expectancy at birth indicators

Items	1990	1995	2000	2002	2003	2004	2005	2006	2007	2008
Share of 65+	10.2	11.3	12.4	12.8	13.0	13.1	13.3	13.4	13.5	13.5
Share of 80+	1.9	2.0	2.0	2.2	2.4	2.5	2.7	2.8	3.0	-
LE at birth										
Male	66.5	67.6	69.7	70.4	70.5	70.7	70.8	70.9	71.0	-
Female	75.5	76.4	78.0	78.8	78.9	79.2	79.4	79.6	79.7	-

Source: GUS 2009

Table 6. Projections

Items	2009	2010	2015	2020	2025	2030	2035
Share of 65+	13.5	13.5	15.6	18.4	21.0	22.3	23.2
Share of 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 of 65+ (which constitutes over 5 million people) will need care and nursing due to considerable limitations in activities (Szukalski). According to a national medical consultant, approximately 1 million people suffer limitations in daily living activities, reaching 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 (2007), more than 80% of households with adults in need of care provide services based on unpaid family work. In the country side, this percentage is even higher at almost 90%. This result confirms other research results which were based on individual assessment. In the well-known Polish public opinion poll, CBOS, 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 Opinion Research Centre]).

Public institutional care in both the health and social sectors is provided only in the marginal, dramatic situations of high dependency and only for people with no relatives and poor people. 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. However, the very widely paid *Giesskanne prinzip* constitutes a significant budget position. Public expenses on extra nursing benefits with the intention of allocating them for LTC services are almost twice as high as expenses on the stationary 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 elderly people in Poland takes place mainly in the family. According to the representative statistical data, about 80% of people aged 65+ don't use any institutional care or home care provided by a third party (AZER study 2007). This indicator is probably slightly overrated as in more well-off households care givers 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 care services. In a questionnaire on the attitude to 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 the economic development), and limited possibilities for care outside the family. In the traditional model of family care, care is performed by the woman (daughter, daughter-in-law), who leaves the labour market much earlier than her husband to provide care in the family; for both the grand children and elder parents. The surveys on the family care for the elderly, the results of which were presented in the reports of two projects: Eurofamcare (Błędowski, Pedich 2004) and AZER (Wóycicka, Rurarz 2007) show that women are the main caretakers of elderly people. The female family caregiver is often-times a person who also receives the old-age pension 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 years and 65 years. Women also leave the labour market earlier as a result mainly of being granted a disability pension. The average age of women granted a disability pension in 2008 was 47,3 years (man – 50,2 years). GUS research on the plans concerning retirement confirm the conviction of the need for women to leave the labour market earlier, significantly earlier than at the age of 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 objection for many years. A typical female care giver 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, 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 in the family is unlikely to continue in the future, both because of 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 75+ or 80+, is sharply decreasing (it will be halved in 20 years); People 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 now, because the level of education and employability of the current female generation will be much higher. Additionally, new labour market changes (lower labour supply) and pension reform (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 stationary care in private care homes, which operate without the proper permission. Both cases are not rare, although in recent years a lot has been done to facilitate the legalization of both activities.

In the households for care of elderly people, the main employees are 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 mainly in big cities and the engagement takes place in 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 for informal care. It seems that the number of persons receiving care informally is the same as those receiving formal care. However, the expenditures for informal care may be lower, as the prices 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 epidemiologic changes as well as by the developments and conditions of the labour market. The unfavorable labour market situation in Poland creates conditions for the early retirement of women, who take up the function of care providers either for their grandchildren or for 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. J. 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 biggest social challenge for the country in the coming years.

3.4.1. Institutional care

According to the survey on household activities (AZER 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 the table below we can see the development of the biggest number of typical social welfare homes provided at the district (powiat) level.

Table 7: Development of residential home care in the social assistance sector provided by powiat self-government (district)

Items	2004	2005	2006	2007
Number of homes	813	795	793	794
Number of places	80 633	80 226	78 918	78 337

Źródło: MPiPS 2008

The number of social assistance homes increased in 1999, after a period of decrease during the 1990s. This was due to an administrative reform which led to an increase in community ownership possibilities and restructuring property for social purposes. The number of residential care institutions increased by about 250 new institutions (25,000 places) compared to the period before the reform (1999). In 2005, the number of social assistance

homes slightly decreased again and then stabilized. The financial crisis of the end of the decade and changes in regulations connected with limitations to 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, waiting time for residential LTC is estimated to be approximately 2.5 – 3 months in the public setting.

Social welfare homes face problems with ensuring the appropriate quality of services, which were defined in 2001. Adjustment to the introduced quality of standards is foreseen to be completed in 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 controlling functions are not performed fully (NIK 2006) and the executive regulations to the law on social welfare that was amended in 2004 are being introduced rather slowly.

LTC services for the persons under care in welfare homes are performed by nurses employed there (so called ‘own nurses’). About 8,200 nurses work in the social assistance homes (DPS), thus for one social welfare home there are 10 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 social assistance homes (DPS), 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 resources⁴.

LTC services in the social sector are less available for people 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 market price which are also offered in the public care homes. This additionally increases demand for non-public LTC services and causes 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 development of establishing private profit-making care and nursing homes are relatively big and in some regions there are more of these homes than public ones or those run by social organizations. Many of them until recently 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 of the voivods, done at the beginning of 2008, showed that there are over 228 profit-making care homes in Poland (of which ¼ are public) and only half of them have legalized status (Maciejczak 2008).

