

THE WORLD BANK

# **The Present and Future of Long-Term Care in Ageing Poland**

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**The Present and Future of Long-term Care in Ageing  
Poland Policy Note**

**The World Bank**

**2015-11-30**

### **List of abbreviations**

ADL – Activities of Daily Living

ADDR – Adult Disability Dependency Ratio

FGD – Focus Group Discussions

DOP – Palliative Care Homes

HLY – Healthy Life Years

IADL – Instrumental Activities of Daily Living

NGO – Non-Governmental Organizations

LTC – Long-Term Care

OPP – Public Benefit Status Organizations

ZOL – Care and Treatment Facilities

ZPO – Nursing and Care Facilities

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## Acknowledgements

This study has been prepared by the team composed of: prof. Stanisława Golinowska, dr Agnieszka Sowa and Anna Kozieł. The team was led by Roberta Gatti and Aparnaa Somanathan. Special thanks must go to Karolina Goraus for the survey and analysis of households presented in the report, Carmen de Paz Nieves for her support in editing the report, and Barbara Nowakowska and Isadora Nouel for their administrative support.

The World Bank team is grateful to the representatives of Millward Brown for the qualitative research that has made it possible to assess care services provided to the elderly in Poland, based on focus groups and individual questionnaires.

The analysis would not have been possible without the support from Ana Maria Munoz Boudet, Beth Zikronah Rosen and Victoria Levin, who helped to adapt the tools developed and used by the World Bank to Polish realities.

Special thanks also go to the workshop participants, and so we would like to thank the following persons for their valuable comments and a fruitful discussion: Magdalena Bardadyn, Ewa Chyłek, Marta Fijołek, Magdalena Krupiarz, Jolanta Kubajka-Piotrowska, Krystyna Łakomska, Zofia Rutkowska, Bolesław Smoliński, Barbara Witkowska and Wojciech Wrona.

We would also like to express our gratitude to the Ministry of Labor and Social Policy, represented by Zuzanna Grabusińska, for their valuable comments to the draft report.

Last but not least, our team would like to thank the following persons for their valuable advice and guidance: Mamta Murthi – Country Director for Central Europe and the Baltic Countries, Marinie Wes – Country Manager for Poland, Andrew D. Mason – Practice Manager, Social Protection and Labor GP and Enis Baris – Practice Manager, Health, Nutrition and Population.

## 1. Introduction

At the request of the Ministry of Labor and Social Policy of Poland, the World Bank has conducted a review of the long term care (LTC) system in the country. The review offers a detailed diagnosis of the long-term care system for the elderly in Poland, while describing the existing systems in selected countries that could serve as a reference for the Polish case. As indicated by the Ministry of Labor and Social Policy, the results of this exercise are expected to serve as the basis for strategic recommendations for the development of a LTC system for the elderly in Poland.

LTC services refer to the organization and delivery of a broad range of services and assistance to people who are limited in their ability to live independently over an extended period of time. These services are designed to minimize, rehabilitate, or compensate for the loss of independent physical or mental functioning and include assistance with activities such as bathing, dressing, eating, or other personal care, meal preparation and cleaning, life management tasks including shopping, money management, and medication management, and transportation. Health care services such as nursing and rehabilitation represent a crucial component of LTC systems across countries.

Rapid population ageing, a result of increasing longevity and declining fertility rates generates challenges that will require adjustments to the LTC system in Poland. The older the population becomes, the more difficulties people will face with regards to the activities of daily living and the higher the incidence of dependency, which will lead to an increase in the demand for various forms of health care, nursing care and support in activities of daily living. These trends entail significant challenges for both the health and social sectors, but also for the education sector, given the growing pressure for the labor force to be prepared to meet these emerging needs.

This paper addresses the key health and social care elements of LTC in Poland. It does neither contain a full description of the system, nor present all possible solutions to the upcoming challenges. Instead, the analysis presented here seeks to diagnose the situation, specifies the key gaps moving forward and provide the main directions that the health and social sectors should take in order to better develop the LTC system in Poland. All the most recent and important strategic documents and programs in Poland, summarized in Table 1 below, have been considered in the diagnosis of the World Bank system.

Table 1: Strategic documents and programs for LTC in Poland

Government level strategic papers	Poland's Long Term Development Strategy 2030. Country Development Strategy 2020 National Strategy of Regional Development Social Capital Development Strategy Human Capital Development Strategy
Ministry of Labor and	Long-term Conceptual Assumptions of the Senior Policy in

Social Policy	Poland for 2014–2020 (ZDPS) and Government Program for the Social Activity of the Elderly for 2012–2013 (ASOS Program).
Ministry of Health	Policy Paper in Health 2015–2020 Current status and development prospects of the long-term care in Poland
Other initiatives	The Green book – prepared by the Working Group on preparation of the new law on Risks Dependence Insurance

Source: World Bank study

As part of the research conducted, the World Bank carried out a pilot Qualitative Assessment of Elder Care Services<sup>1</sup>, which comprised two parts. Part 1 was a demand assessment including both focus groups discussions (FGDs) with women from a variety of perspectives, and individual questionnaires. The FGDs included an exploration of time use and also examined care needs of families with elderly household members and barriers to accessing care. The second part was a supply assessment by FGDs. It investigated the types of elder care services available to households, both public and private, and explored their quality, cost, and accessibility, as well as the social perception and legal regulations around care and the use of the available alternatives. The summaries of the findings of both parts of this research are included in Annex 1.

Chapter 2 elaborates further on the concept of long-term care systems, their main features, components and the existing arrangements. Chapter 3 offers the rationale for the present exercise and the relevance of long-term care given the current demographic trends in Poland. Chapter 4 reviews the different systems in Europe and OECD countries, with a particular focus on financial aspects. Chapter 5 presents the organizational structure of long-term care in Poland. Chapter 6 moves onto the analysis of challenges and opportunities moving forward, both from the perspective of the demand for the LTC services and of the supply of the LTC services, and assesses relevant aspects (related to the long-term care) such as trends in the demographic structure and health status of the Polish population, social norms and perceptions, limited provision of care, constraints related to human resources and financial issues. Finally, chapter 7 provides strategic directions and recommendations for the Government to improve and strengthen the Polish LTC system.

## 2. What is Long Term Care?

There are many definitions of the long-term care in the literature on the subject. It could be uniformly defined as a range of services required by persons with a reduced degree

<sup>1</sup> The instruments used in the research were originally created by World Bank (Levin, Victoria, Ana Maria Munoz Boudet, Beth Zikronah Rosen, Tami Aritomi, and Julianna Flanagan. 2015. “*Why Should We Care about Care? The Role of Informal Childcare and Eldercare in Aging Societies*”. Research Report for the World Bank’s Poverty and Social Protection and Labor Global Practices, World Bank, Washington, DC.).

of functional capacity (physical or cognitive) and who are consequently dependent for an extended period of time on external assistance with basic activities of daily living. LTC services can also be combined with lower-level care related to help with the so-called instrumental activities of daily living (e.g., domestic help or help with organization and administration), (WHO 2009, OECD 2011, European Commission 2015).

According to the World Health Organization (WHO), the goal of LTC systems is “to ensure that an individual who is not fully capable of long-term self-care can maintain the best possible quality of life, with the greatest possible degree of independence, autonomy, participation, personal fulfillment and human dignity” (WHO 2002).

The personal care component of services related to assistance with Activities of Daily Living (ADL<sup>2</sup>) is frequently provided in combination with basic medical services such as nursing care, prevention, rehabilitation or services of palliative care. Instrumental Activities of Daily Living (IADL<sup>3</sup>) are mostly linked to home help (Colombo et al., 2011).

Long-term care has been traditionally provided in an informal manner (Box 1), predominantly by the family. However, and due to changes in the family model and life-styles, family care (or informal care) is no longer the dominant form of care for dependent people. In response to the growing care needs of the population, formal care organized by the state or private institutions is progressively replacing traditional informal care provision (thus responding to the social needs that cannot be fulfilled within the family. (Box 2).

#### Box 1: Long term care informal and formal arrangements

The provision of long-term care (LTC) for the elderly can be organized and provided both informally and formally. Care for dependent older people has traditionally been a domain of the family. Informal care is in most cases unpaid and usually provided by the family, close relatives, friends or neighbors. “Care” refers to the relationships and activities involved in meeting the physical and emotional requirements of dependent adults and children.

The main features of informal care, from the perspective of caregivers:

- Caregivers are non-professionals and not trained to provide care, although in some cases they may benefit from special training.
- Caregivers do not sign contracts regarding care responsibilities.

<sup>2</sup> Activities of Daily Living (ADL) include basic self-care activities, such as bathing or showering, dressing, eating, personal hygiene activities and the use of the toilet.

<sup>3</sup> Instrumental Activities of Daily Living (IADL) include housework, preparation of meals, dosing and taking medication, management of personal finance, shopping, using a telephone or another form of communication, using public transport.

- Caregivers are not paid although they are increasingly obtaining different kinds of financial contributions.
- Caregivers perform a wide range of tasks (also performed by formal care providers) including emotional support and assistance.
- There are no limits to the time spent on care, as informal caregivers are never/rarely officially ‘off duty’.
- There are no general entitlements to social rights for caregivers.

The main features of formally provided long-term care:

- Services are provided by trained, licensed and qualified professionals.
- Services are controlled by the state or other types of organization.
- Caregivers sign contracts specifying care responsibilities.
- Caregivers are paid and entitled to social rights and working regulations.
- Care tasks are specified according to professional qualifications.
- Care workers have a time schedule and go ‘off duty’.

Source: Interlinks European Project (Triatntafillou et. al 2015)

Formal LTC can be provided in three main types of settings: institutions (residentially), home and the community. Home- and community-based care refers to professional care at the home of the recipient or within the community in which he/she lives<sup>4</sup>, while institutional residential care refers to professional care in an institutional setting outside the home. In order to support families caring for older dependent people, many countries have developed public schemes focused on LTC provision at home (formal home care), community-based care and care at 24/7 care institutions. Such schemes include care services or cash support to assist dependent older people aged 65 and over living in their own homes. Home care (sometimes also called “domiciliary care”) covers all activities that are undertaken in the home where the dependent older person usually lives, with the objective of enabling people to stay in their own homes as long as possible. Usually, a small part of care for dependent people is organized in residential institutions.

Analysis of the available research findings and data (as described in detail further down in the document) shows that in Poland the long-term care sector is still poorly developed, despite the large number of institutions providing care, with family care being the dominant type of care provided to the dependent population. However, changes in the population structure in the coming decades will have a major impact on the needs for care in the country (European Commission, 2015). The following chapters will further explain why LTC is a key policy priority for the future, analyze whether Poland is prepared to adjust to the emerging challenges, and provide some

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<sup>4</sup> There have been long-running semantic debates about the use of terms like “home care”, “community care”, “personal care” and “social care”. “Home care” and “community care” are often considered synonymous in the Anglo-Saxon literature (Degavre et al., 2012).

recommendations regarding potential lines of action that could lead to improvements in the Polish LTC system.

### **3. Why it is important to think of LTC in Poland now**

Since the share of older population in Poland is rapidly increasing, it makes long-term care provision a crucial policy matter moving forward. Poland has one of the most rapidly aging populations in the European Union (EU): the share of the population aged 65-79 is expected to double and the share of population 80+ is expected to triple by 2060. (European Commission, 2015). Old age dependency ratios will thus sharply increase from about 14,0 in 2015 to 27,8 in 2060.

The demand for LTC does not depend on the size of the 65+ population alone, but on the number of persons that will need assistance from others because of problems with daily life activities. As described in detail further down in this document, Poles are living longer, which represents a significant success of the last 25 years. However, the gap in life expectancy between men and women is still large: life expectancy for women is 81 years, compared to only 73 years for men (GUS 2013). In addition, longer lives are usually unequally distributed among different social groups, and very often do not entail healthier lives for all.

The new challenge is thus not only to live for longer, but also to stay healthy over those extra years of life. Studies of health in older age cited in Chapter 6 reveal different tendencies with some pointing to a slight decrease in the health status of the elderly (expansion of morbidity associated with growing levels of dependency due to disability and higher levels of chronic conditions and multi-morbidity), and others pointing to improvements in health status among the elderly (compression of morbidity).

The results of the Polish study “Polsenior” based on social and medical interviews with seniors aged 65+ from a representative sample of the older population and the SHARE survey show a high level of functional limitations among Polish older people, similar to those observed in Southern European countries such as Italy and Spain (InChianti project – Balzi 2010) and in other Eastern European countries. Functional limitation increases with age, with women being particularly affected. The critical age for being significantly dependent was 85 years, and the incidence of dependency in old age is more pronounced in rural than in urban areas. More than 20% of the surveyed seniors 85+ are fully dependent (Wizner, Skalska, Klich-Rączka, Piotrowicz, Grodzicki, 2013). The European Commission estimates that the number of dependent persons in Poland will increase from 830,000 in 2013 to 3,393,000 in 2060 (European Commission, 2015).

As already mentioned above, much of the care for older dependent people is provided informally in Poland. This means that the caregivers are family members or friends who receive little or no financial remuneration for the care provided. Polish and international

studies indicate that the care of the elderly in Poland takes place mainly within the family. 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), although in wealthier households caregivers are employed informally, which is not reflected in the statistics. However, and even when taking this into consideration, this percentage is still the highest among all EU countries.

A large share of the family care for the elderly is the result of the traditional obligation to provide care in families related to cultural conditioning and the specific phase of economic development where Poland belongs, and of the limited possibilities for care outside the family. In the traditional model of family care, activities are performed by a woman (daughter or daughter-in-law) that exits the labor market much earlier than her husband to perform such duties with regards to children, grandchildren and the elderly. Indeed, the Polish survey on family care for the elderly - the AZER research (Wóycicka and Rurarz, 2007) - shows that women form the majority of caregivers, but are also the recipients of care. A higher share of women among dependent persons is related to the fact that women live longer than men, and more often seek help, e.g. medical help.

Although the number of patients in LTC facilities has been growing since 2009, formal care remains underdeveloped in Poland. The increase in institutionalized LTC patients was observed only among stationary care patients, while home care provision has decreased. Home care provided formally is so small in numbers that is hardly visible in international statistics (Huber et al. 2009). Residential stationary care is better developed, although with just 17 beds in LTC institutions per 1000 population aged 65 years old and over Poland has the lowest number of institutional beds per 1000 persons for LTC facilities in the entire OECD.

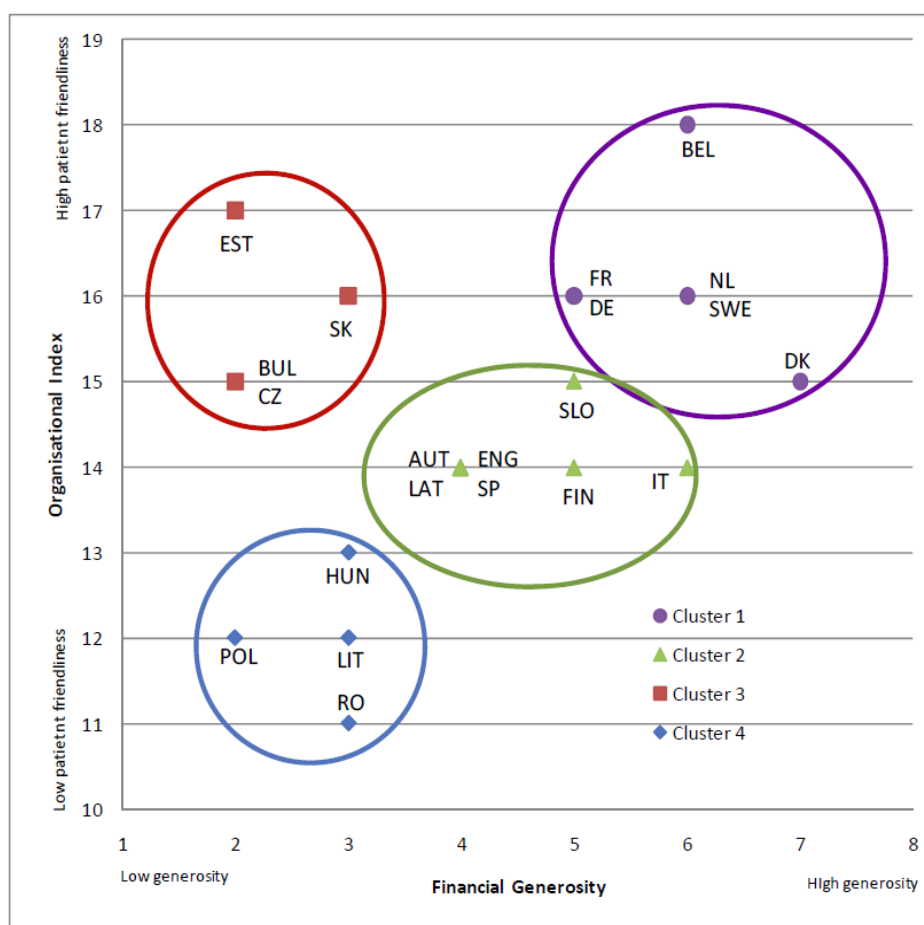
Polish administrative data shows that there has been a constant increase in personnel at long-term care institutions, although, on average, the numeric proportion of the personnel to patients still remains among the lowest in the European Union. Since 2004 the number of nurses in LTC institutions almost doubled and a strong increase was also observed among doctors, physiotherapists, psychologists, social/medical workers and auxiliary personnel. These trends, although moderate, indicate that some adjustment to the increasing number and needs of the elderly is taking place in the country. These issues are documented in further detail in chapter 6.

#### **4. LTC in comparative perspective**

Since LTC is a relatively young and heterogeneous sector, efforts to standardize care activities and expenditures and carry out comparative analysis have been made as part of a few research project initiatives. In the European research project ANCIEN (Kraus et al., 2010) two dimensions were taken into account: organizational development (depth) and expenditures as share of GDP. Based on such features, four clusters of countries were identified (Kraus et al. 2010) (Figure 1).



Figure 1: LTC systems in Europe



Source: Markus Kraus, Monika Riedel, Esther Mot, Peter Willemé, Gerald Röhrling and Thomas Czepionka, *A Typology of Long-Term Care Systems in Europe*, ENEPRI Working Paper No. 91, Centre for European Policy Studies, Brussels, August 2010 ([www.ceps.eu](http://www.ceps.eu)).

Countries of Western and Northern Europe, shown on the diagram above in Clusters 1 and 2, are characterized by relatively high LTC expenditures accounting to 1.5% of the GDP, with the highest expenditure registered in the Netherlands (2.5% of the GDP) and Sweden (3.5% of the GDP). Countries in Clusters 3 and 4 are characterized by low levels of public spending on LTC, as it does not exceed 0.8% of GDP.

Organizational depth refers to various features of the long-term care, including entitlement and access to care (means or non-means tested, decentralization of governance and capacity planning, supply of care and types of benefits). Access to long-term care is regulated by entitlement rules often related to nationality, disability or functional capacity and might be regulated by means testing. In most of European countries access to care does not depend on means testing. In others, however, long-term care services are means-tested, although the degree of means-testing varies: in some countries it means targeting services to the poor while in those with more generous systems it means only excluding the very high-income population from access. Access to care also varies geographically and between urban and rural areas.



#### 4.1 Financing LTC: balancing sustainability and equity in access

The high cost of LTC, which can place a significant burden on users, and the associated uncertainty as to when and to what extent such services will be required, offer a powerful rationale for introducing publicly funded LTC coverage to complement family and volunteer care. The way public financing of LTC is organized is important to consider. Three main arrangements can be identified: (1) universal schemes, (2) means-tested schemes, and (3) mixed systems (OECD, 2011).

Although private long-term care insurance does not play a major role in financing long-term care in any OECD country, out-of-pocket payments are a common feature of all systems (e.g., Switzerland, 60%, Portugal, 45%, Spain, 30%, the United States, 22%) (OECD, 2011). Co-payment for services impacts negatively on the generosity of LTC systems. Denmark has the most generous system in Europe, with cost sharing only for residential care, while in other countries, even with higher public expenditures than in Denmark, cost-sharing is more widespread. In Eastern Europe, private contributions for LTC services are common.

In countries where social solidarity is highly valued and the right to long-term care is placed at the same level as the right to medical care, coverage is universal. In these countries, all individuals assessed as eligible can access publicly funded nursing and personal care. Three main sub-models can be distinguished: i) tax-based models (e.g. Nordic countries); ii) public long-term care insurance models (e.g., Germany, Japan, Korea, the Netherlands, and Luxembourg); and iii) personal care and nursing care through the health system (e.g., Belgium) (OECD, 2011).

At the opposite end of the spectrum, countries such as England, New Zealand and the United States have strict income or asset tests to set income/financial thresholds for eligibility to publicly funded long-term care services, which are provided through means-tested safety-net schemes. Means-tested arrangements offer a safety net to those individuals that cannot pay for care on their own. Although this approach may be effective at limiting costs, it can also create inequities and incentives to use health care for LTC purposes, and be administratively expensive (OECD, 2011).

In between of these two extremes there are mixed systems where long-term care is provided through a mix of universal programs and benefits and/or a mix of universal and means-tested long-term care entitlements. These systems can be further classified into i) parallel universal schemes (e.g., Scotland, Italy and Czech Republic); ii) income-related universal benefits or subsidies (e.g., Ireland, Australia, Austria and France); iii) mix of universal and means-tested (or no) benefits (e.g., Switzerland, New Zealand, Greece, and Spain). These systems can leave a significant share of the cost to be paid out-of-pocket by users and their families (OECD, 2011).

The practice of some OECD countries suggests that a universal LTC financing system

offers the most equitable coverage. For countries with rapidly ageing populations a targeted universalism approach, building on the principle of universal coverage while targeting benefits for individuals with relatively higher care needs may be the most suitable option. For younger countries, community-based approaches hold promise. LTC systems in OECD countries are evolving in common directions with regards to financing arrangements. While some means-tested, safety net approaches have been called into question, based on fairness concerns and growing needs (for LTC), in comprehensive universal coverage countries, the range of services eligible has been subject to scrutiny and targeting to those with most severe needs has increased (OECD, 2011).

Having “dedicated” financing channels for LTC as in Germany, Japan, Korea, Luxembourg and the Netherlands can help ensure a reliable source of revenue. On the other hand, these systems are generally more expensive, while the separation of health and long-term care budgets may lead to cost-shifting incentives between different providers and thus require special coordination efforts. In the future, maintaining cost growth within financially sustainable limits will be central (OECD, 2011).

Certain barriers to access to LTC can be highlighted in European countries. Access to services, for instance, is found to vary between urban and rural areas. Countries such as the Czech Republic, Slovenia or Spain tend to have large variations in supply of different types of care between regions. In the Netherlands, on the contrary, the supply of care is geographically distributed in an equal manner, as facilities are made available in the closest neighborhood (up to 5.2 km). Another important and common barrier in accessibility of care are the long waiting times for residential care observed in most European countries, including Denmark, Estonia, Latvia, Hungary, Netherlands, Slovakia, Spain, Sweden. Long waiting times might be related to the poor supply of care, waiting for receiving a service at the preferred facility or to means testing.

Consumer choice and flexibility have become a major goal of modern LTC systems, mostly through the provision of cash benefits instead of in-kind services (OECD, 2011). Cash benefits are provided either directly to the person in need or in relation to the care provided by an informal caregiver. In Austria, for instance, cash benefits are provided to persons in need for care irrespectively of age, income or assets. The benefits can be used either to buy home care services or to pay for an informal caregiver. In Finland most of care is provided in the form of services, although cash benefits are also granted to persons in need for care and in relation to extra costs related to their disability or illness. In Germany care recipients can choose between benefits in cash and in kind. Typically, individuals receiving informal care tend to choose cash benefits, while individuals receiving formal home care choose services in kind. In Italy cash benefits are available for persons with assessed needs for care.

Although public financing for in-kind services requires the development of costly infrastructure, given budget constraints cash benefits would likely be insufficient to provide a decent income in many countries. Indeed, in most countries, long-term care is

provided in the form of in-kind services rather than cash benefits (OECD, 2011). In countries such as Denmark, France or Belgium only needs-tested benefits in kind are available for home care services.

## **4.2 Delivery of LTC: balancing the mix of services**

Informal provision of LTC accounts for the majority of LTC services provided in many OECD countries. Informal and formal care provision is often combined, particularly where there is severe dependency. As illustrated in Box 2, the reliance on informal care is associated with costs to both households and employers.

Across OECD countries, 24/7 institutional care (as opposed to home or community care) dominates the formal provision of care. Even so, it covers only a small percentage of all care provided to older people. In the European Union countries, on average 3% – 4% (Huber 2009) and in Poland about 1% of people aged 65+ receive formal institutional care.

The level of public supply of residential and home-based care varies considerably between countries. Northern European countries (Sweden, Denmark) are characterized by a high supply of institutional residential care, although in recent years there have been attempts to reduce the number of residential facilities and beds and move patients towards home based care. In countries of Western Europe (France, Germany, Austria) the provision of residential care is moderate, while in Eastern European countries the provision of residential care is low. The provision of home-based care also strongly varies, whereas in countries such as Denmark a high level of home based care can be observed, those services are more limited for instance in (Sweden) or Germany. In Eastern Europe the provision of home care is also rather low, as it only reaches a few percent of those in need (European Commission, 2015). In almost all Eastern European countries informal care largely dominates, and a high degree of resilience to formal care exists.

In some countries, the use of institutional care has even been encouraged, inadvertently perhaps, by policy. In Japan, for instance, and notwithstanding traditional values around the role of the family in taking care of their elderly, the reduction of co-payments for medical care over the 1970s and the expansion of social admission of elderly people without health problems into special hospitals led to the general perception that 24/7 institutional care is not only acceptable but attractive. A similar process unfolded in Korea, where the heavy reliance on LTC hospitals to meet the needs of the older population has become entrenched (World Bank, 2015).

Shifting away from (formal) institutional care to formal services provided in the home or community is more cost-effective and is associated with a better quality of life for the elderly. The USA offers an example of progressive shifting from institutional care and toward home and community based services over the past several decades. Today, home

and community-based services account for nearly half (48%) of total Medicaid long-term care expenditures, and recent health reforms aim to further expand community-based services and to accelerate the pace of rebalancing. In China, the government is also emphasizing home and community-based services through a three-tiered long-term care system (World Bank, 2015).

#### Box 2: Hidden costs of informal care – evidence from the United States of America

Most of the 11 million people who need LTC in the USA live at home and rely solely on informal family caregiving (approximately 31% of households).

Caregiving costs employers between \$17 billion and \$34 billion a year in lost productivity. The top cost categories to employers are replacing employees, workday interruptions, leaves of absences, reduction in work hours and job scope, turning down of promotions (and costs related to employee investment), or early retirement. In addition, caregiving employees have health care costs that are 8% higher than those of employees who are not providing informal care (providing care has been found to be associated with depression and other health-risk behaviors such as smoking and alcohol consumption).

The total estimated aggregate lost wages, pensions, and Social Security benefits of people ages 50 and older providing parental caregiving amounts to nearly \$3 billion.

Source: IOM (Institute of Medicine) and NRC (National Research Council). (2014). Financing long-term services and supports for individuals with disabilities and older adults: Workshop summary. Washington, DC: The National Academies Press.

### 4.3 Decentralization of LTC services

In most of European countries LTC is governed by various organizational levels: from central government to regional and/or local administration<sup>5</sup>. The most decentralized countries in this matters are Finland and France with decisions on resources allocation, planning and organization of LTC made either at regional or local level of administration. In Belgium responsibilities are shared between national, regional and local authorities. Overall capacity planning, budget and finances allocation are decided on centrally, with some responsibilities on quality monitoring and allocation of services shared between central and regional administration. Home care services are allocated regionally and managed locally. Eastern European countries differ with respect to governing long-term care with some countries (i.e. Czech Republic, Hungary, Lithuania) managing care in more centralized manner and other (i.e. Slovakia, Bulgaria) in less centralized way, sharing responsibilities between national and regional or local administration. (Riedel et al., 2010).

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<sup>5</sup> Riedel M., Kraus M., The organization of formal long-term care for the elderly. Results from the 21 European country studies in the ANCIEN project. ENEPRI Research Report No.95, 2011.

In Austria, individual regions of the country deal with the provision of appropriate social services on their own (Riedel, 2010). If a region does not provide such services itself, it is obliged to ensure the provision thereof (with an appropriate standard and quality) by other institutions. Management and organization of social services vary between the regions. There are four providers of social services and LTC (provinces, municipalities, social organizations and social funds). The Austrian example also shows the problem of coordination between the health and social sector, as well as the need to monitor and manage the flow of funds and ensure a good assessment of the LTC needs (Riedel, 2010)<sup>6</sup>.

Capacity planning is also shared between the central and regional or local administration. Only in Hungary capacity planning for both types of formal care (residential and home care) is fully centralized. In the Netherlands capacity planning was centralized until 2009, when planning responsibilities were decentralized as a result of previous under provision of care and increasing waiting times in institutional residential care. Since then, individual long-term care facilities decide upon the supply of services. In Germany, with insurance companies operating at the regional level, capacity planning is also a regional responsibility.

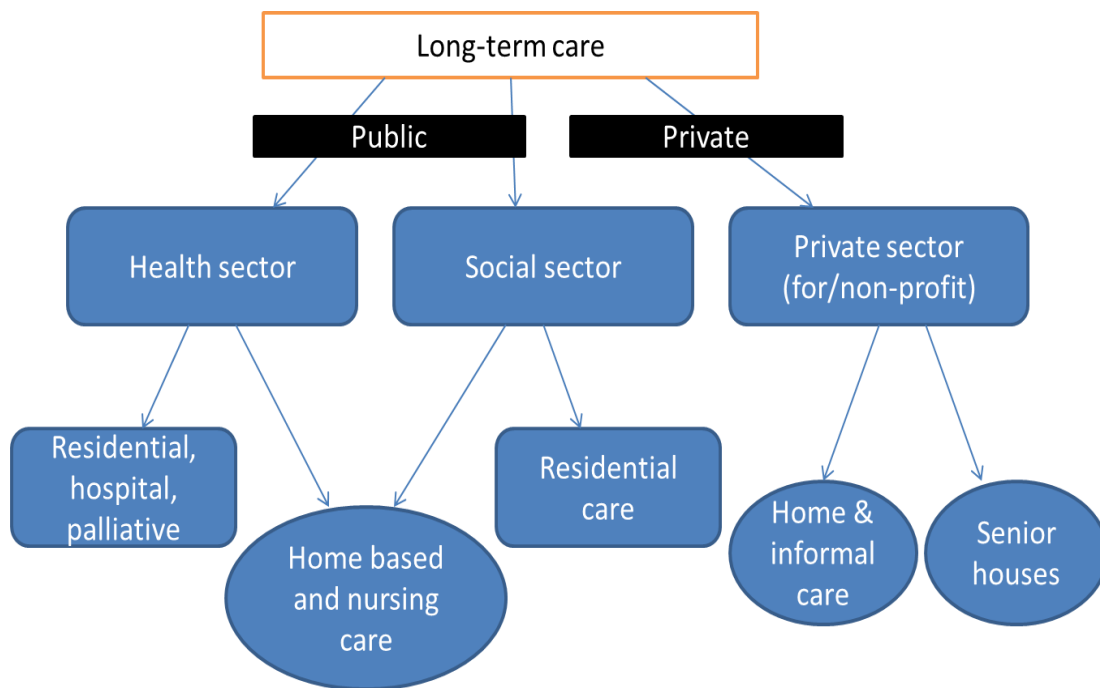
## **5. LTC organization in Poland**

In Poland, the organization of formal care for dependent elderly people, as depicted in Figure 2 below, is complex. The following sections provide a detailed account of how provision is organized for both publicly and privately financed long-term care.

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<sup>6</sup> <http://www.ancien-longtermcare.eu/sites/default/files/ENEPRI%20RR%2069%20ANCIEN%20Austria%20Rev1.pdf>

Figure 2: Organization of long-term care services in Poland



## 5.1 Public LTC services

Public care for dependent elderly people is provided through two sectors: (1) the health care sector, which includes cases of dependency care, requiring a range of medical services; and, (2) the social sector, which includes care for dependent elderly people who are also in a socially difficult situation, i.e. living alone, come from dysfunctional families, or are poor. In both sectors home care and 24/7 residential care services are available. Additionally there are several types of cash transfers available to different types of beneficiaries: older people, dependent people with motor disabilities, and caregivers of children with various disabilities.

### 5.1.1 Home care services

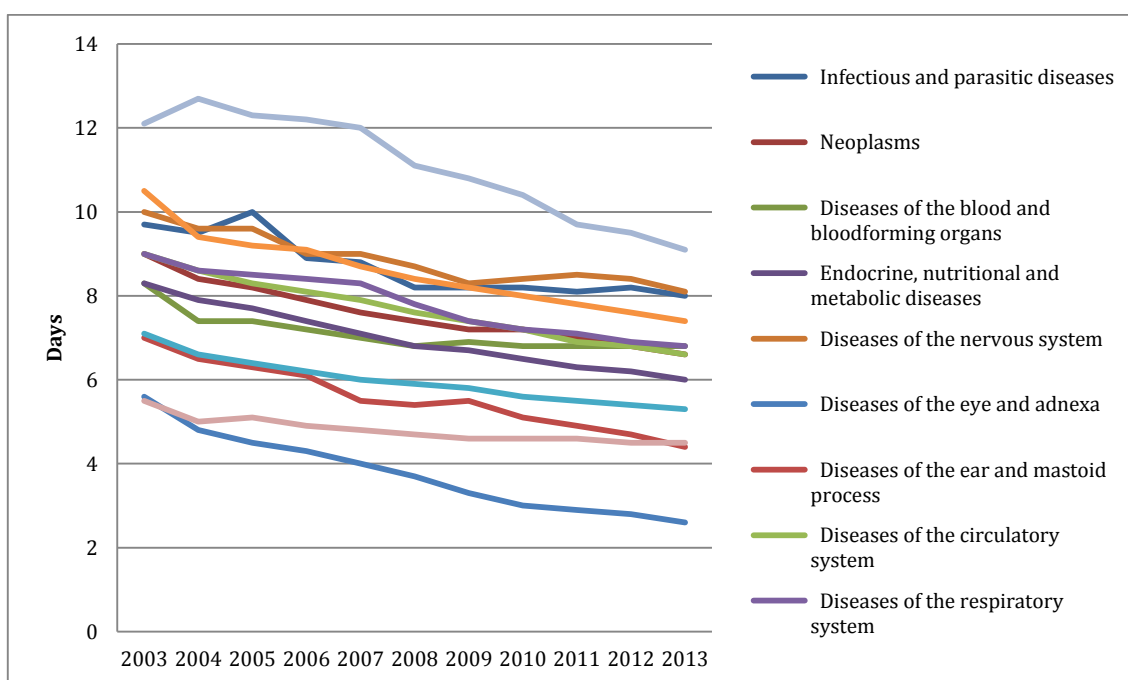
Home-based care comprises: nursing services provided through the health sector and managed by the primary health care units; and, care services provided through the social sector and managed by the social assistance centers. Entitlement to services provided in the health sector is based on the assessment of health needs. Services provided in the social sector can be obtained following a decision of the social assistance center and based on the information on (low) income and other family difficult conditions. Special care services are targeted at the population with mental health problems.

### 5.1.2 Residential services

Public residential care services are also provided in both the health and social sector, with different eligibility criteria, financing rules and types of services provided.

In the health sector there are three types of residential long-term care homes: care and treatment facilities (zakład opiekuńczo-leczniczy ZOL), nursing and care facilities (zakład pielęgnacyjno-opiekuńczy ZPO) and palliative care homes (domy opieki paliatywnej DOP). Some of the care facilities in the health sector were a result of the hospital restructuring processes. At the end of the 1990s a development program of residential care homes for dependent people was created and functioning standards defined. The territorial self-governments participated in the process of establishing the system of care and treatment facilities and nursing and care facilities, and the National Health Fund (NFZ) contracted the services at the established homes. The establishment of these homes contributed to the reduction of the average length of stay in hospitals in Poland (Figure 3).

Figure 3: Average length of stay in hospitals (ALOS) in Poland



Source: OECD Health Data 2013.

In the social sector, there are two kinds of residential homes organized mainly through the social assistance (welfare) system: stationary (social assistance homes – DPS) and family nursing homes. Nursing homes can accommodate full-time residents providing protection as well as supportive services. Its residents include persons who require permanent institutional care. In Poland there are several kinds of nursing homes, separated according to the kind of persons provided with care, that is:

- older people
- chronically ill

- mentally ill
- intellectually disabled adults
- intellectually retarded children and youth
- physically disabled people.

As shown in Box 3, all types of residential care facilities have to ensure access to adequate health care for their residents, which highlight the need for good coordination between the health and social sectors.

**Box 3: Providing adequate health care in residential care homes – findings from the Qualitative Study Pilot in Katowice<sup>7</sup>**

In 9 nursing homes, elders have access to regular healthcare. Elders of all the homes included in the research have access to physical therapists and psychologists. In 8 homes, they also have access to ophthalmologists and dentists. The services are provided by medical specialists (doctors) on regular duties.

The nursing home's policies concerning hospitalization of their elders do not differ much from those of ordinary care centers. In 7 instances, hospitalization is managed by the nursing home – the personnel contacts the hospital and the home provides transfer to the hospital. 2 homes organize hospitalization, but do not provide transportation. 1 home declares that they call an ambulance.

As for the monitoring of elders' state of health (including dementia, depression, mood swings, memory problems, sense of loneliness etc.), all the homes ensure 24h nursing care on each floor, and in 5 homes every room is equipped with an emergency button. 1 home uses camera surveillance.

In most nursing homes (9 homes), the persons who suffer from the Alzheimer or other related diseases are offered health exams and given medications (8 homes).

Source: Millward Brown, 2015. Qualitative Assessment of Elder Care Services in Poland – Pilot.

Family nursing homes provide care and residential services to persons who cannot be given such care at their regular place of residence. Family nursing homes' services are provided 24/7. They are targeted at the elderly or the disabled who require a permanent assistance. Family nursing homes extend their care over three to eight people. The establishments are managed either by private persons or by third-sector institutions.

### **5.1.3 Semi-residential care**

Local governments with social assistance centers manage day nursing homes for persons living with their family, but whose members are not able to provide care to older people due to their professional activities. During working hours, (usually between 09.00 am and 04.00 pm), i.e. 5 days a week for no more than 12 hours a day,

<sup>7</sup> Detailed information on the study can be found in Annex 1.



the dependent person can spend time in the day stay homes, where he or she receives all the needed living and care services. Day nursing homes also provide a range of activities for older people such as excursions, exhibitions, etc. Most often, day nursing homes are located at Social Assistance Centers, and cooperate with other locally active establishments, such as the Local Activity Support Center.

#### 5.1.4 Cash benefits

Apart from in-kind services, various cash benefits related to care are provided by public institutions (also shown in Table 2). Cash benefits are related to specific types of and needs for care (related to care for children and adults with disabilities or older persons) and are of the following types:

- Nursing benefit (*zasilek pielęgnacyjny*) is a care-related benefit granted to persons providing care to:
  - Children below 16 years of age requiring permanent assistance.
  - Children above the age of 16 with a moderate disability that began at the age of entitlement to family allowance or seriously disabled persons, without age criterion.
  - People over 75 years of age.
- Nursing allowance (*świadczenie pielęgnacyjne*) established as a means to support people who cannot take up employment or must resign from it due to a necessity of providing care to a child with a disability and thus acts as a wage replacement. Additionally, families below an income threshold of 664 PLN per person are entitled to a special care allowance (*specjalny zasilek opiekuńczy*).
- Care supplement (*dodatek pielęgnacyjny*), which is a universal benefit granted to persons entitled to an old-age, disability or survivors' pension who are over 75 years old as well as to persons of any age who are entitled to an old-age, invalidity or survivors' pension, and are completely incapable of working and need every-day assistance.

While the nursing benefit, the nursing allowance and the special care allowance are managed by the social assistance centers, care supplements are granted by the Social Insurance Institution (ZUS). Those who provide care to adults with disabilities but lost a right to receive nursing allowances due to the changes introduced in family benefits in 2013 retain the right to receive an allowance as caregivers (*zasilek dla opiekunów*).

Table 2: Overview of services and benefits related to long-term care

	Health sector	Social assistance/ Family benefits	Social security
Residential care	Care facilities (ZOL, ZPO), hospices, and palliative care units	Social assistance homes (DPS)	--
Day care	--	Day care centers	--
Social services	Assisted living facilities	Home services and specialized home services	--
Cash benefits	--	Nursing benefit (zasilek pielęgnacyjny) to caregivers of disabled children and people 75+ (153 PLN/month) Nursing allowance (świadczenie pielęgnacyjne) for full-time caregivers of disabled child (1200 PLN/month) or special care allowance for families with a disabled child, which fulfill the income criterion for family benefits (520 PLN/month)*	Care supplement (dodatek pielęgnacyjny) – universal benefit to 75+ (206.76 PLN/month)

\*amounts in 2015

Source: Authors' own compilation based on the website of the Ministry of Labor and Social Policy ([www.mpips.gov.pl](http://www.mpips.gov.pl))

## 5.2 Private and non-profit LTC services

Little is known about care services that are privately provided and financed as some of them are provided in the grey economy and not reported, while others are provided based on market regulations and not monitored.

### **5.2.1 Private home care**

Individual home care paid for out-of-pocket is usually provided in the grey economy, with no registered income. Services are provided by qualified and non-qualified caregivers, including many immigrants.

### **5.2.2 Private residential care units**

With the introduction of market mechanisms (the deregulation of prices, economic freedom and privatization etc.), private entities offering nursing and care services for those in need (including the elderly) started to appear in the 1990s. Private institutions are beginning to proliferate, and increasingly larger shares of senior citizens are taking advantage of the services they offer. Private institutions are not always commercial. Some of them are run by non-governmental organizations (NGOs) and are not profit-oriented (subchapter 5.2.3).

Information on privately paid and privately provided long-term care is scarce. According to the media and individual opinion private institutions do not always have a good reputation, although there are examples of outstanding private residential long-term care providers. One of the reasons for differences in the quality of privately provided long-term care is the variations in their service standards. The quality of care services is subject to limited or no supervision<sup>8</sup>. A significant change in approaches to quality control in the provision of long-term care based on a set of standards that are adequately monitored and enforced is needed for the successful development of private sector LTC services.

### **5.2.3 Non-profit LTC providers**

Non-governmental organizations, particularly religious ones, have played a key role historically in providing care for dependent older people in Poland. New social organizations developed during the transition to the market economy following the passage of the law on public benefits activity<sup>9</sup> (2003): foundations and associations whose statutory mission include the services for the disabled or the elderly. Under this law, social organizations can seek a public benefits status (OPP). However, only about 10 % of NGOs currently have such status (GUS 2014).

Care for older people is not a primary area of work for NGOs in Poland. Of the current approximately 80,000 NGOs in Poland<sup>10</sup>, about 8% declare social assistance activities, and 40% of them are run by religious organizations. Older people account for 14% of

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<sup>8</sup> In many countries, the media have been revealing the scandalous treatment of residents in private nursing homes, which has resulted in dwindling support for the development of this sort of facility from politicians and the local communities, even if the cases focused on by the media are only isolated and most institutions function properly.

<sup>9</sup> J. of Laws 2014.1118 2016.01.01, amended: J. of Laws 15.1333, Article 5, the ACT of 24 April 2003 on Public Benefit Activity and Volunteering.

<sup>10</sup> 74,000 NGOs (Klon/Jawor Association); 83,500 NGOs (GUS).

recipients of the so-called “third sector organizations” activities (GUS 2014). Overall, 3% of the total number of third sector organizations’ main activity involves the provision of care and nursing services (GUS 2014).

Third sector organizations operate about one-quarter of all care homes. Of these, around 25% are run by religious organizations, which account for 18% of all organizations working for the benefit of frail older people (Paulina Sobiesiak 2011). In addition, non-government hospice facilities are developing rapidly in Poland and are strongly supported by religious organizations. NGOs that target older people also provide educational (third age universities) and cultural or inclusion oriented activities. Various types of active women senior clubs in towns and local centers in rural sites (koła gospodyń wiejskich) are among the most popular.

There is large regional variation in the provision of care by NGOs. The highest number of NGOs is in the voivodeships with the most stable historic experiences and continuity of traditions: Małopolskie, Podkarpackie and Śląskie (Box 4). However, NGOs are largely absent in regions with higher density of population displaced from the former Eastern Poland, i.e. in Lubuskie or Zachodniopomorskie voivodeship, and in Świętokrzyskie voivodeship, which is among the poorest regions in Poland.