⁴ In Poland only 4% of GDP is allocated for health care. It is one of the lowest indicators in Europe (Eurostat 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 ongoing. At the beginning there were more than 100 such homes in operation with more than 9,000 beds and now there are more than 420,000 beds.

Table 8. Number of facilities (homes) and beds of the LTC in the health care system

Items	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	9382	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 care of older persons. Even if the local self-government properly recognizes the needs of care, what it can offer the elderly depends more on the resources which 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 home care, which is provided by the environmental nurse, financed by the National Health Fund (NFZ).

Access to LTC at home depends on one's rating of independence (Barthel test), which is obligatory in the health sector. The institution of the environmental nurse may be widened to a care givers 'team' which would include visits by physicians, psychologists or even priests. This would then constitute a unit of home 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 NFZ (21,500) was reduced by 1/3 as a result of a change in criteria for care, namely the introduction of the Barthel test for home care at the 40% index.

3.4.3 Semi-institutional care

Adult day care centers (DDPS) for persons needing help, but who are more independent than those in stationary 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 in 2004, although centres of this type were functioning earlier. The DDPS are for the elderly on the basis of the diagnosis done by the social employee concerning his/her disability (physical or mental) and a difficult living condition (poverty) qualifying for the 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 are care for persons suffering from comas or Alzheimers 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 the application submitted to the centre of social assistance.

In Poland there are 250 such homes, and about 20,000 people use them. The current financial crisis has slowed the development of those units. Moreover, wider usage of the day care homes makes the transport of the person difficult. It is bothersome for the elderly person, for the family and for the local self-government responsible for the state of roads and local infrastructure. In many regions of the country it would be a big problem.

4. LTC policy

The policy concerning LTC for the elderly in Poland is defined mainly in the health sector. In the period of 2006-2007 in the Ministry of Health, work on the so called nursing law was carried out, which aimed not only to separate the LTC sector in the system of social protection and health protection, but also to plan a new insurance, based on the example of Germany, i.e. nursing insurance, enabling to finance this care. A replacement of the nursing extra benefit for individuals above 75 years of age with a selective benefit for the poor in need of nursing care was discussed at the same time. Later (2008 – 2009), these works were given up. Nowadays political interest in this problem is growing, but mainly among the experts. It is

hard to predict what kinds of directions will be specified in the political sphere. Due to 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 – 2010 which was approved by the Cabinet in December 2008:

- development of 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 the private LTC facilities
- introduction of a more effective system of quality control of the LTC services
- creation and introduction of the information system on the LTC

The goals have been directed to the Health Ministry. However, 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 LTC infrastructure, and for information on the resources. In order to manage it, the self-governments need more capacity, especially know-how and financial resources.

4.2. Integration policy

So far, the policy of integrating LTC services realized in two different sectors, health and social assistance, has not been the subject of debate. The responsibility of the health sector is rapidly developing. The activities of the national consultant of nursing⁵ are very significant. His/her yearly reports are not only 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

⁵ The institution of 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 and comments on a disputed issues, consults and gives opinion on administrative decisions as well as important developments in medical field.

providing LTC and nursing care came to 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 caused limitations in access to LTC services. Medical professionals active in the LTC system criticize 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 to the actual cost of 120-150 PLN per day). At the same time it requires that complete service, as specified by the contract for care and nursing, is provided (national consultant on the nursing of the chronically ill and disabled, 2007, www.mz.gov.pl). As a result of insufficient funding, low quality services are provided, mainly due to the dereliction of 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 a subject of discussion on the highly insufficient care within the LTC system in Poland. At the same time the Barthel index, which is used as an access criterion to the stationary care 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 favorable to LTC services development 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 day care centers. At the same time, the rules of co-payment in the care homes have been changed, and the payment from the family (not only of care receivers) was introduced. This slightly reduced the queue to DPS. However, generally, access to LTC services is now significantly limited.

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

4.4. Critical appraisal of the LTC system

The elderly with functional limitations do not constitute as yet a group of significant health care policy interest in Poland although this group is becoming increasingly numerous. The number of elderly people (65+) is currently estimated at about 3.2 million and the oldest ones (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 of the healthcare policy in relation to the discussed group requires several simultaneous actions:

- increased education of doctors (particularly GPs and geriatricians) oriented toward treatment of old-age illnesses
- increased skills of basic healthcare doctors (through appropriate life-long training) in the scope of healthcare, nursing care and social care within local communities
- increased education and motivation of nurses to work with the elderly with functional limitations
- development of the occupation of integrated health and social protection knowledge based on upper secondary vocational schools; university education should not be the exclusive way to get nursing qualifications
- verification of the Barthel index in order to estimate the appropriate level of needs for nursing and care
- integration of the LTC services provided independently in two sectors: health care and social assistance through the establishment of an extra body for that at the territorial self-governmental level
- development of the network of public and private (nonprofit and for profit as well) LTC institutions with quality control and quality assurance of the standards and practice
- significant widening of home care over dependent elderly people 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 worsened by the financial crisis), the services of this type of care are developing dynamically, mostly in the private and informal sector. In the formal sector there have been some access limitations introduced.

Dynamic 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 of LTC services development. However, the current agenda is dominated by the financial crisis and promoting reforms in the public sector which decrease social expenditures.

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Assessing Needs of Care in European Nations



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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>).