#### Box 4: NGOs activities oriented towards older people in the Małopolskie Voivodeship

About 15% of the NGOs registered in Poland are in the Małopolskie Voivodeship (one of the regions with the highest percentage of non-governmental organizations, together with Mazowieckie (Warsaw), and Wielkopolskie and Śląskie). These organizations are mostly active in towns: Cracow, Tarnów, Nowy Sącz, Oświęcim, Zakopane, Gorlice, and Nowy Targ. Around one-third of them are active in the social protection sector. About 66% of NGOs in the region were established after 1989. While new organizations are active mostly in cultural, educational, recreation and health areas, older organizations are most active with regards to social assistance. Indeed, up to 17% of beds in social assistance homes belong to NGOs, particularly to religious organizations.

Source: according to the Marcin Mikos expertise submitted to the Małopolska Regional Development Strategy document (part of the Silver Economy development concept - 2010)

In Poland, volunteers are more likely to get involved in charitable or social aid oriented organizations than in the rest of Europe (28% in Poland compared to 16% in the EU-27). On average, in EU countries only 7% of volunteers declare participating in the activities deployed by organizations targeted to older people, including those providing LTC (TNS 2011).

### **5.3 Decentralization of LTC services**

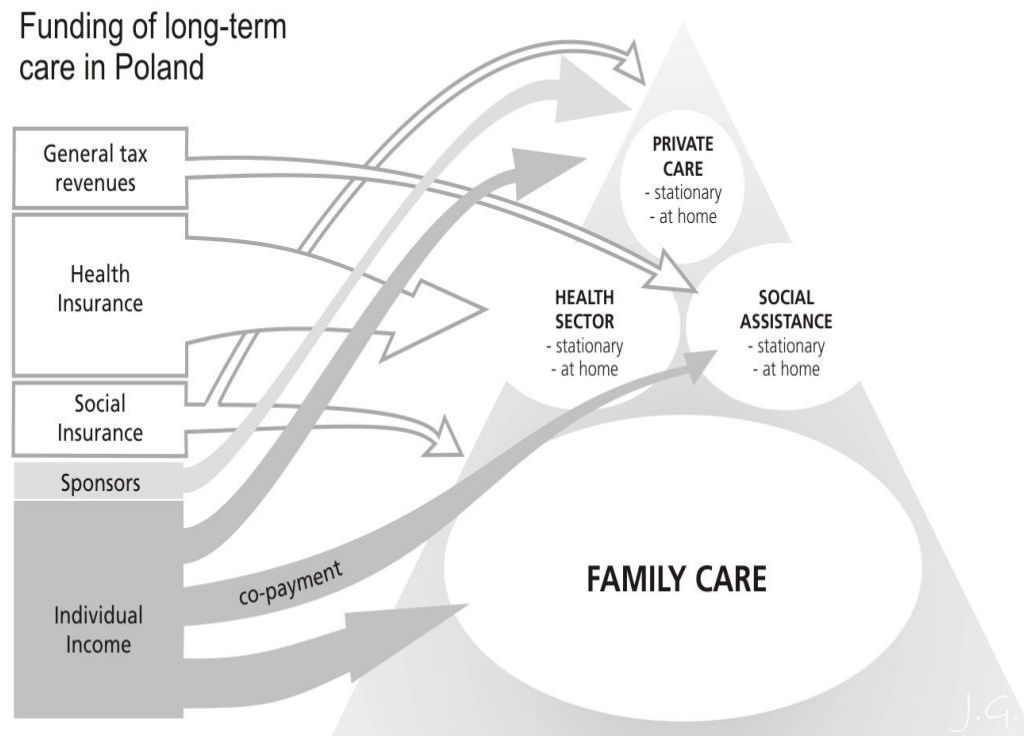
Another important factor affecting the development of LTC is the decentralization of government and public administration. Decentralization reforms meant that the responsibility for the organization of long-term care became the task of local governments. Meanwhile, the substantive responsibility for the form and content of care and its financing remained the responsibility of the health care sector. This caused difficulties in the coordination of actions. Regional governments (provide strategic 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 should inform investment planning in the long-term care infrastructure and services. The adequate coordination of activities organized and financed within the health and social sectors remains a key challenge. Despite the impression of a multiplicity of solutions, access to formal long-term care is still limited.

### **5.4 Financing LTC in Poland**

Long-term care is financed from public and private resources (Figure 4). Care provided by private units and informal care remain fully paid for out-of pocket by users and their families. The main sources of public LTC funding are health insurance, general budget, self-governments' budgets and social security funds. Home nursing and residential nursing care provided within the health sector are financed mainly from the social health insurance. In the case of residential care in nursing facilities in the health sector, only the costs of accommodation and board are covered through co-payment (European Commission, 2015).

Social assistance services are financed through taxes, but there is an obligatory co-payment for residential and home care services. The co-payment cannot exceed 70% of the individual incomes of the care recipient. Individuals whose income is below the statutory criterion of eligibility for social benefits, local self-governments finance the co-payment instead. Cash benefits are paid from the central budget by the social assistance centers (nursing benefit, nursing allowance, special care allowance and allowance for caregivers) and from the social security funds (care supplement).

Figure 4: Financial flows in the long-term care in Poland



Source: Golinowska 2010

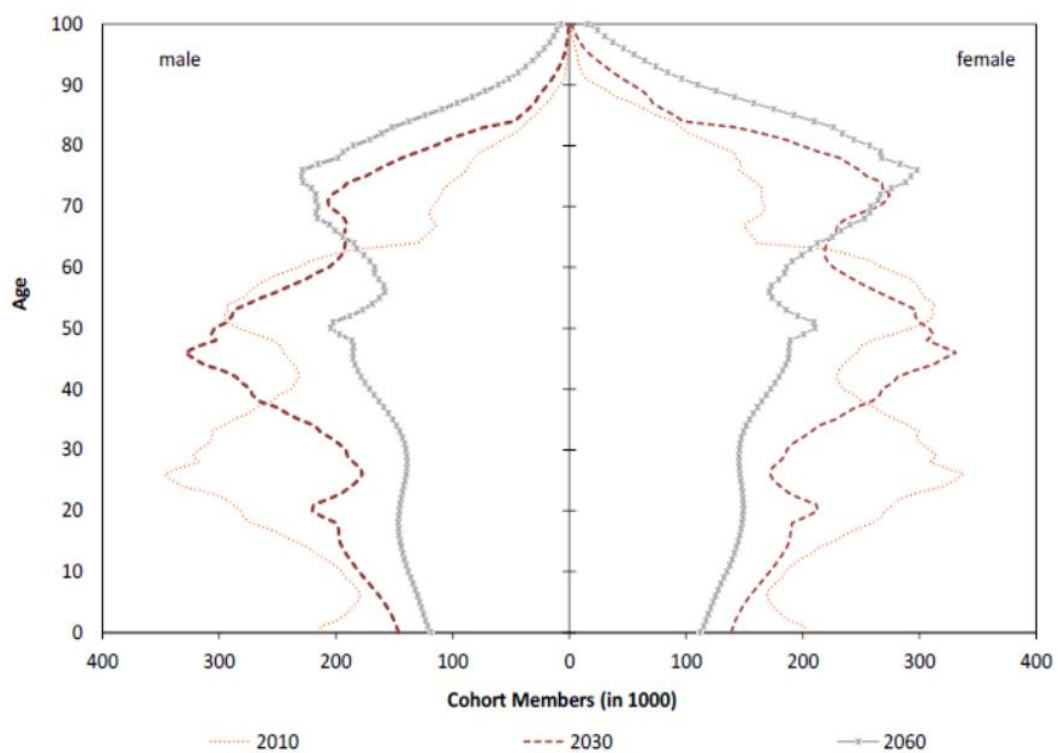
## 6. Challenges and opportunities for LTC in Poland

### 6.1 Growing demand for services

#### 6.1.1. Demographic pressure on care needs

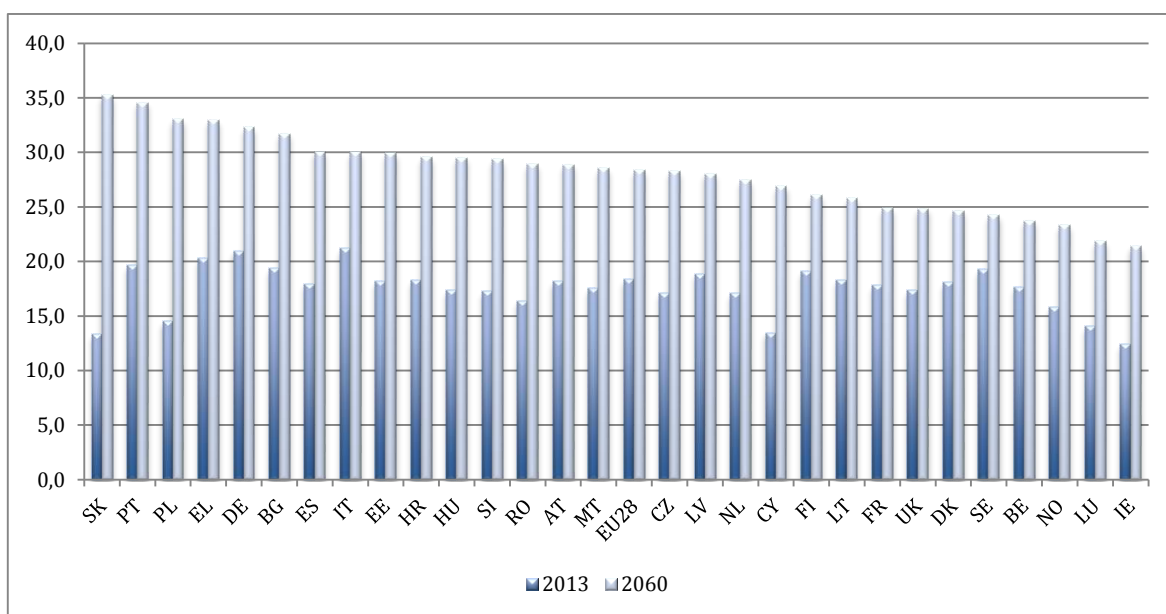
Poland is undergoing important demographic changes mostly due to the dynamics of population ageing. The share of older population (65+) in the total population is projected to increase from 14.5% in 2013 to 33% by 2060, while the share of the oldest old (80+) will grow from 3.8% in 2013 to 12.3% by 2060 (European Commission, 2015) (Figures 5, 6 and 7). These demographic trends are underpinned by both the cohort of post-war baby boomers approaching older ages and one of the lowest fertility rates in Europe (1.3 in 2013). This demographic trend signals dynamic growth of the demand for LTC over a 45-year horizon, including both home care and residential care with the majority of 80+ beneficiaries.

Figure 5: Population structure in Poland, 2010 and projection for 2030 and 2060



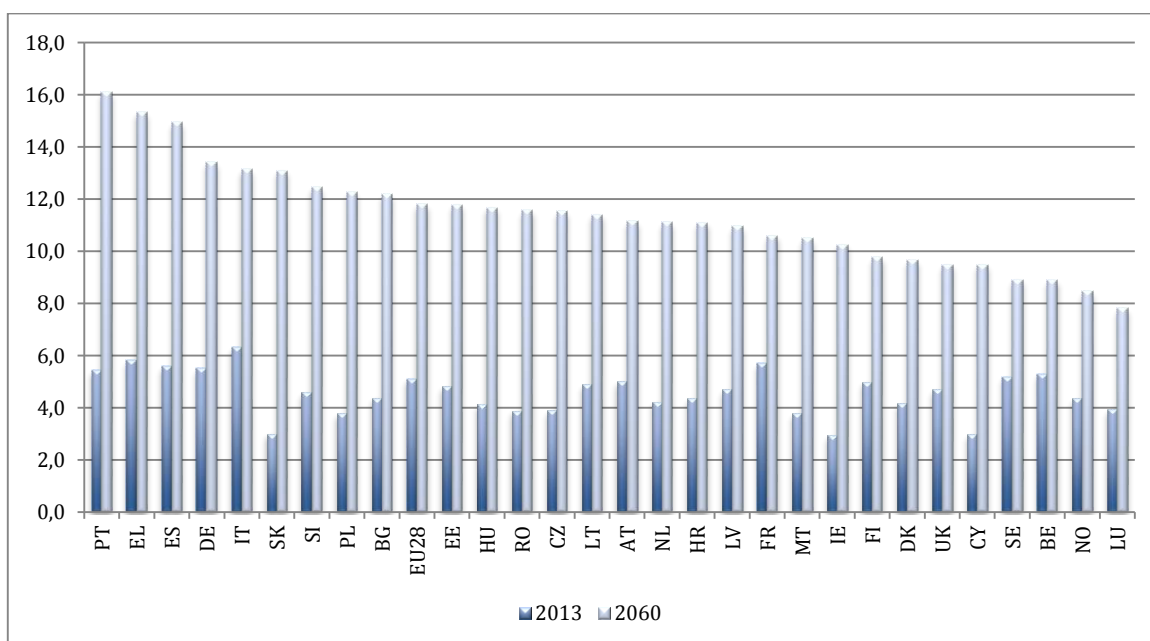
Source: J. Jabłonowski, Ch. Müller (2014)

Figure 6: Projected increase in the share of 65+ population 2013–2060



Source: European Commission, 2015

Figure 7: Projected increase in the share of 80+ population, 2013–2060



Source: European Commission, 2015

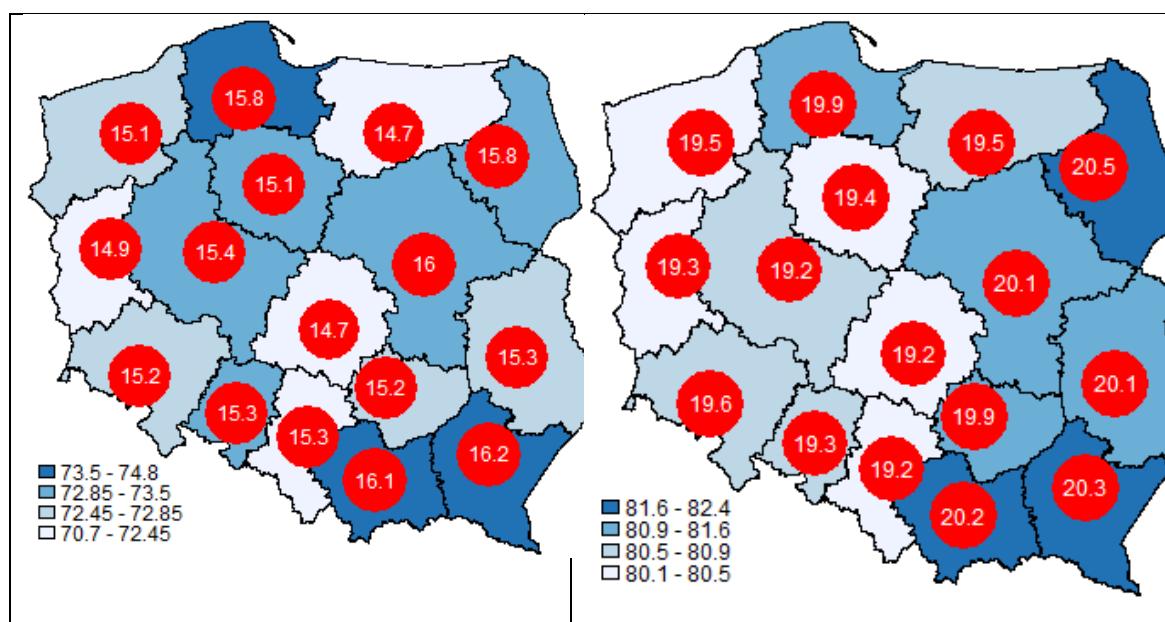
As a consequence, Poland will be characterized as one of the European countries with the oldest populations. The forecasted Polish dependency ratio will be one of the highest in the European Union, and it is expected to increase from 22% to almost 67% for the population aged 65+, and from slightly over 5% to 25% for the population aged 80+ by 2060 (European Commission 2015). Inevitably, the pressure of increasing older cohorts will have a direct impact on the number of people in need for care.



### 6.1.2 Large regional differences in care needs and provision

Longevity, a key descriptor of the demand for LTC varies significantly by region and by gender (Figure 8). The highest longevity for both men and women concentrates in voivodeships with the relatively lowest share of older persons in the population, i.e. Podkarpackie and Małopolskie, where men and women aged 65+ years register 16 and 20 additional years of life respectively. The highest longevity for women is observed in the Podlaskie voivodeship, while the highest longevity for men is registered in Pomorskie voivodeship. The lowest potential demand for care, expressed as the lowest share of older people and the lowest longevity is in Lubuskie voivodeship. Łódzkie, on the other hand, is the region with the highest share of older people (65+) and the lowest longevity.

Figure 8: Life expectancy at birth and life expectancy at the age of 65+ by voivodeship, men (left map) and women (right map).



Source: Local Data Bank of the Central Statistical Office (GUS), 2014 data.

### 6.1.3 Improving longevity among older people with persistent chronic conditions and functional limitations

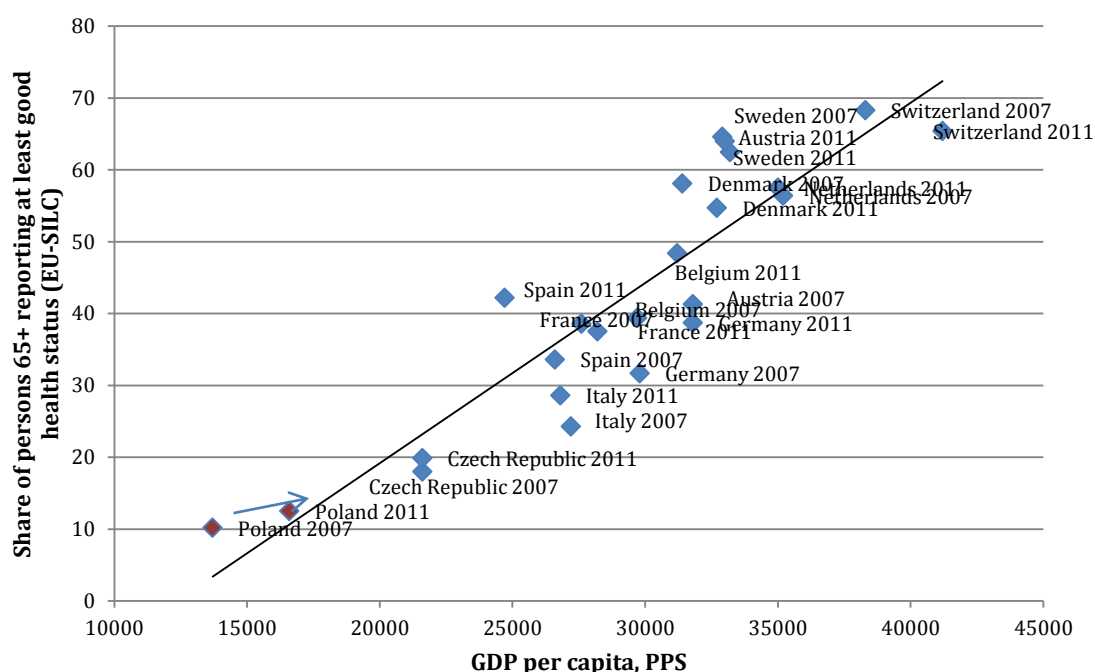
The longevity of the Polish population improved by 7.2 years for men and 6.1 years for women between 1990 and 2012 (GUS, 2014). However, the quality of life of older Poles is still unsatisfactory due to a considerable burden of chronic conditions. Self-reported health of older Poles has been improving, although, compared to other European populations, older people in Poland declare poor self-rated health more frequently: 40% of the population 65+ assessed their health as poor or very poor compared to the EU-28 average of 22.4% in 2013.<sup>11</sup> Nonetheless, the health status of

<sup>11</sup> Self-perceived health status based on the EU-SILC survey.

the older population is in line with the development level measured in relation to the GDP and has been improving with wealth (Figure 9).

It should be noted that the health status of the cohorts 65+ is influenced not only by the current living conditions but also by various factors from the past, particularly by hard working conditions in a country that has undergone a late and rapid industrialization process (Okólski 2004).

**Figure 9: Health status of the population 65+ in relation to the GDP, 2007 and 2011**



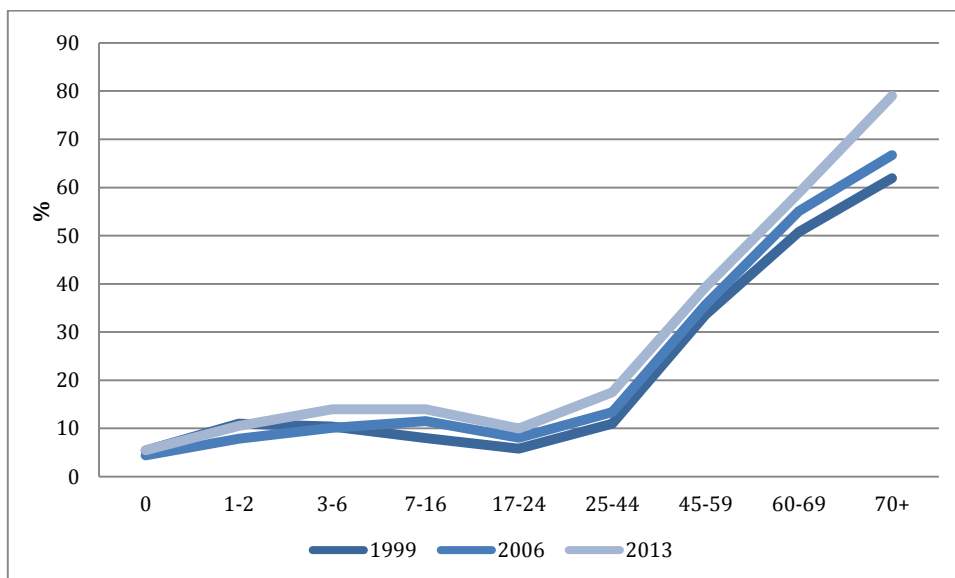
Source: Eurostat 2007, 2011.

The poor self-rated health among Poles can largely be attributed to the considerable prevalence of chronic diseases and multi-morbidity, defined as the co-existence of two or more chronic conditions. Around 65% of Europeans aged 65 years old and over suffers from multi-morbidity, i.e. two or more chronic diseases. The results of the *Ja-Chrondis* project (Onder et al 2015) suggest that in European countries 65% of the population 65+ suffers from chronic conditions and for the population 85+ this share raises to 85%. The situation in Poland is similar with 60% of the 60-69 years cohort and almost 80% of 79+ cohort suffering from chronic conditions (GUS 2000-2015). The most common chronic diseases in older age are cardiovascular diseases (hypertension and ischemic heart disease), pulmonary diseases, diabetes, osteoporosis and arthritis, vision and hearing impairments and cognitive disorders (PolSenior: Wizner, Skalska, Klich-Rączka, Piotrowicz, Grodzicki, 2013).

The likelihood of having a chronic condition and the number of (intercurrent) chronic conditions both increase with age, which further increases demand for LTC (Figures 10-

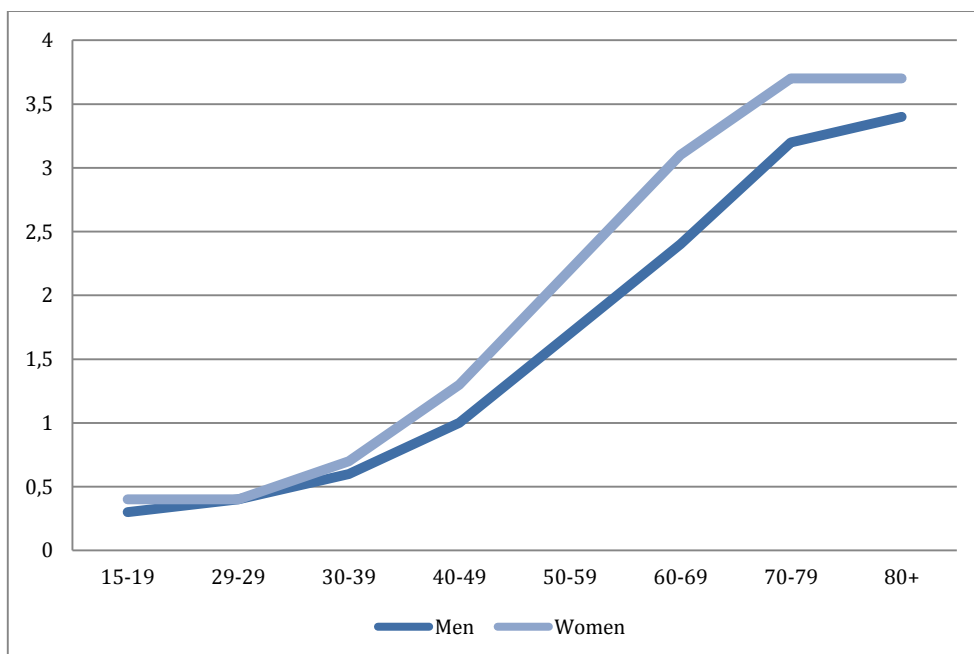
11). People aged 70+ suffer on average from three or more chronic conditions. This in turn might strongly affect functional abilities and the psychological conditions of the older generation, which increases the demand for LTC.

Figure 10: The frequency of chronic conditions by age in Poland



Source: GUS 2000, 2007, 2015 Ochrona zdrowia w gospodarstwach domowych

Figure 11: Average number of chronic conditions per capita in Poland



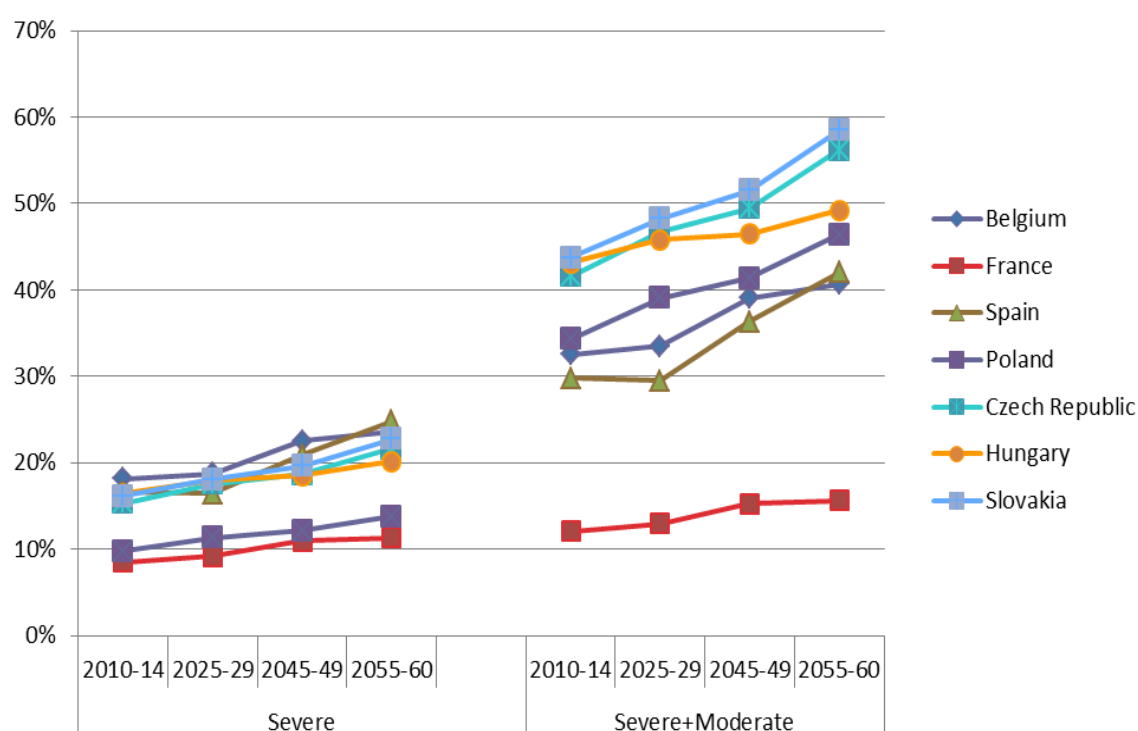
Source: European Health Interview Survey (EHIS) 2009

Central Statistical Office data points to a deterioration of the health status of older Poles between 1999 and 2013, with a 10% increase in the number of people reporting chronic conditions in that population (GUS 2000–2015). The result may be related to an

increase in the elderly cohort but also to an increased longevity: people live longer but this entails a higher burden of chronic diseases and multiple co-morbidities. Analysis conducted as part of the European 7<sup>th</sup> Framework Program project: MOPACT shows that healthy life years (HLY) at age 50 might slightly decrease over the period 2005–2012 (Luijben, Gelenkampvan den Ploeg, Deeg, 2013). Other studies showed that HLY will increase at a faster pace than longevity, thus making the period of non-healthy life years shorter. These differences may be explained by the methodology used for HLY calculations and the time period to which calculations relate.

Various studies point to different trends in the estimation of the time spent in older age without chronic conditions or disabilities. As an example, projections of future disability changes based on an indicator of adult disability dependency ratio (ADDR<sup>12</sup>) indicate a possible increase in the share of the dependent population in the coming decades from 35% in 2010–2014 to almost 50% in 2055–2060 (Figure 12). However, given variations in estimations of past trends and possible future changes in the severity of chronic conditions, healthy life years and disability, it is not possible to make any reliable predictions about whether morbidity will continue to expand into older ages or not.

Figure 12: Adult Disability Dependency Ratio (ADDR) for selected countries (current and projections)



Source: M. Bussolo, J. Koettl, E. Sinnott, Emily, 2015. *Golden Aging: Prospects for Healthy, Active, and Prosperous Aging in Europe and Central Asia*. Washington, DC:

<sup>12</sup> It is defined as the number of adults at least 20 years old with disabilities, divided by the number of adults at least 20 years without them (Sanderson and Scherbov, 2010).

World Bank, 2015, © World Bank.

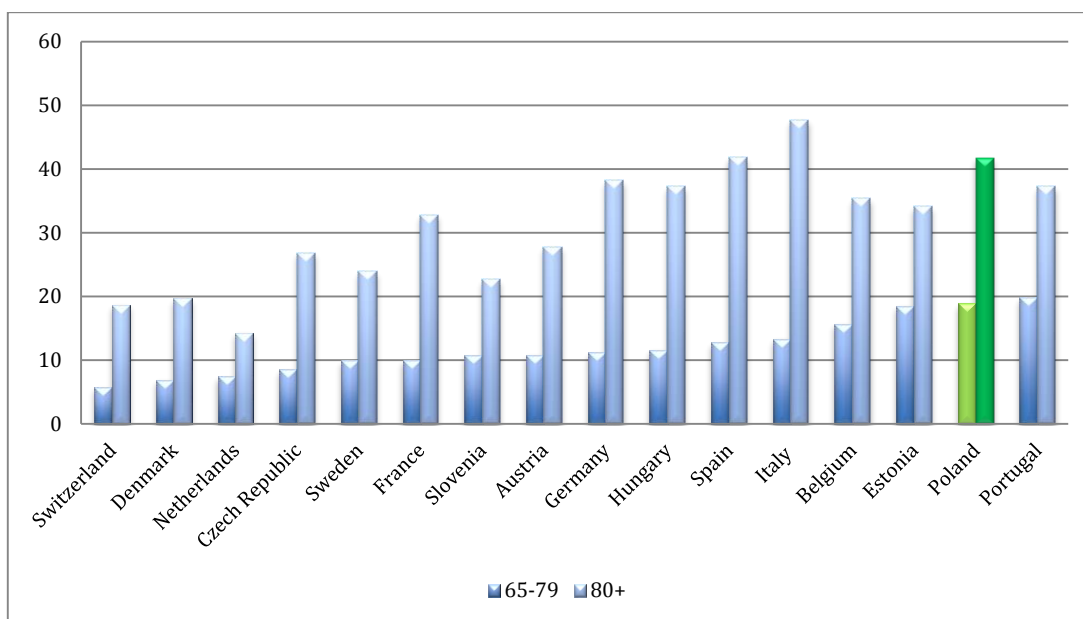
<https://openknowledge.worldbank.org/handle/10986/22018> License: CC BY 3.0 IGO

Results from the SHARE study (2010–2011) show that the proportion of older individuals with functional limitations, which is a proxy for the demand for some form of assistance in daily activities, is high compared to other countries (Figures 13 and 14). Almost 20% of individuals aged 65–79 and over 40% of individuals over 80 years of age declares facing difficulties in basic every day activities such as dressing, bathing or showering, eating/cutting up food, walking across the room, and getting in or out of bed, which could be an indication of the need for personal care. A higher proportion of older people (23% of 65–79 and 54% of 80+ population) declares having difficulties in instrumental activities of daily life such as making a telephone call, taking medications, managing money, shopping for groceries and preparing a hot meal.

Although the persistence of limitations seems to be higher than in Western European countries, SHARE data for 2010–2011 point to a slight decrease in the frequency of functional limitations over time and to a decrease in the gap between Poland and other European countries represented in the survey. The proportion of people in Poland not having problems with ADL or IADL was higher in 2010–2011 than in 2006–2007, and the progress has been most pronounced among those 65–80 and above the age of 80.

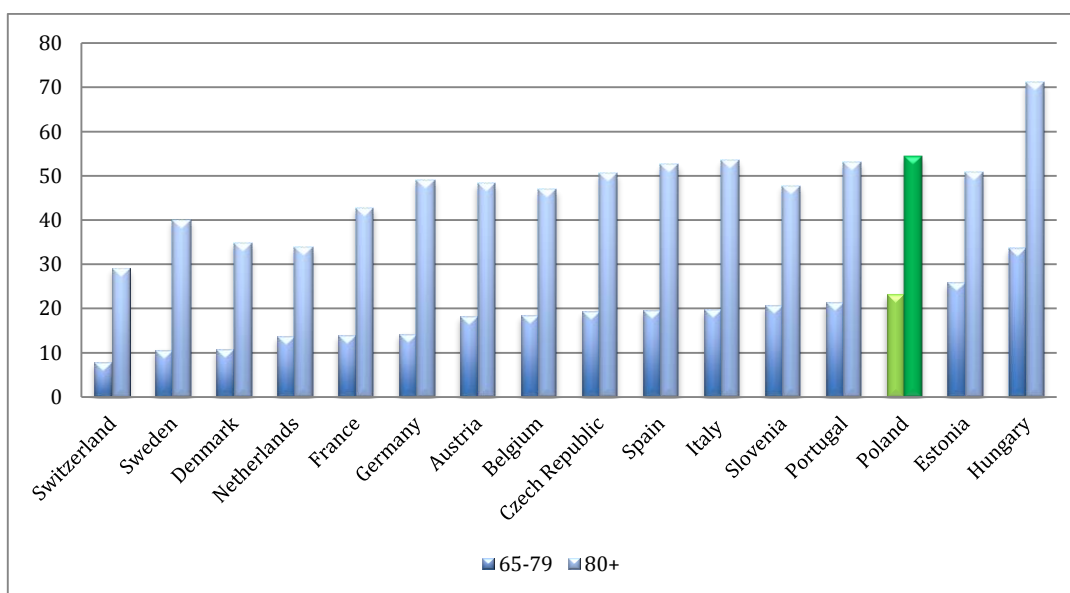
It should be noted that the difference in the prevalence of limitations between the countries can be correlated with the differences in the availability of infrastructure for the elderly which helps them in overcoming functional limitations. An example is the fact that better infrastructure in Western Europe, such as ramps or elevators can have a positive impact on the persons' ability to function. In the United States there are estates for the elderly, which do not provide long-term care but offer homes with ramps, bathroom grips, doorways that are wide enough for wheelchairs, etc. All these elements help older people to function independently for longer time.

Figure 13: Proportion of individuals with functional limitations in basic activities of daily life (ADL)



Source: Own calculations based on SHARE 2010–2011 data.

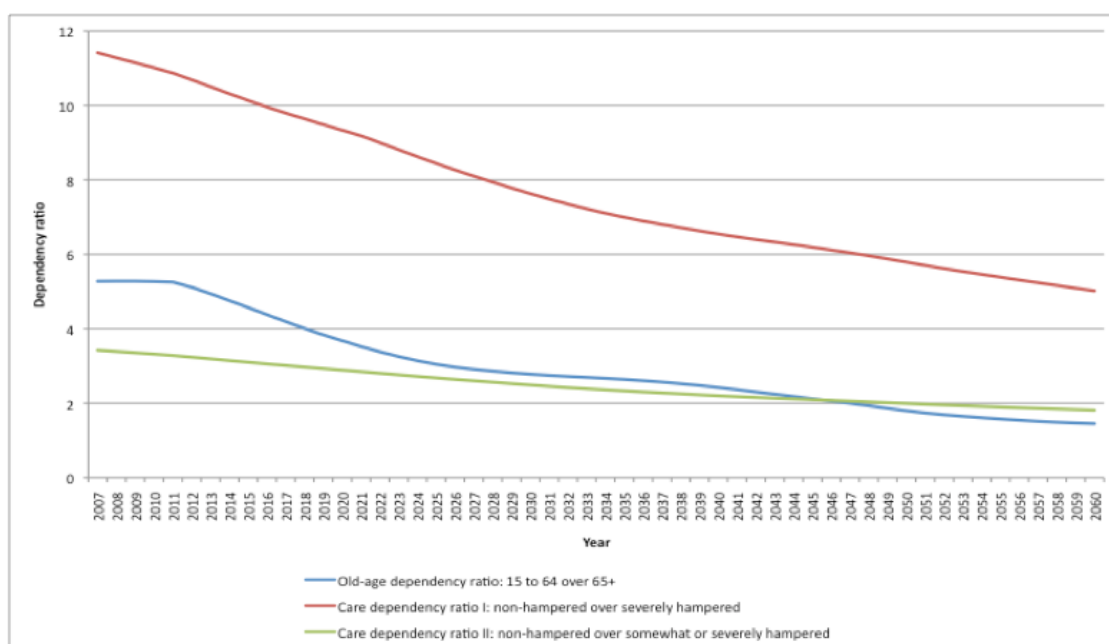
Figure 14. Proportion of individuals with functional limitations in instrumental activities of daily life (IADL)



Source: Own calculations of the World Bank based on SHARE 2010–2011 data

The current proportion of 11 healthy persons per 1 severely dependent is foreseen to change to only 5 healthy people per 1 severely dependent over the next four decades. The unfavorable relation between potential care recipients and potential care providers questions the future ability of informal care provision to meet the demand for care and thus indicates the need for further formal services development.

Figure 15: Projected inversed dependency rates 2013-2060



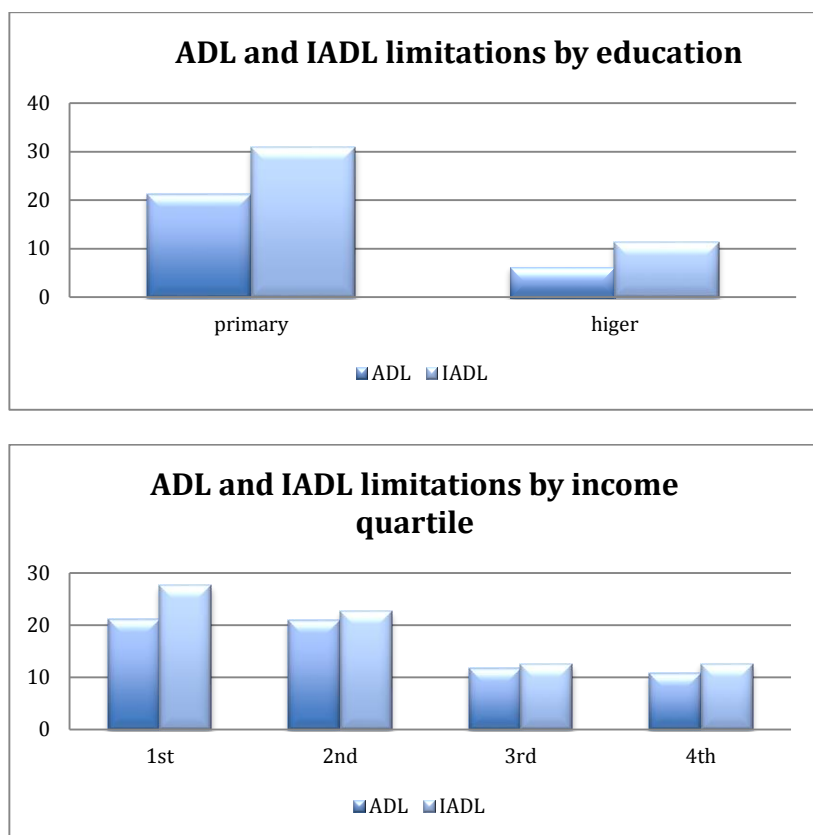
Source: World Bank staff calculations.

#### 6.1.4 Socio-economic inequalities in functional limitations

Poland is a country with a highly unequal distribution of mortality and morbidity across socio-economic groups. Inequalities are more persistent than in Western European countries and increased over the previous decade (Mackenbach et al. 2007, Sowa 2011, Boulhol et al. 2012), highlighting the need for public health actions targeted at the poorer population. The high level of health inequalities in the society among the older population, i.e. the diversification of the health status across social and economic groups might result from human capital differences (gender, race, occupation, education, etc.) and wealth, as well as from differences in access to health care, including pharmaceuticals.

The need for care due to high functional limitations among older people is distributed unequally in the population, with functional limitations occurring twice more frequently in the lowest income quartile than in the highest one and three times more frequently among population groups with primary education level compared to individuals with an university degree (Figure 16). There is an adverse effect of higher needs for care among the population with lower incomes and poorer education, who also have more limited ability to obtain care in the private market or on the basis of co-payment.

Figure 16: Inequalities in functional limitations among the older population (65+) in Poland



Source: Own calculations based on SHARE 2010–2011 data.

## 6.2 Limitations in the supply of LTC services

### 6.2.1 Informal care and its impact on the labor market performance of women

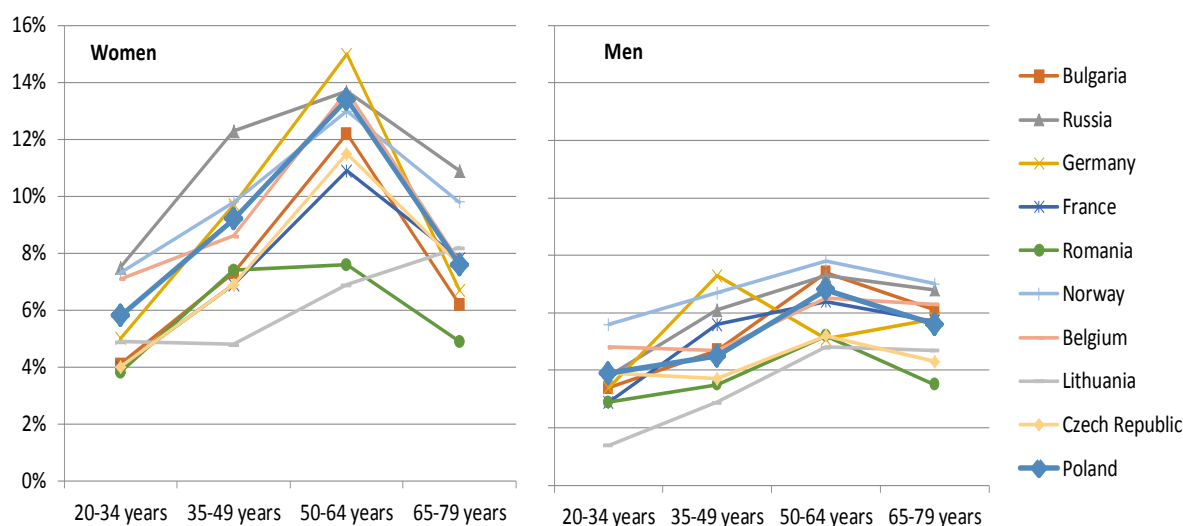
The supply of LTC is informal and in the family domain in Poland, with care largely provided by family members and at home. Several different and independent estimates show quite consistently that the majority of the older dependent population receives informal care: from 80% (Kotowska, Sztanderska, Wóycicka et al. 2007) to 93% (Łuczak 2013). The reasons behind the high level of informal care provision in Poland include traditional family relations and frequent co-residence of older people with their children (high co-residence index).

In most cases informal LTC services are provided by women, who often become dual caregivers over the life-cycle, providing care to their children in the 30s and 40s, and to older parents and parents in law in their 50s and 60s (Wóycicka, Rurarz 2007). Provision of care by men is twice less frequent (Figure 17). Data from the European project – Eurofamcare 2006 – characterize informal caregivers as follows: mainly women (76%); the mean age is 55 years; 22% have spouses; 60% have children or children-in-law (60%); 41% is employed; and 56% lives in the same household (or



same building). The intensity and duration of care is high: mean hours of care amount to 46hrs per week and the mean length of time spent on care related tasks is 60 months.

Figure 17: Percentage of respondents who reported that they gave someone regular help with personal care in the last 12 months (excluding small children)



Source: World Bank compilation based on GGS data (most recent wave for Bulgaria, Russia, Georgia, Romania, Lithuania, Poland, Czech Republic, Germany, France, Norway, and Belgium), 2015.

Quite inevitably, the high reliance on informal care has an adverse impact on the employment rate of women in their 50s and 60s. (Kotowska, Sztanderska, Wóycicka 2007). Although the employment rate of females aged 55-64 increased between 2010 and 2013 from 24.2% to 31.0% (GUS 2015), it remains far below the EU average of 43.3%. The high rates of labor market inactivity and/or early exit amongst females aged 50-64 years are a consequence of family responsibilities, including care for older parents or parents-in-law, the underdeveloped supply of formal publicly financed care, or the lack of affordable private care establishments (Wóycicka, Rurarz 2007, Raław 2012). FGDs with women in Katowice carried out as part of the Qualitative Assessment of Elder Care Services confirm that the responsibility of providing LTC to family members poses numerous challenges to professional women (Box 5).

#### Box 5: Challenges faced by professional women - findings from the Qualitative Study Pilot in Katowice<sup>13</sup>

Some research participants (three persons out of twenty subjects) declared that looking after an elder had a negative impact on their professional lives because they had to quit their jobs. It has to be noted that the professionally inactive respondents usually have lower education than the professionally active ones. Therefore, the former may have

<sup>13</sup> Detailed information on the study can be found in Annex 1.

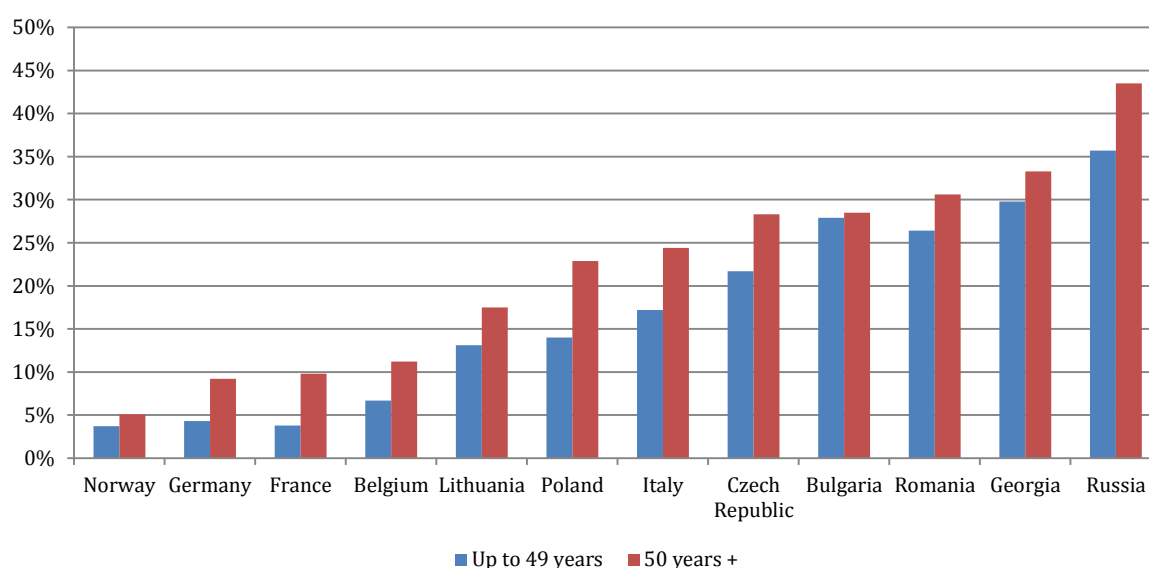
lower chances of getting jobs and receiving incomes high enough to compensate for staying at home and not working.

Among professionally active women, there were no declarations of a negative impact of looking after an elder on their employment or professional career. However, the research participants stress that the possible impact on their professional situation depends heavily on their attitude as employees.

Source: Millward Brown, 2015.

The reliance on informal LTC services is underpinned by strong cultural and social support to informal, family care with a powerful tradition of children (mainly daughters) being regarded as the primary care providers (Figure 18 and Box 6). The tradition is especially strong in the countryside (Wóycicka, Rurarz 2007). The perceptions of traditional family roles and care obligation in Poland are similar to those in Eastern and Southern European countries.

Figure 18: Perception of care responsibilities: agreement with the statement “When parents are in need daughters shall take more responsibility than sons”



Source: World Bank staff based on GGS data (most recent wave for Bulgaria, Russia, Georgia, Romania, Lithuania, Poland, Czech Republic, Germany, France, Norway, and Belgium), 2015.

### 6.2.2 Limited public provision of formal long-term care

The provision of publicly financed and provided LTC services is limited, with the exception of the care supplement – a universal benefit provided to all individuals above 75 years of age. As a result, while the coverage rate of the dependent population with a universal cash benefit is relatively high at 62%, the coverage of the dependent population with needs-targeted services (residential and home care) is among the lowest

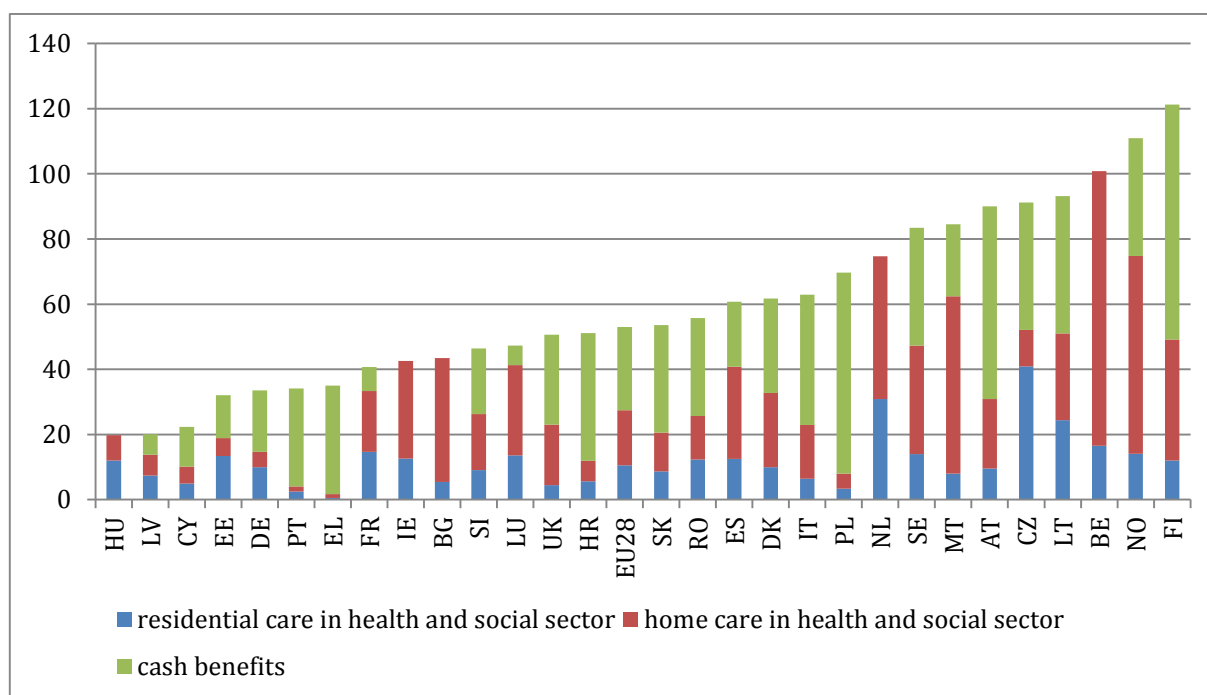
in the EU (European Commission, 2015). Only 4.6% of the dependent population receives formal home care and 3.4% receives formal care in residential institutions (2013) (Figure 19).

Limitations in the supply of formal public LTC services are compounded by societal attitudes and perceptions about nursing homes disfavoring formal, institutional care. In the FGDs carried out in Katowice as part of the Qualitative Assessment of Elder Care Services, the female caregivers expressed the following opinions about nursing homes:

- It is difficult to find a place in public nursing homes, and the waiting time is long. The costs of such care also tend to be too high.
- There are more places in private nursing homes, but they are expensive.
- The eldercare standard in some nursing homes (public and private) is low, while good private nursing homes are expensive.
- The biggest problems of nursing homes are understaffing and the lack of a friendly atmosphere.

The respondents expressed a strong reluctance to send their elderly family members to nursing homes. In general, the use of nursing homes raises a lot of doubts, which are amplified by society's negative assessments of families sending their elders to nursing homes, especially when other family members object to sending an elder to a nursing home.

Figure 19: Country-specific coverage rates of formal long-term care recipients as % of dependent population



Source: World Bank compilation based on the European Commission data, 2015.

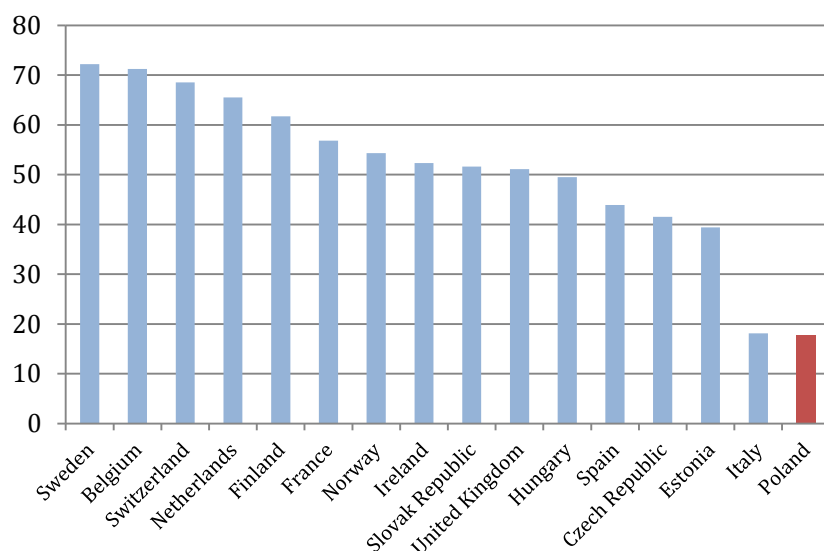
An evaluation of the targeting of care to the dependent population finds that only about 2% of older families in need for care receives support from formal publicly financed institutions (Wóycicka, Rurarz 2007). According to the results of the PolSenior survey, approximately 40% of the population 65+ is in need for daily care, but less than 10% receives support in the form of care services provided by publicly financed institutions (Błędowski 2013). The low provision of home care reflects the limited ability of social assistance centers (Błędowski, Maciejasz 2013). Barriers to the provision of formal care services at home include poor information on the services available, poor legal knowledge related to home care provision among social workers, financial constraints of social assistance resources and induced by the co-payment obligation as well as the low number of professionals who could provide this type of care.

In the health sector, the utilization of long-term care nursing home services is low with only 4 persons per 1000 using this type of service in 2013 (GUS 2015). The utilization of nursing home services is highly correlated with age, as over 70% of clients are over 70 years of age. The demand for services is rising, as the share of clients in need for frequent medical and nursing assistance has increased from 44% to 77% between 2010 and 2013 (GUS 2015). Utilization is higher in cities than in rural areas, which might be related to gaps in the availability of services between urban and rural areas, and the preservation of a more traditional family model.

Semi-residential activities in day care centers organized by local governments remain underdeveloped with only 226 units in operation across the country covering 19.3 thousand people (MPiPS 2014) in 2013. An opportunity to invest in this type of facilities by local governments is provided by two governmental programs: Senior-WIGOR and ASOS. Under the former, 100 facilities should come into existence by the end of 2015.

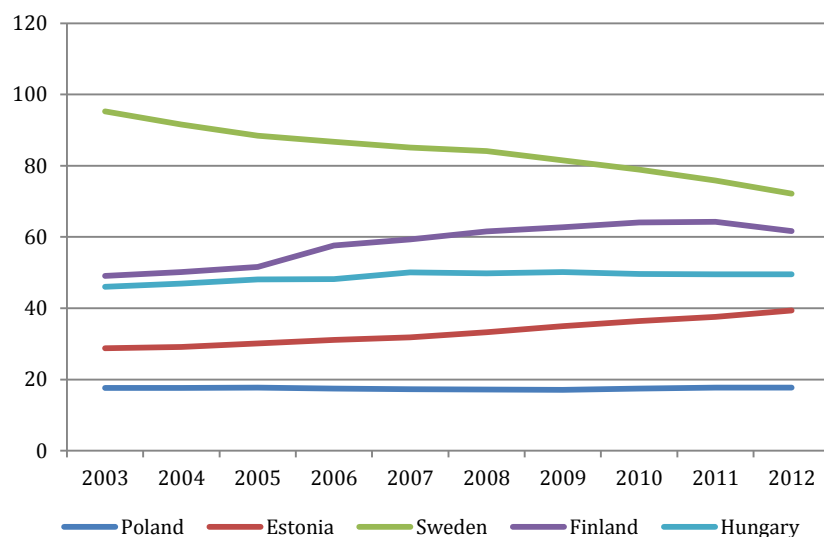
Poor access to formal residential care remains a weakness of the LTC system in Poland. The density of beds in residential facilities in the health sector is among the lowest among OECD countries, with less than 20 beds per 1000 population 65+ (OECD 2014) (Figure 20). The provision of long-term care beds has been stable over the past decade in Poland, while in other European countries a convergence process can be observed: in Nordic countries, where the utilization of this type of costly services was high, the provision of residential care has decreased, whereas in countries with previously poor access to long-term residential facilities (i.e. Estonia), an increase has been registered (Figure 21).

Figure 20: Number of beds in long-term care per 1000 population 65+



Source: OECD statistics, 2014.

Figure 21: The number of beds in long-term care per 1000 population 65+, OECD countries



Source: OECD statistics, 2014.

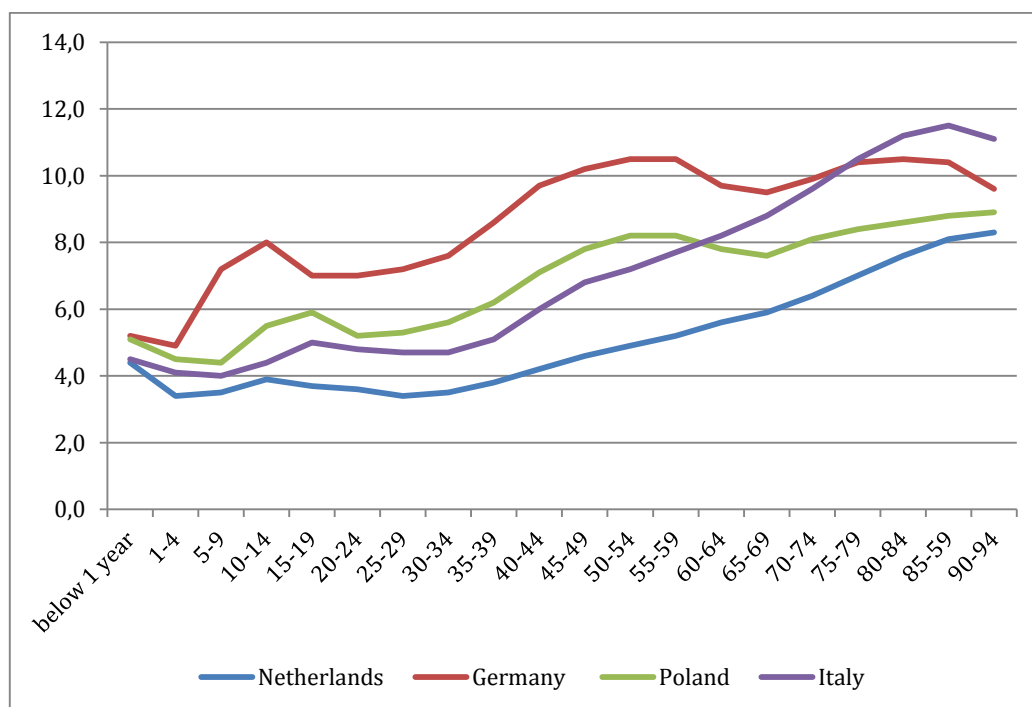
Most of the patients in long-term care residential facilities belong to the older age groups. In LTC facilities in the health sector, almost 74% of residents are aged 65+ years and more than 50% aged 80+ years (GUS 2014). Most of residents are women, which is probably related to their higher longevity. In the social sector people aged 65+ constitute on average 54% of residents (MPiPS 2014). The highest percentage of older

people in residential care is in wards for older people (92%) and in homes for chronically ill (77%).

As shown on the figure below, the use of health care facilities is especially high among the elderly. While residential care facilities provide nursing and care services, medical care is provided in medical facilities of primary, secondary and tertiary care. The rate of hospitalizations among older people (age 65+) is twice that among the total population (27 per 100 persons 65+ compared to 14 in 100 persons in the overall population). The frequency of repeated hospitalizations over the year is also higher among older people. Trends in ALOS are similar to those in other countries, with ALOS visibly increasing for the population 65+ (Figure 22).

Notably, the 65+ age group make relatively less intensive use of medical care facilities and greater use of nursing and palliative care facilities. The number of patients in hospital wards for chronically ill decreases in the last years amounting to only 5.1 thousand, as chronically ill patients move to palliative care and wards for chronically ill are transformed into palliative or long-term care units. Also the number of patients in geriatric hospital wards, at 19.3 thousands, is low (GUS 2015). These trends indicate that hospitals are not substituting for residential or palliative care, and are instead moving patients from medical care and into nursing or palliative care as appropriate. In some countries (i.e. Germany, Netherlands) the average length of stay is found to decrease for the oldest old (from 65+ group). This trend is not yet evident in Poland.

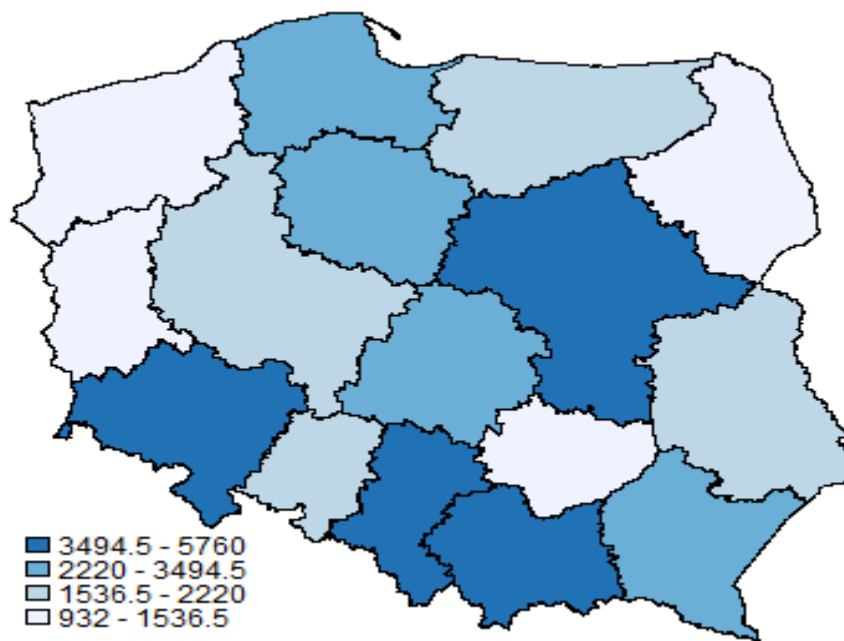
Figure 22: Average length of stay in hospitals by age in selected European countries, 2011



Source: Eurostat, 2012.

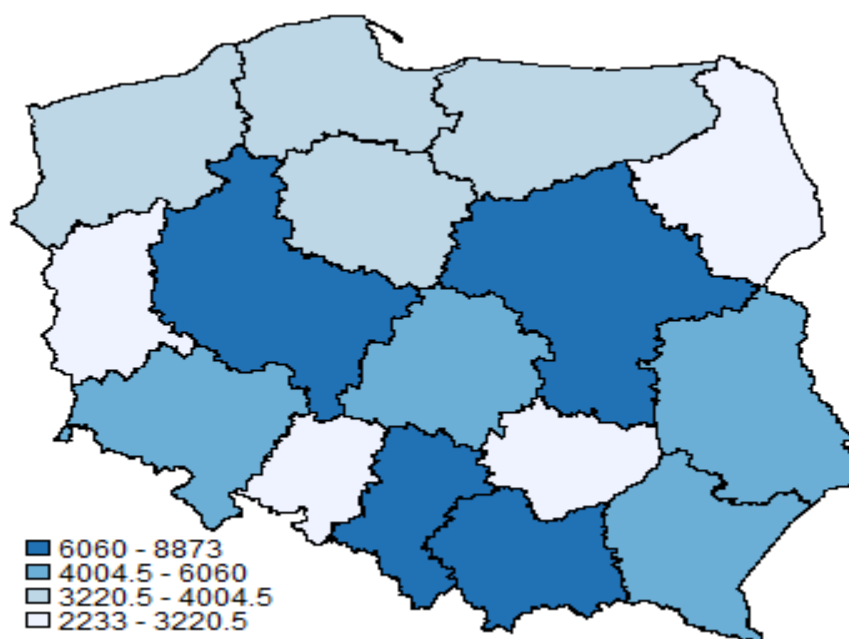
There are large regional differences in the provision of long-term residential care as well (Figures 23 and 24). The highest number of recipients of both residential nursing and care in ZOL and ZPO and residential stationary care in DPS can be found in Southern and Central Poland: Małopolskie, Śląskie, Mazowieckie and Dolnośląskie voivodeships. The number of recipients of nursing care is high in Dolnośląskie for the health sector and in Wielkopolskie voivodeship for the social sector. The lowest number of residential care recipients is in Podlaskie, Świętokrzyskie and Lubuskie voivodeships, in Zachodniopomorskie in the case of ZOL and ZPO, and in Opolskie for DPS.

Figure 23: Regional differentiation in provision of residential long-term care for adult population in ZOL and ZPO (number of care recipients)



Source: NFZ statistics, 2013.

Figure 24: Regional differentiation in provision of residential long-term care for adult population in DPS (number of care recipients)



Source: MPiPS statistics.

This distribution of the available infrastructure (residential care facilities) does not necessarily match the share of older population. As presented above, Małopolskie and Śląskie voivodeships are regions with a high share of 65+ population, but not the oldest old (80+), who typically have higher needs for full-time care. The highest share of the oldest old (80+) is in the Podlaskie, Mazowieckie, Świętokrzyskie and Łódzkie voivodeships, where the provision of formal residential care – with the exception of Mazowieckie – is low (Podlaskie and Świętokrzyskie voivodeships) or modest (Łódzkie voivodeship), which indicates a likely high level of informal care provision in the latter three regions. Opolskie is also a specific region with poor provision of residential care, high levels of population 65+ and high migration, which can negatively impact the possibilities of provision of informal care in the future as the cohort of 65+ will age and face higher care needs.

### 6.2.3 Low level of long-term care funding

Long-term care is financed from public and private sources. Overall, total public expenditures on LTC<sup>14</sup> were estimated to be about 0.8% of the GDP in 2010–2013 (Golinowska 2010 and European Commission 2015), which is among the lowest shares in the EU. Care provided by private sector facilities or homes, the costs of accommodation and board in residential and nursing care facilities and all informal care

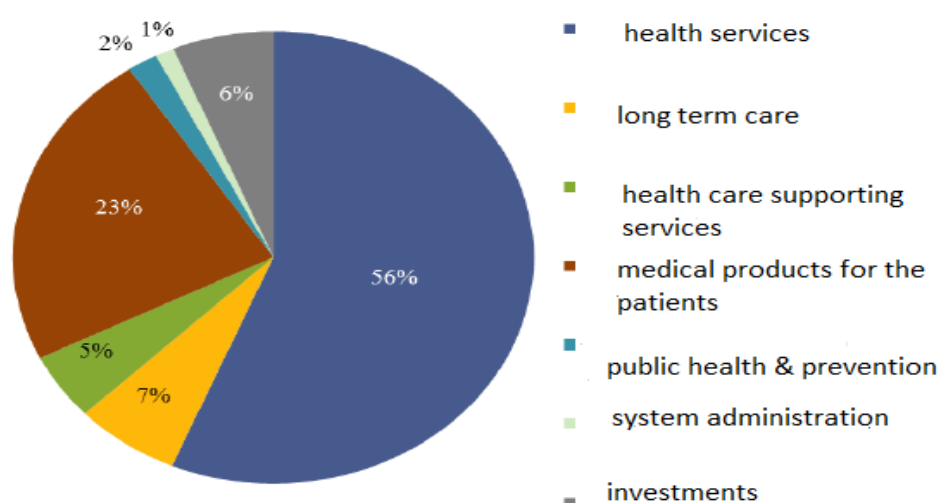
<sup>14</sup> Estimations cover public expenditures on residential nursing care in the health sector, residential care in the social sector, home nursing care in the health sector and home services and specialized home services in the health sector as well as cash benefits.



are paid for entirely out-of pocket. As in many countries, no reliable estimates are available of the level of out-of-pocket spending on LTC.

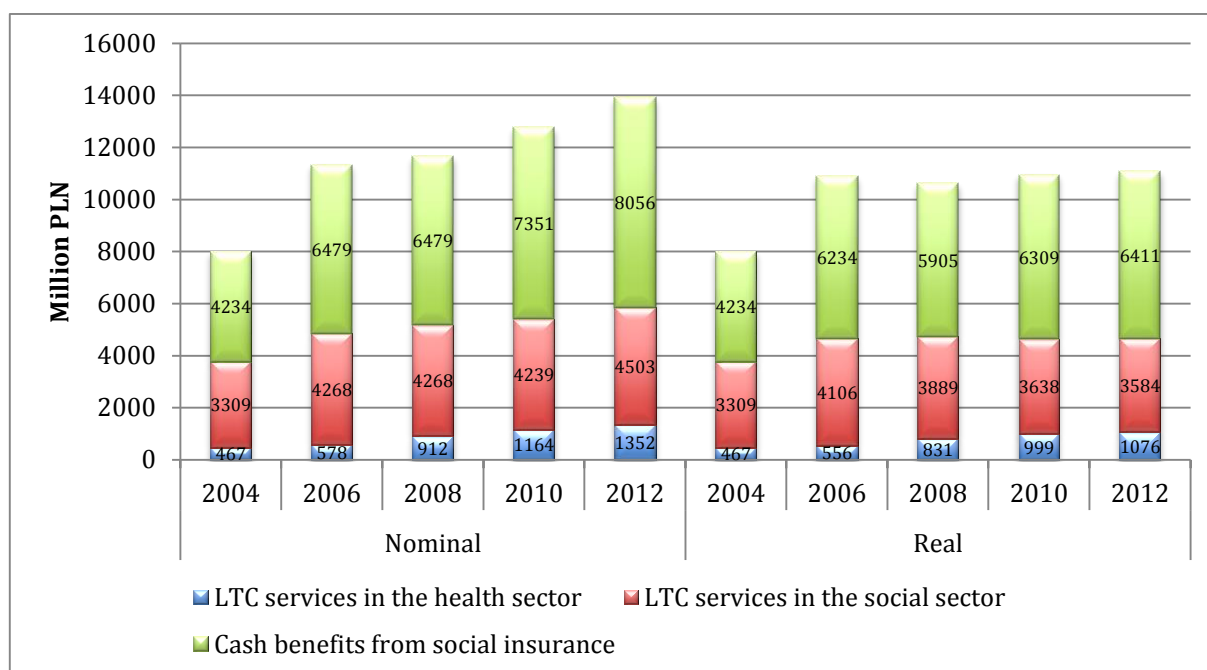
Residential and nursing home care provided within the health sector are paid mainly from the social health insurance. LTC expenditures account for 7% of the total health expenditure in Poland, and this share has slightly grown in recent years (GUS 2014) (Figures 25 and 26). Given that current public health care expenditures in Poland are among the lowest in the European Union (4.4% of the GDP in 2012) and that formal LTC is almost fully financed from public resources (93%), this share is relatively low.

Figure 25: Long-term care expenditures as a share of the total health expenditures in Poland



Source: Health and health care, GUS 2013.

Figure 26: Past trends in long-term care public expenditures in Poland

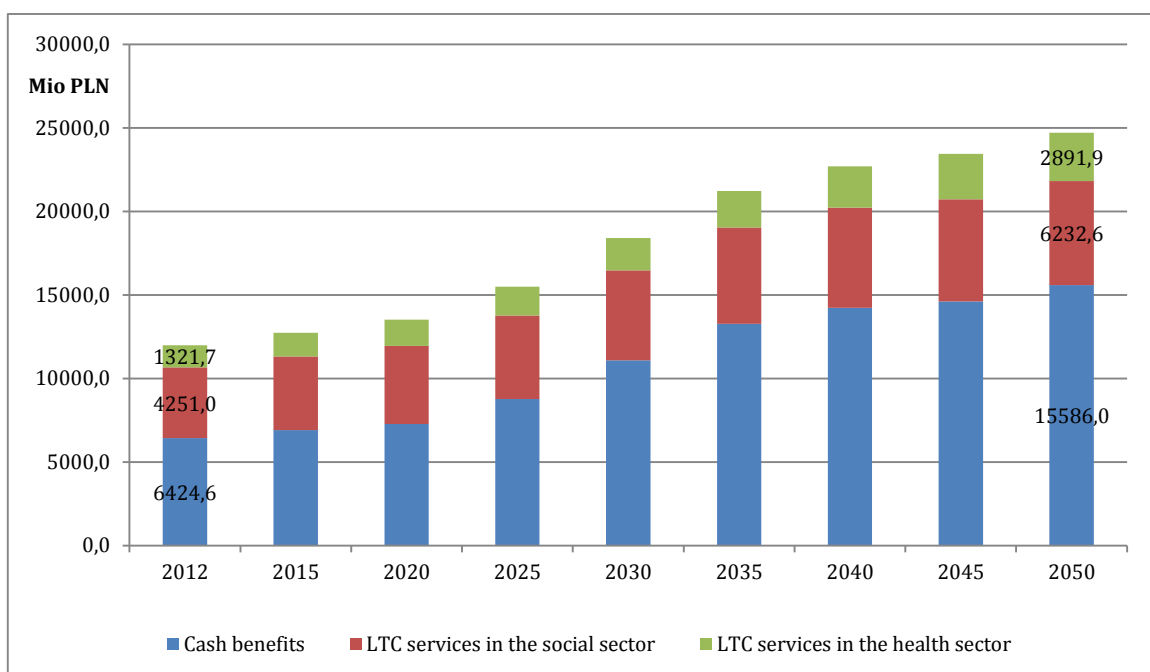


Source: Golinowska, Kocot, Sowa 2013.

Although LTC is targeted at various groups of people in need (such as the disabled, including children), most of the expenditure on long-term care services is related to care provided to the older population. In the residential care units in the healthcare sector 80% of expenditures were made on services for the population 65+ and 51% for the population 80+ in 2011–2012. The share of expenditures for the population 65+ is as high as 85% of the total in the case of nursing care costs (Golinowska, Kocot, Sowa 2013). Similarly, most expenditure on residential care and care services in the social assistance sector covers services for the older population. This expenditure structure is related to the fact that the future financial burden on the LTC system will grow along with the share of the elderly in the population.

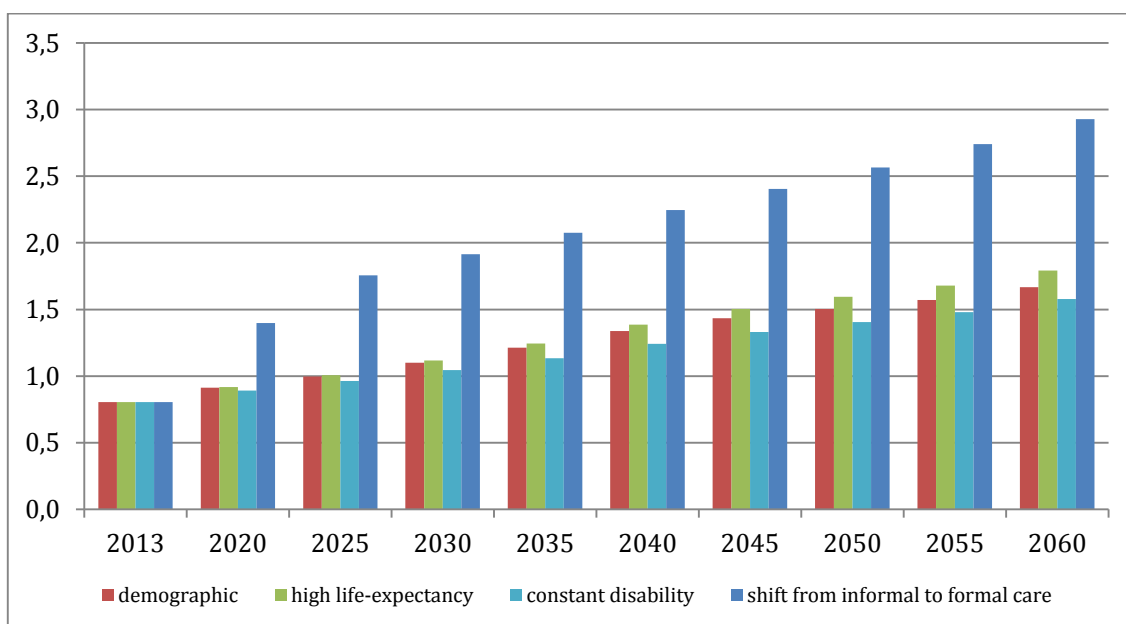
Given changes in the age structure of the population causing an increase in demand for services, expenditures are projected to double by 2060 (Figures 27 and 28; Box 6). The increase might be slightly less substantial if health status improvements lead to a decrease in functional disability in older age, i.e. if there is compression of morbidity and disability (European Commission 2015). On the other hand, the size of the increase depends on the types of institutional changes introduced in long-term care provision. The increase in expenditures, however, seems to be inevitable at least to the level that is currently the norm in Western European countries.

Figure 27: Projections of long-term care expenditures in million PLN, 2012–2060



Source: Golinowska, Kocot, Sowa 2013.

Figure 28: Projections of long-term care expenditures in relation to the GDP, 2013–2060



Source: European Commission 2015.

#### Box 6: EU projections of LTC expenditure

In 2014 the European Commission conducted a projection exercise that aims to forecast the future evolution of public expenditure on long-term care services in EU countries<sup>15</sup>. Such exercise uses different scenarios based on assumptions about demographics (e.g. life expectancy, disability rates) and policy developments (convergence in coverage and/or costs of formal LTC).

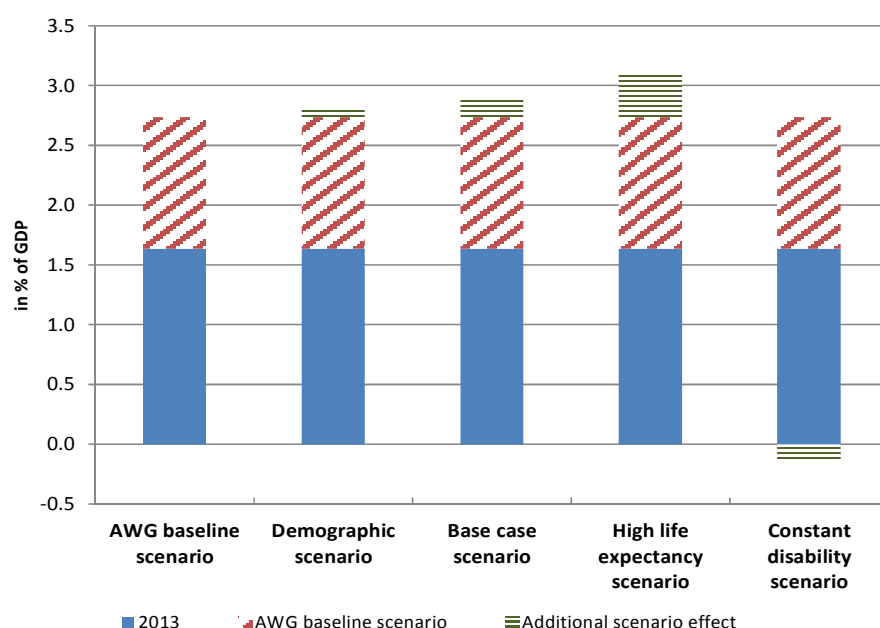
The Aging Working Group (AWG) reference scenario assumes that one half of future “gains” in life expectancy will be spent in good health and the other half in disability, whereas public LTC expenditure in the EU is projected to increase from 1.6% of GDP to 2.7% of GDP, i.e. an increase of 67% up to 2060. Under both the demographic scenario, where the share of the older disabled population who receive care is kept constant, and the base-case scenario, linking LTC unit costs to workers’ productivity, total expenditure as a share of GDP is projected to be only slightly higher than using the AWG assumptions.

Under the “high life expectancy scenario”, which assumes life expectancy to be higher for all age groups than in the reference scenario, public spending on LTC would be the highest, accounting for over 3% of GDP in 2060. On the contrary, according to the constant disability scenario, which assumes a gradual decrease over time in disability prevalence for each age cohort, spending would be the lowest, and actually decrease as a share of GDP.

Figure 29: Scenarios with demographic assumptions, EU in % of GDP

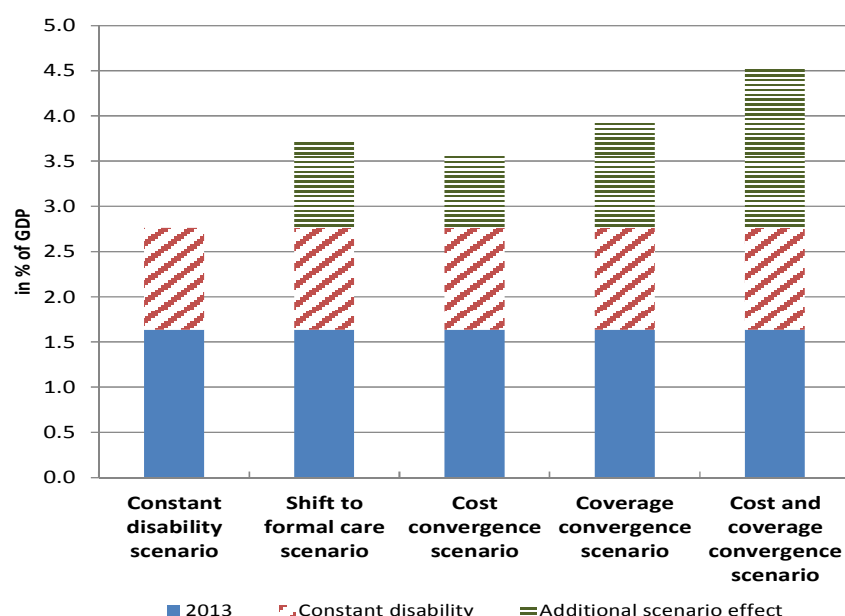
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<sup>15</sup> Projections for public expenditure on long-term care (LTC) from 2013 to 2060 were run using Commission services' (DG ECFIN) models on the basis of the methodology and data agreed with the Member States delegates to the Aging Working Group (AWG) – Economic Policy Committee (EPC).



The inclusion of policy developments in the projections, and thus assuming convergence in costs and coverage of LTC services by 2060, leads to a more substantial increase in LTC public expenditure: Under such assumptions, it is projected to increase up to 4.1% of GDP in the EU. Using coverage convergence and cost convergence assumptions separately leads to relevant although smaller spending increases. The shift to formal care scenario, which instead assumes a progressive shift into formal care of the elderly who have so far received only informal care, also forecast a substantial increase in spending (to approx. 3.5% of GDP).

Figure 30: Scenarios with cost and coverage assumptions, EU, % of GDP



The report concludes that ageing and non-demographic drivers of long-term care

expenditure will exert a continuous pressure on public finance, which will require striking the right balance between the need for broader formal care coverage and the need to ensure the sustainability of public finances. In particular, the shift of informal to formal care and a convergence process in terms of coverage and costs of LTC for those countries that are below EU average levels will likely imply a substantial financial risk for such countries.

Source: European Commission, 2015

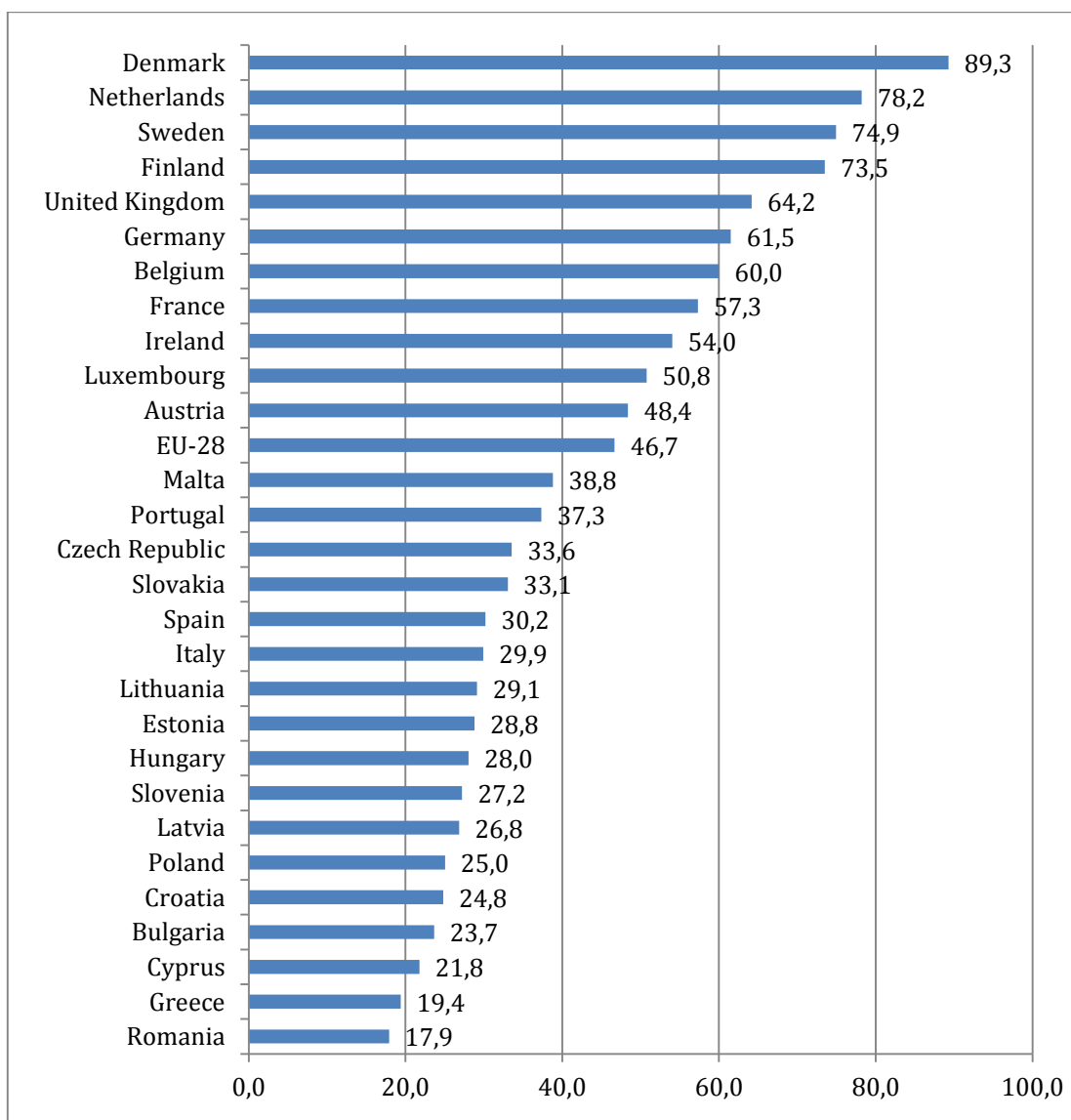
#### **6.2.4 Unmet demand for medical care and therapeutic personnel**

Employment in the human health and social care sectors<sup>16</sup> represents 5.7% of total employment compared to the average of over 10% of total employment in the EU-27 in 2011. Poland thus has one of the lowest densities of employment per 1 000 population in these two sectors in the entire European Union (25.0 employees in Poland compared to 46.7 in the EU-27 in 2014) (Figure 31).

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<sup>16</sup> This refers to formal employment in health sector and social sector (social assistance). Immigrants are included only if they are registered and employed (what is marginal as majority of them works providing unregistered care paid out-of-pocket).

Figure 31: Density of employment in human health and social care sectors in European countries per 1000 inhabitants



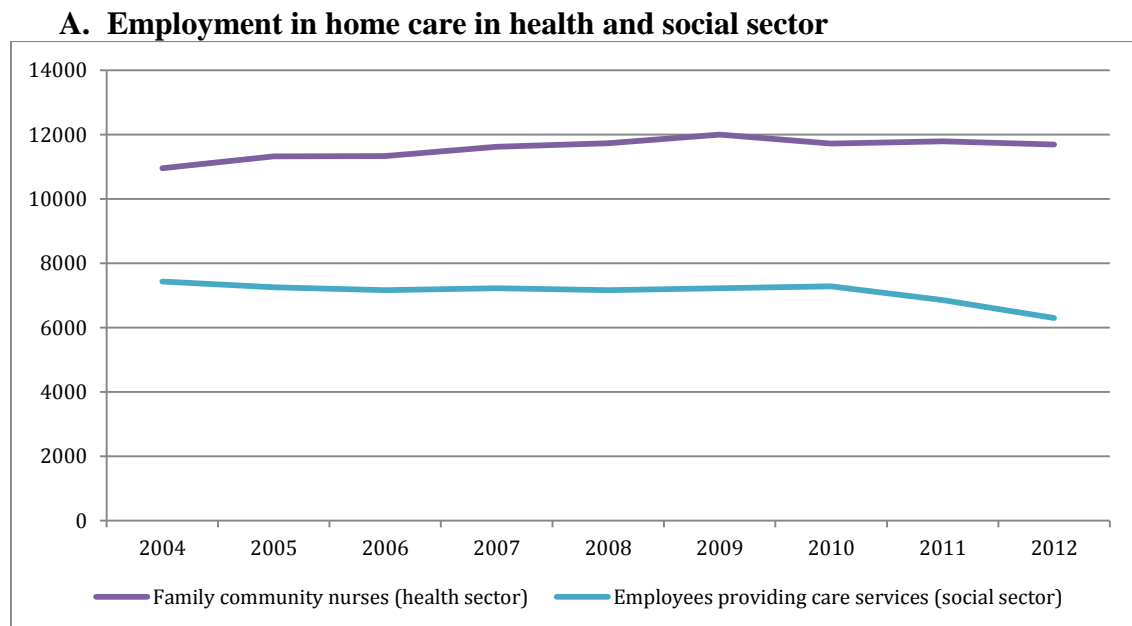
Source: Own calculations of the World Bank based on Eurostat labor market statistics and population statistics.

Only a small part of the health sector and social assistance employees is involved in the provision of long-term care (Figure 32). In the health sector most employment is related to the provision of medical and nursing services in primary, secondary and tertiary care rather than nursing and care in long-term care facilities. Similarly, only a small proportion of social workers (caregivers) are involved in the provision of care rather than typical social assistance services related to poverty relief.

According to the central registry of nurses and midwives, there were 145 nurses and midwives with a foreign background registered officially in Poland in 2014 mostly coming from non-EU countries.

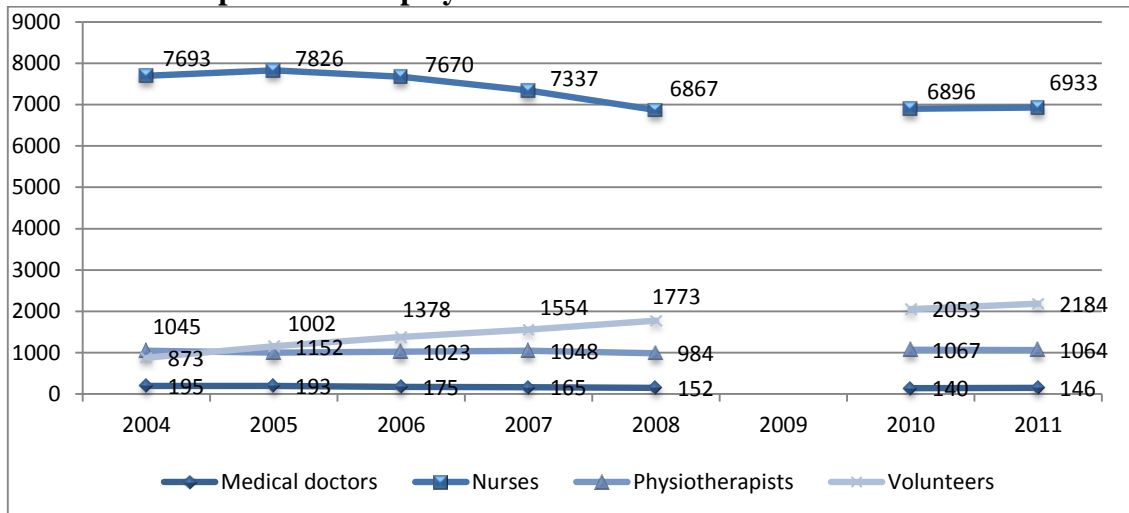
Despite the low density of employment relative to other EU countries, the overall number of employees in long-term care has increased over time. There are different trends in home and residential care employment (Figure 32). In home care (Panel A) the number of employees has remained stable in the health sector, while it has decreased in the social assistance sector. In residential care (Panel B), the employment of professionals has increased. In the health sector (Panel C) long-term care residential facilities the increase can be attributed to the rising number of physicians (from 810 in 2004 to 2547 in 2013), nurses (from 5138 in 2004 to 10479 in 2013) and caregivers, including the new profession of medical workers (from 948 in 2004 to 2959 in 2013). Meanwhile in the social assistance residential care facilities the number of physicians and nurses decreased (from 195 physicians in 2004 to 163 in 2011 and from 7693 nurses in 2004 to 6933 in 2011) and the number of therapeutic and care personnel increased (from 20759 in 2004 to 29768 in 2011) (Golinowska, Sowa, Kocot 2014; CSIOZ 2014).

Figure 32: Trends in long-term care employment in Poland

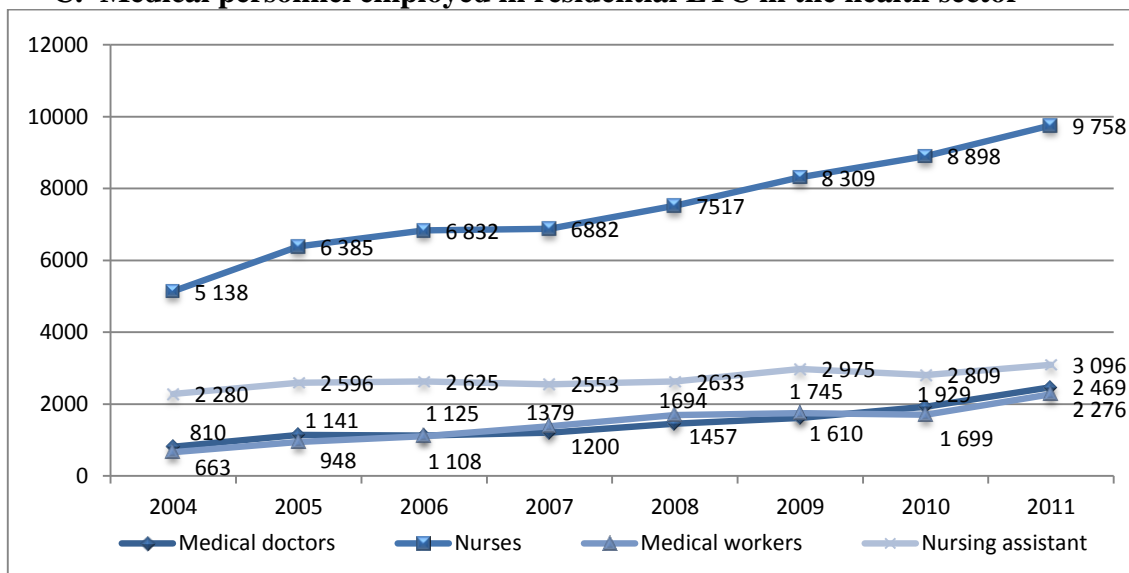




### B. Medical personnel employed in the social assistance homes<sup>17</sup>



### C. Medical personnel employed in residential LTC in the health sector



Source: Golinowska, Kocot, Sowa, 2014

The changes are related to the main field of activities of residential care institutions, which are more oriented towards nursing in the health sector and towards care in the social assistance sector. Indeed, it is not uncommon for medical services in social assistance residential care to be provided by primary care physicians operating in a given location, without a separate contract (Golinowska, Sowa 2010).

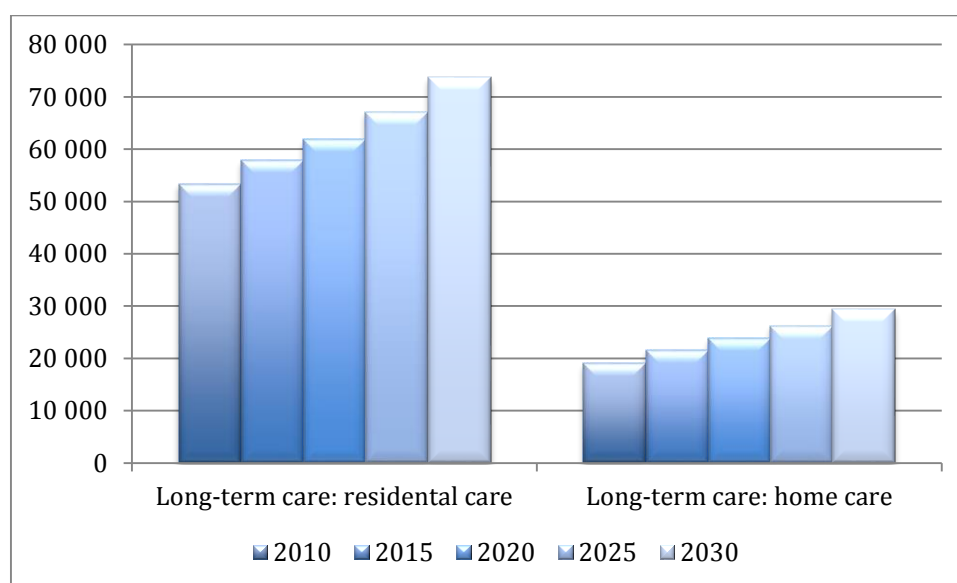
The introduction of new professions – the long-term care nurse (in 2003), medical worker (in 2007) and caregiver in social services (2001) – has helped address the growing needs for care of the older and dependent population, although it is still insufficient to cover the existing needs. There is a great deal of interest in the new professions, especially medical workers. The number of medical workers employed in residential care facilities has increased significantly. Additionally, the involvement of

<sup>17</sup> Due to a change in the GUS reporting system, 2009 data is not publicly available.

volunteers working in long-term care is also rising, although not as strongly as among medical professionals.

Demographic changes and the projected increase in the need for care services will put pressure on the demand for long-term care professional workers (Figure 33). In home care, and for both sectors, the demand for employees will increase by 54% compared to the employment level of 2010, while in residential care it is foreseen to increase by 38%. Immigration provides a potential additional pool of employees for LTC service provision.

Figure 33: Projection of the demand for long-term care professional personnel, 2010–2030



Source: Golinowska, Kocot, Sowa 2014.

### 6.2.5 The quality of services: an unfinished agenda

The quality of care is monitored separately in the health and social sectors, on the basis of a range of instruments, with special emphasis on residential care standards. However, much of the focus is on inputs (necessary to provide care services) rather than outputs (or even outcome) of care (Box 7).

#### Box 7: Quality in LTC

The quality of long-term care services is relevant for different reasons. Service users want to have a say in and control over their lives, while the cost of services keeps growing. In addition, governments need to protect vulnerable elderly from abuse. The experience across OECD and EU countries shows that the most effective combination of policies to drive LTC quality would include: (1) regulatory standards, (2) standards to normalize care practice and to monitor that quality indicators match objectives, and (3) market incentives for providers and users. In addition, an for quality oversight and assessment purposes, adequate indicators need to be measured.

**Quality indicators** – Indicators of LTC quality, including measures of clinical quality, users satisfaction or quality of life are useful for measuring and assessing service provision. However, few countries systematically measure whether their LTC systems are safe, effective and centered around the needs of users. International lessons suggest that indicators should rather focus on outcomes, and not processes, be constructed from administrative data using standardized coding systems and be built on a single item, rather than on a multi-item scale.

**Regulatory standards** – Although all countries have legislation regarding adequate and safe care, only in two-thirds of OECD countries, accreditation or certification of care facilities is compulsory or common practice (e.g., England, Spain, Ireland, France, Australia, Germany, Portugal, the United States, Switzerland). Poland has a DPS certificate for 24/7 care establishments. Minimum standards are often used as evaluation criteria for the authorization of provision. However, enforcement of standards has often lagged behind, given the difficulties and costs entailed for both the authorities and providers to supervise/comply with them.

**Standards to normalize care practice** – Standardized assessment tools can be helpful to develop care plans and interventions, promote consistency in care and prevent adverse events. Examples include: the Resident Assessment Instrument (RAI) used in Belgium, Canada, Finland, Iceland, Italy, the United States, and Spain; the AGGIR scale in France; and KATZ in Belgium. Public reporting on LTC quality is also mandatory in some countries, such as the United States, Japan, England, Germany, Portugal, the Netherlands, and Canada. Evidence about the effectiveness of such tool to encourage providers to improve their standards is however mixed.

**Market incentives for providers and users** – Rather than focusing on caregivers, a third of OECD countries allow users to make decisions on service provision, for example through cash benefits. Although these mechanisms have been associated with higher satisfaction among users, their unregulated use can also negatively affect the quality of care. Few countries (e.g., Korea, some USA states) use performance-based incentives in LTC. While data suggests that financial incentives can help to improve certain outcomes, stimulate reporting and the use of assessment tools, better impact evaluation on clinical and other aspects of quality is necessary before more widespread use is recommended.

It must be finally noted that regulatory oversight and quality assurance is more visible and rigorous in institutional care settings, while home or community-based care settings are subject to little or no regulation. Information technology, however, offers great potential to advance rapidly in this area for home or community-based services too.

Source: OECD, 2013. *A Good Life in Old Age*. World Bank, forthcoming. Long Term Care in Aging EAP.

In the health sector, standards regarding residential and home nursing care are maintained through various instruments, including professional requirements (Box 8) and an annual procedure of contracting services by the National Health Fund, which defines standards for services provision. In residential care, the basic quality and adequacy of provision is assured through the monitoring of the number of caregivers to patients (Golinowska, Styczyńska 2012).

**Box 8: Professional requirements in nursing homes – findings from the Qualitative Study Pilot in Katowice<sup>18</sup>**

All the nursing homes set specific requirements regarding the caregivers' education and qualifications: 4 homes require university education, 4 homes require secondary education, and 2 homes require postsecondary education, while 2 homes additionally require medical education. The representative of one nursing home refused to answer the question.

In 5 out of 10 studied nursing homes, caregivers are offered the possibility of further education, training and professional growth: 2 homes offer a course in nursing home care, whereas the caregivers of the other nursing homes can attend courses and trainings independently. New caregivers go through a training or probation period, which usually takes 1–3 months in 5 homes, 6 months in one home, and 9 months in yet another home.

Half of the nursing homes use specific caregiver assessment criteria, which include aptitude for teamwork, attitude to elders, empathy, commitment and independence. 2 homes had no such criteria. 3 homes refused to answer the question.

Source: Millward Brown, 2015. Qualitative Assessment of Elder Care Services in Poland – Pilot.

In the social sector, employment standards are set by the minimum requirement of completion of a first aid course and possession of an adequate professional diploma (i.e. a diploma for a caregiver to older people, an environmental or home care caregiver, a medical worker, an assistant to a person with disabilities, a nurse). Accommodation and boarding standards in social assistance homes are set under the Act on Social Assistance of 2004 and relate to home furnishing and equipment (i.e. rooms' size, furnishing, access to toilets and bathrooms, access for people with motor disabilities).

Regardless of the sector of care, employment standards, contracts and legal regulations define the types of services that could be provided. Basic monitoring concentrates on the volume of services provided and on expenditure (especially in the health sector). However, there are no performance indicators oriented towards results of care (Box 9).

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<sup>18</sup> Detailed information on the study can be found in Annex 1.

#### Box 9: Home care policies performance measures and assessment systems in Europe

Performance assessment is playing an increasing role in the governance of home care services in Europe. Different quality assessment systems coexist, which differ with regards to the levels of marketization/bureaucratization, the specific measures, focus and tools, and with regards to the objective and thus the public nature of the results of home care services. Although ideally performance assessment would evaluate the outcomes for everyone affected by the home care service, structural indicators are also often used for the assessment of service quality.

Structural quality indicators refer to the characteristics of the providers, their tools and resources, and the physical and organizational setting (e.g. the qualifications of staff, and their training levels). Process indicators refer to the activities within and between care workers, informal care providers and service users (e.g. methods for assessment, lifting, feeding or bathing and punctuality). Outcome indicators relate to the final results of the activity (e.g. functional status of individuals, their satisfaction with care and their quality of life).

In Italy, where performance assessment remains limited, such activities generally focus on workers, relying on accreditation and to a lesser extent on activity data usually collected by non-governmental organizations. Other forms of performance assessment including evaluations are not common at the national level, although significant regional and local variation exists.

In Belgium performance assessment is based on activity reports on intermediate outputs or structural aspects of quality, although evaluation or reviews of programs are also conducted. Despite the fact that providers must basically comply with input-related standards, some attention is paid to final outcomes, in connection with workers rather than users, as in the Italian case. The aim of the performance reports is to inform public authorities, and not the general public.

On the other side of the spectrum, Germany and England have more sophisticated or developed performance assessment systems in place. In Germany, where a drive to move performance assessment away from inputs towards results for users exists, the system focuses largely on providers. Recent developments aimed to improve market efficiency, either through quality control or through stimulating competition. Contrary to the Italian or Belgian cases, there is no focus on the workforce.

In England, the marketization of the home care sector has also been a dominant trend in the last years, and assessment has mostly aimed to improve efficiency through minimum standards or by providing information about quality. The focus is on outcomes for service users, although attention is also paid to the effect of services on informal caregivers. Government requires the collection of data, and mandates regular reviews to provide accountability to the public, rather than to control behavior. In addition, quasi-experimental (and experimental) evaluations of pilots of new policies

initiatives have become commonplace.

The observed differences in assessment systems between countries are largely shaped by the way a country organizes its home care system and the political context. Where quasi-markets exist (e.g. Italy, England and Germany), purchasers lack mechanisms of direct control, and thus gathering data about the providers' operations is required for quality assurance and accountability. On the other hand, where provision is organized within a bureaucratic model (e.g. Belgium) there are close and longstanding relationships between purchasers and providers, although often in an environment that does not drive improvements in performance.

England and Germany, which exhibit developed markets where users exercise choice and providers compete, also have the greatest use of inspection and focus on outcomes, while information on quality is publically available. However, in Italy, where there is a quasi-market for home care, there is limited use of inspection and the focus of accreditation is on inputs, which can be attributed to the limited use of formal provision. Only in England performance assessment activities focus on informal care providers, probably due to the difficulties involved in collecting adequate data.

There is no consensus on what approach is to be deemed more effective. In England and Germany, disentangling the direct effect of services on outcomes from those of other unrelated factors remains challenging. On the other hand, the difficulty with structural measures stems from the fact that their relationship with outcomes is not clear. Although data from the US suggests that a system focused on inputs may achieve good outputs, there is no certainty about how it would fare under fiscal pressure, and in contexts where services are highly diverse. Standardized and impersonal evaluation methods may fail to reflect subjective dimensions of quality, which could be incorporated by incentivizing the participation of all relevant actors in the development of services.

Source: 2012. *Care Regimes on the Move. Comparing home care for dependent older people in Belgium, England, Germany and Italy*. Centre Interdisciplinaire de Recherche Travail, État et Société, Université Catholique de Louvain, Charleroi, Belgium.

Private providers of care, operating under the same regulations as any other type of private organization – either for or non-for-profit – are becoming more common. Typically, they cooperate with local governments in the provision of home care services or provide residential care. The activity of private care providers is not supervised by any public institution involved in care management and the quality of their services is not monitored. Privately paid (out-of-pocket) home care is provided mostly in the grey economy and in many cases by immigrants.

Residential care providers may be registered as associations, as business entities or not registered at all. In the absence of clear information about quality, there is anecdotal evidence that LTC users and their families may be relying on the type of registrations as

signals of the level of quality control. In the Pilot Qualitative Study carried out as part of this review in Katowice, residential homes registered as associations were fully occupied and had waiting lists, while those registered as business entities or un-registered had vacancies (Millward Brown, 2015).

## 7. Strategic directions and recommendations

### Structure of intervention

Actions in the policy area (policy)	Mechanisms	Time scope	Institutional responsibility/costs
Health and active aging	Health prevention from early years, physical activity, social activity, etc.	To be included in the currently implemented policies (as soon as possible)	Multisectoral activities/horizontal financing
Increased supply of LTC services at home with the use of modern technologies; promoting aging at the place of residence			The organizational and financial burden on the regional level; support in the policy directions on the central level, including by financial incentives and promoting innovation

	Creating incentives and an appropriate organization to strengthen coordination	Short-term action	On the governmental level/low costs of implementation
	Priority given to the LTC activities; identifying methods for reallocation of the existing resources in a more effective way to control costs.	LTC spending review – Short-term action.	Action on the central government and local government level.
	Diversification of LTC supply solutions by inclusion of private (for-profit) and non-profit service providers.	The system for inclusion of new providers should be proposed as a short and medium-term solution.	Implementation on the governmental level along with the strengthening of institutional capabilities on the regional level.
	Development of LTC human resources along with an appropriate incentive scheme.	Short- and medium-term action.	Implementation on the governmental and regional level.
	Creation of a sustainable system for long-term care financing.	Medium- and long-term actions.	Implementation on the governmental level.

Source: Own compilation of the World Bank.

The purpose of developing formal systems for the financing and delivery of LTC services is to improve the quality of lives of the senior citizens and promote independence, especially for those with functional disability; reduce the burden of care on families, and minimize the costs associated with long-term hospitalizations (Houde et al., 2007; Kang et al., 2012; Geraedts et al., 2011). This chapter focuses on the policy actions needed for the further development of LTC systems in Poland in keeping with the above objectives.



All of the recent national policy documents dealing with LTC consistently identify the following issues as critical for developing and strengthening LTC in Poland:

- increasing the importance of health prevention and healthy ageing;
- better coordination between different stakeholders towards developing an efficient, financially sustainable and good quality system;
- establishing sustainable financing mechanisms for LTC;
- greater attention paid to the development of new tools that take advantage of technology to develop LTC;
- providing more space for development of the NGO sector in LTC;
- insufficient number of workers providing LTC particularly in the health but also in the social sector.

These are also consistent with the key challenges identified in Chapter 6. Thus, the remainder of this chapter will set out a series of recommendations to address the critical issues listed above.

### **7.1 Promote active and healthy ageing through appropriate policies in all sectors and cross-sectoral collaboration**

Promoting healthy lifestyles as well as active and healthy ageing can help extend independent living into older ages, and thus compress future demand for LTC services. Integrated and holistic approaches based on the principle of active and health ageing are needed in all aspects of public policy in order to promote this goal. Three key strategies are identified.

- (1) Full implementation key public health and health care strategies are needed to promote active and healthy ageing: health promotion, prevention and rehabilitation services; strengthening the gerontology and geriatric care sub-specialties in medicine to ensure that the health and LTC workforce can address the needs of an increasingly older population.
- (2) Develop cross sectoral cooperation for health between different levels and sectors of the government administration, including economy, finance, education or sport sectors.
- (3) Progressively shifting away from institutional, particularly hospital-based solutions to LTC. Institutional care is an important component of LTC systems, but by nature it is a “high intensity” (capital intensive) solution. In many countries in the region, the delivery of long-term care can suffer from being conceptualized as medical care with relegation to institutional settings particularly given the legacy of hospital overcapacity (Norton, 2000; Smith and Nguyen, 2013). This trend should be avoided at all costs. To achieve cost effectiveness and financial sustainability, LTC

strategies need to provide a range of services to address different levels of needs. Care to meet differing levels of dependency can take many different forms (Box 10).

- (4) Place greater emphasis on community-based systems of LTC. In richer countries, long-term care is continuing to shift from residential settings to a range of dedicated community-based services. LTC provided in the community has fiscal and health benefits (Mandeville et al, 2015). There are fiscal and psychosocial benefits to people maintaining the autonomy and independence of receiving care in their own home, rather than relying on residential facilities for long-term care (Kaye et al., 2010). Residential care is expensive due to overheads and labor costs. Home services are often more financially efficient and more highly rated by recipients (World Bank, 2010). An important pathway to developing sustainable long-term care services is to invest in community-based services (Kaye et al., 2010).

#### Box 10: Types of long-term care

Personal care: Non-skilled care, including help with ADL such as bathing, dressing, eating, getting in and out of bed or chair, and using the bathroom.

Domestic care: Assistance with IADL (e.g. cooking, cleaning, managing finances).

Health/nursing care: Medical acts (e.g. administering medication, changing dressings).

Community-based services: Services in the community, such as adult day services, home delivered meals, or transportation services. Designed to help older people stay in their homes as independently as possible.

Day services: Services provided during the day at a community-based center. Programs address the individual needs of functionally or cognitively impaired adults by providing social and support services in a protective setting, but not residential care.

Assisted living facility: Residential living arrangement that provides individualized personal care and a protective environment. Care is not as intensive as care offered at a nursing home and is designed to allow people to remain relatively independent.

Residential care/Nursing home/Long term care facility: Facility where older people live that provides general nursing care to those who are chronically ill or unable to take care of daily living needs.

Source: Mandeville et al., 2015. Adapted from LongTermCare.gov (U.S. Department of Health and Human Services).

## 7.2 Establish the right institutional arrangements and incentives to enhance coordination

The international experience indicates that a high level of coordination between the health and social sectors is vital for ensuring the delivery of effective and good quality services for the elderly. It is also critical for ensuring financial sustainability. Without good coordination, the system results in unnecessary re-admissions and shifting of patients between sectors, which is expensive and undermines patient satisfaction.

In Poland, “horizontal” coordination between the health and social sectors is complicated by the high level of decentralization (Kazepov, 2010), which weakens the link between central, regional and local levels. At the central level, the ministries of labor and health are responsible for setting policy parameters, funding, and regulation. The regional government is responsible for creating the long-run strategy for regional development, including for social services. The responsible institution for this task is the Regional Center for Social Policy (ROPS). In practice, the activities of the ROPS tend to be limited to current social assistance problems, and so the tasks related to helping the poorest (Golinowska, Rysz-Kowalczyk, 2013). Gminas are responsible for delivering a variety of social services. Gminas prepare their own strategy (of social problems solving) and finance it with earmarked funds obtained from the central budget or central funds (NFZ, FUS, PFRON). Responding to local needs without their own funding is often a challenge<sup>19</sup>. Moreover, the capacity of Gminas is often limited, particularly with regards to appropriate delivery strategies to promote health ageing.

Four key strategies can be proposed to create the right incentives to promote horizontal and vertical coordination:

- (1) Coordination could be carried out by institutions at the regional level, while some tasks (e.g. system monitoring) could be delegated to national level institutions.
- (2) Capacity building at the regional level on planning and communication for LTC to ensure that LTC is fully integrated into regional strategic plans.
- (3) Capacity building at the local level, especially regarding various components of healthy ageing to improve the ability of Gminas to integrate older people socially through learning, cultural and physical activities.
- (4) A well-structured system of monitoring and evaluation is needed to provide policy makers with the necessary elements for evidence-based policymaking. An institutional assessment could help identify precisely what set of incentives and monitoring could support the coordination and effectiveness of LTC provision.

### **7.3 Establish a sustainable financing mechanism for LTC**

To protect against what can become impoverishing costs, comprehensive long-term care entitlements need to be expanded to all those who need it, including the better-off. Comprehensive long-term care entitlements include nursing, personal and domestic care. Health financing systems traditionally cover only health and nursing costs of long-term care with social care or welfare services providing additional services targeted to the most disadvantaged populations (typically the poor and disabled). Countries that provide comprehensive services to the entire population spend typically between 2 percent and 3.5 percent of GDP on long-term care (Mandeville et al, 2015).

Additional social insurance for LTC or separate long-term care insurance, as in Germany and Japan, has been proposed recently in Poland. In 2009, the Polish Senate

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<sup>19</sup> At the moment (June 2015) MPiPS offers additional funds for gminas for creating day centers care (“Senior Vigor” Program).

presented a proposal for a LTCI system, with contributions of between 1 and 1.5% of income. The new LTCI scheme would have covered all those currently insured by the health care insurance. A new fund would have been created, to be managed by the National Health Fund (Augustyn, 2010). This proposal was however criticized because it implied raising taxes and labor costs (Bednarski).

General tax revenues are by default the primary source of financing for all public LTC in Poland. As discussed in Chapter 6, with the projected increase in LTC expenditures, the current model of financing LTC is simply not sustainable.

Recent work by a parliamentary group<sup>20</sup> with the support from the country top experts resulted in the following, selected recommendations regarding the Polish financing system: (i) control costs and consolidate current LTC expenditures and financing sources; and (ii) rethink the existing cash benefits scheme for the 75+ group.

The following specific strategies are identified, consistent with the recommendations of the parliamentary group<sup>21</sup>:

- (1) A targeted universalist approach to LTC financing is the most appropriate given the dramatic increase in the demand for LTC, potential fiscal constraints in raising revenues and large disparities in access to care outlined in Chapter 3. This involves providing comprehensive LTC for the poorest individuals with high needs. As population ageing evolves further and economic conditions improve, the system can be expanded to accommodate those with lower needs and higher incomes. Eventually, the various mechanisms can be consolidated into one universal, comprehensive scheme.
- (2) Complementary financing mechanisms can be made available to some but not all income groups, as in France and Switzerland (Box 11). LTC could be delivered as a combination of services to targeted persons in need and free of charge, or with limited co-payments and cash benefits (care allowances). The allowance could be used to purchase care services on the market. The role of the state differs according to the emphasis that each of these components has in the chosen mix: to the extreme, if there is sole reliance on cash benefits, the role of the state would be limited to defining and controlling basic quality standards in the private sector of care services.
- (3) Options for reforming the universal cash allowance for 75+ group include:
  - (i) Imposing limitations on the benefit granting. For example, limit the benefit exclusively to dependent older pensioners 80+ (assumed to be more in need

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<sup>20</sup> The parliamentary group of experts operating under the Civic Platform umbrella senator's club from 2010 to 2014 has developed a bill concerning the dependency insurance law.

<sup>21</sup> The parliamentary group of experts operating under the Civic Platform umbrella senator's club from 2010 to 2014 has developed draft regulations that included, among others, the above-mentioned proposals.

of care) while increasing the value of the benefit to a level more adequate to the cost of care<sup>22</sup>;

- (ii) Target the benefit to the 75+ on the basis of certified levels of disability. This would make the benefit more relevant to needs, but would increase administrative costs.

Recognizing that these measures might be politically difficult, further analytical work based on administrative data is needed to quantify the costs and benefits of these two options.

#### Box 11: Examples of complementary financing mechanisms

Typically, health systems provide for nursing care, while social care systems or other financing mechanisms ensure access to additional long-term care services for the severely disabled with means-testing for the poor. Complementary financing mechanisms may also be available for some, but not all income groups, often with benefits decreasing with income.

Switzerland provides a means-tested cash allowance to cover the cost of personal care in addition to covering universal, in-kind nursing care through its mandatory health insurance. France's general councils fund a cash allowance, the Allocation personnalisée d'autonomie, for disabled people over the age of 60 with the benefit amount varying according to need and income.

Source: OECD. 2011. *Public Long-term Care Financing Arrangements in OECD Countries*, in: *Help Wanted? Providing and Paying for Long-Term Care*. Paris: Organization for Economic Coordination and Development, p.p.213–245.

## 7.4 Developing a skilled workforce for LTC and getting incentives right

After retirement, providing care to family members is currently the second most cited reason why those who are out of work (OOW) report not to be working (Morgandi and Gatti, 2015). In particular, there is substantial scope to improve the participation of those 50+ women who currently are not active on the labor market. A number of these face a multiplicity of barriers to participation: employability constraints, since a large share only has lower education; and participation constraints, since many of them are sandwiched between providing care to aging parents and to their grandchildren. Changing the way care is delivered now – essentially privately – towards more organized and efficient care provision could provide a source of labor demand for older women, while slacking their home care constraints. Moreover, the silver economy can also be an important avenue for employment for the young as well. There surely exist challenges to developing the workforce in this sector, including retention and

<sup>22</sup> To the extent that relatively more wealthy elder survive to older age, this targeting strategy would be skew resources away from the most disadvantaged.

appropriate qualifications, compounded by the fact that Poland is both a receiving and a sending country for migrant workers.

However, the experience of other countries (such as the United Kingdom, Germany or Spain) indicates that adequate immigration frameworks and policies can help incentivize and retain migrant workers to work in the care sector, for instance through specific programs that facilitate and encourage the immigration of LTC workers or ex-post legalization measures (Box 12).

**Box 12: Immigration policies and workers retention in LTC**

Foreign-born workers offer a potentially relevant pool for the LTC sector, and are likely to play a critical role in the near future. Indeed, foreign-born workers accounted for over half of the 6% increase in institutional care employment in the European Union between 2008 and 2009. Based on the OECD guidelines for labor immigration, the main steps, also applicable to the LTC sector, in setting up an adequate policy framework would include: (1) identify unmet labor needs, (2) provide work permits according to such needs, (3) develop means for matching workers to jobs, (4) establish efficient permit processing and delivery procedures, (5) develop means for employers to verify the status of potential employees, and (6) set up effective border control and workplace enforcement procedures.

Countries with policies to encourage greater immigration such as Canada and Israel are targeting LTC workers through specific programs. The Canadian Live-In Caregiver Program (LCP) allows immigrants to obtain permanent residence after two years of full-time work as “live-in caregivers”. The program is employer driven, and applicants must have a sufficiently high level of education, equivalent to Canadian secondary education, six months training course or experience, and adequate language proficiency. In 2008, approximately 13 000 foreign nationals entered the country on such work permits. In Israel, long-term care is the main route through which foreign workers enter the country, and since 1988 an LTC benefit exists for elderly people to employ migrant care workers, who can stay in Israel for a maximum of 63 months.

In other OECD countries immigration policies applicable to LTC workers exist. In Italy, LTC workforce immigration has been supported through ex-post legalizations. In the United Kingdom, LTC caregiving is an occupation with recognized shortages, and thus entry has been facilitated to foreign caregivers. Migrants with the required skills to work in the LTC sector can enter Australia through General Skilled Migration (GSM) and employer nominated visa programs. In Japan, bilateral agreements with Indonesia, Vietnam and the Philippines allow a limited number of care workers to immigrate into the country although language and formal requirements has reduced the inflow. Qualified LTC workers can stay in Japan indefinitely.

In addition, some countries have developed policies to reduce irregular labor in the LTC

sector. Germany, for instance, issued special working permits for workers from countries that entered the European Union in or after 2004, and a tax benefit that can save up to 20% of the costs of legally hired care. France developed tax deductions and lighter administrative regimes for those hiring LTC workers formally. In 2007, Austria developed a framework to regularize previously illegal care workers and pardoned those who hired undeclared migrant caregivers if they registered them properly. Such measures are often accompanied by awareness raising campaigns (Switzerland).

Source: OECD, 2011. *Help Wanted? Providing and Paying for Long-Term Care*.

A number of initiatives to build skills in the LTC have been implemented in the last decade.<sup>23</sup> However, further efforts are required to respond to the increasing needs in LTC. Potential specific strategies include the following:

- Increase the volume of training of nurses and social workers<sup>24</sup>. Nurses are now trained on the third level of education based on the EU funds. Training nurses and caregivers on the second occupational level as well will be required moving forward.
- Adequate and similar wages arrangements for care personnel across sectors and places. Valuing the LTC workforce, and raising job quality, will be important to improve retention rates, through for instance improving wages and working conditions. Positive experiences in this regard exist in Germany, the Netherlands, Sweden and Norway (OECD, 2011) (Box 13).
- Legalization of employment of foreign caregivers, by revisiting the regulation on casual work (Box 14).

#### Box 13: Improving retention of LTC workers

Despite care work being demanding and burdensome, not only wages in LTC are generally low across OECD countries, but also experience of care workers may not be adequately remunerated. Poor working conditions can lead to recruitment problems, high turnover, workers leaving the sector and workers limiting the number of years spent working in the sector. The estimated turnover costs for the US public programs Medicaid and Medicare are USD 2.5 billion.

Many OECD countries have developed and implemented measures to improve recruitment and retention in the sector. Some have workforce planning initiatives, such as Canada, Germany, the Netherlands, New Zealand, the United Kingdom and the United States. Most countries report measures to stimulate entry into LTC through

<sup>23</sup> 2003 – a new, specialized nursing qualification was defined; a qualification in LTC nursing required by NFZ regulation – “the card of nursing activities for an LTC nurse”, 2007 – a new profession of medical worker was introduced after a special vocational school or post-secondary school.

<sup>24</sup> Last decisions on reducing subsidy for educational places for social workers are threat for sufficient development of qualified care personnel as well.



traineeships (United Kingdom), additional job creation (Austria and Norway), additional public funding for training (Australia, Belgium), the development of a standardized training course (New Zealand) or new curricula (United States). Ireland and England aim to recruit more LTC workers by offering the option of entering without qualifications under the requirement that relevant qualifications will be gained during employment. New Zealand has developed public-private partnerships, where employers provide mentoring, on-the-job training and help job seekers to obtain a certificate.

Some countries offer financial incentives to re-recruit workers (Australia), while other countries specifically aim efforts at specific target groups, such as young people, those re-entering the labor market and under-represented groups or alternative labor pools (Germany, the Netherlands, United Kingdom, United States). Japan has implemented various policies to attract and retain LTC workers. For instance a fund was set up to assist providers in offering higher salaries, while subsidies are offered to attract young people in the LTC sector.

Increasing wage levels can reduce turnover, although measures aimed at such objective should be combined with a better recognition of experience to wage levels, and entitlement to benefits. German and Swedish data indicate high job appreciation and low tendency to leave, where work-related benefits are provided. In the Dutch system, benefit packages for LTC workers, such as annual wage increases reflecting work experience, extra compensation for irregular hours and – limited – compensation for travel costs for home-care workers are associated with high loyalty to the sector.

Other countries report measures related to continued education and training, for instance, for enrolled nurses to up-grade to registered nurses (Australia), or the requirement for all LTC workers to acquire specific targeted skills, such as gerontological skills (Finland). Germany has recently increased public funding for the third and last year of training of older workers who want to change career into LTC, where it previously only paid for the first two. Germany and the Netherlands recognize previously gained competences, enabling those with relevant knowledge, skills and experiences, to skip parts of the vocational education. Educational innovation and career building opportunities can also enhance recruitment and retention.

Additionally, worker-centered policies increase the likelihood that workers feel valued in their work. For instance, appropriate human-resource management strategies reduce work-related stress among LTC workers and improve the wellbeing of LTC recipients. Worker recognition, especially merit recognition (including membership of a professional organization or a trade union), has also proved to be advantageous.

Source: OECD, 2011. *Help Wanted? Providing and Paying for Long-Term Care*.



## 7.5 Take advantage of technology to promote “aging in place”

In OECD countries, LTC systems are increasingly taking advantage of technology to allow those in need of care to remain at home or in the community for longer, i.e. “aging in place”. Box 14 summarizes some of these strategies, which could also be adopted in Poland.

### Box 14: Technologies can assist for “aging in place”

For communication and engagement, e-mail, chat, games, video, cell phones, smart phones, and various kinds of portable and desktop computers can change how teams of caregivers can co-ordinate within themselves, with the elderly, and with the families of the patient.

For safety and security, webcams, fall detection devices, home monitors, and other kinds of safety and security devices would help care become more targeted and timely.

In the area of health-related technologies, tele-health applications, medication management technologies, disease management technologies, and fitness technologies can help improve quality of health.

In terms of learning and contribution, technologies for enabling education, volunteering, and work can keep the elderly active--even those with dementia or in nursing homes.

Source: IOM (Institute of Medicine) and NRC (National Research Council). (2014). Financing long-term services and supports for individuals with disabilities and older adults: Workshop summary. Washington, DC: The National Academies Press.

## 7.6 Strengthen community and NGOs role in LTC

The weak coordination between the health and social sectors, or within those sectors, is one of the central issues that will need to be addressed for LTC systems to improve their effectiveness. The provision of LTC services, but also the coordination of those services could be done at the community level with the support of all important stakeholders.

The participation of older people throughout all stages of planning and delivery will be central for social inclusion, ensuring that they contribute their expertise and knowledge and that their needs will be addressed. Local governments can play a role in developing the skills and confidence required for active engagement at the community level<sup>25</sup>.

For older people, making sure that they actively participate in the society could bring benefits not only for their living conditions or health but also for the overall society. A combination of actions including meaningful involvement, aging in place, respect and inclusion, communication and information, transportation and mobility, and health and

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<sup>25</sup>Jane Lewis, *Older People and the Health–Social Care Boundary in the UK: Half a Century of Hidden Policy Conflict*, Social Policy Administration, 2002.

well-being could bring about a new paradigm for community aging that places older adults as a core social resource<sup>26</sup>.

Indeed, in developing social inclusion policies some countries such as Ireland and the UK explicitly address issues and concerns specific to older persons, including access to health services, transport, financial protection, and resources that promote psycho-social wellbeing<sup>27</sup>.

Community development along with the strong involvement of Non Governmental Organizations can also play an important role in the development of LTC: (1) NGOs can provide institutional care (currently most of the hospices in Poland are run by NGOs), (2) they support the provision of all other forms of care (home care, community care), (3) they can be part of the institutional framework of coordination of LTC, and (4) they could offer opportunities for the elderly to become volunteers.

Volunteerism “is also reflected in a paradigm shift in the work with older people that comprises the following objectives: (i) the stronger integration of older people into society; (ii) increasing the participation of seniors; (iii) increasing the solidarity between and within the generations; (iv) putting the potential of older people to good use; and (v) taking into account the differences in the self-help and productivity potentials of the elderly”<sup>28</sup>.

Several actions could be adopted in order to increase both older people’s and NGOs involvement in LTC provision and community building:

- Strong development of the NGOs dealing with LTC.
- Strengthening the capacities of the NGOs (including HR and volunteers).
- Creation of a space, possibly an institutional arrangement, in the community for the further development of social inclusion measures, but also developing inclusive processes at the community level that would strengthen the LTC local system development and favor the participation of older people in service planning and delivery.

In addition to long-term care that is based on communities and non-profit organizations, there is also the issue of an unregulated market of private care providers. As stated in Chapter 6, we still face the challenge of providing an adequate number of services while having limited funding and institutional capabilities at our disposal. In order to solve this problem, we should consider the potential of private service providers. For example, if there are good private LTC entities whose market prices are high, public contracting of their services at lower (negotiated) rates could be a solution. Indeed, there are similar mechanisms existing in the health sector, where the price is a key element

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<sup>26</sup> [Black K, Dobbs D, Young TL](#). Aging in community: mobilizing a new paradigm of older adults as a core social resource.

<sup>27</sup> <http://www.ifa-fiv.org/wp-content/uploads/2012/11/SOM-Country-Report-Final.pdf>

<sup>28</sup> <http://www.eyv2011.eu/images/stories/279845-en.pdf>.

for contracting a given provider with the use of public money. Another possibility would be vouchers for people who need long-term care, which could be used in various (including private) establishments. In order to develop similar mechanisms, we should develop the supply system of LTC services that would involve private (for-profit and non-profit) service providers.

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