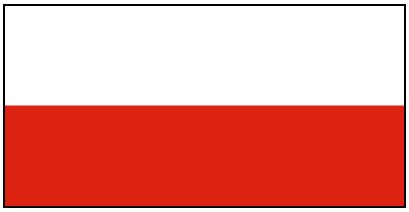
Gesellschaft für
Versicherungswissenschaft
und -gestaltung e.V.

Study on the Social Protection Systems in the 13 Applicant Countries

Poland
Country Study



January 2003

Study financed by the European Commission – Employment and Social Affairs DG

Authors:

Prof. Dr. Stanislawa Golinowksa, Jagiellonian University Crakow/IpiSS Warsaw and associated to CASE, Warsaw
Katarzyna Pietka, CASE, Warsaw
Christoph Sowada, Jagiellonian University Crakow
Prof. Dr. Maciej Zukowski, University of Economics Poznan

Social Protection in Poland

1. INTRODUCTION: ECONOMIC, FINANCIAL, SOCIAL AND DEMOGRAPHIC BACKGROUND

1.1 Main influencing factors for social protection

1.1.1 Economic and financial factors

After the first years of transition Poland entered the phase of high economic growth. In 1995-1997 Polish GDP registered high growth rates (6-7%, see Table 1.1 in the Annex). The Russian crisis in 1998 and a general economic slowdown in the world economy following the Asian economic crisis contributed to a GDP slowdown in the years 1998-2000 (4-5%). Delays in implementing further structural reforms accompanied by unfavourable external environment hampered a quick recovery. 2001 turned out to be a year of stagnation at the level of 1.0 % growth.

Inflation rate. Although Poland managed to stabilise hyperinflation in the beginning of the 90ies, the further pace of disinflation turned out to be quite slow. In 1995 the CPI grew by almost 28%. The main factors behind this inflation included several monopolies, persistent inflationary expectations, an automatic price indexation of many social transfers and a crawling peg of the currency. The introduction of free floating of the currency PLN (zloty), low oil world prices as well as weakening of domestic demand allowed for pushing inflation down to 5.5% in 2001 and even 1.9 % in 2002.

Economic outlook. The assumptions of future developments and macroeconomic forecast are based on the last quarterly publication "Polish Economic Outlook" (November 2002 issue) prepared by the macroeconomic group at CASE.

After stagnation of economic growth in Poland at the level of 1.0 % in 2001 and 1.2 % in 2002 (estimates) only the moderate acceleration of GDP dynamics is expected in 2003 (up to 2.3 %). Data for the previous quarters indicate a low sensitivity of household consumption to the economic slowdown and rising unemployment. It takes place at the expense of savings. We believe that further deterioration of the savings rate is very unlikely (most of households do not have any savings and their access and demand for credits is limited). Therefore, despite increasing trend in real incomes, household consumption will grow slightly slower. The investment will start to rebuild around mid-year. However, the annual dynamics will be

moderate. We see some limitations on the micro-level. Low profitability of enterprises during last two years will not support rebound of investments since more than half of investments are financed from the own resources of companies. On the other hand, credit rates did not follow the central bank interest rates cuts throughout last two years. Commercial banks have registered increase in the bad loans ratio (21% by mid-2002) and are very reluctant in lending to companies.

With regard to external influencing factors economic activity in the EU is assumed to improve in 2003 though outlook for Germany (main trade partner) is not impressive. Growing economies in the Central and Eastern Europe should offset partly this tendency and Polish exports will continue growing.

The outlook for 2004 is slightly better (GDP growth at 3.2 %). Improvement in the investment climate (further interest cuts, stable household demand and exports growth) should contribute to growth in investment. Also, acceleration of growth will stop job reductions and improve dynamics of the wage bill. Household consumption will regain.

On the front of key structural reforms, public finance reform, breaking remaining monopolies, effective policies strengthening small and medium enterprises, reduction of labour costs are considered to be unlikely. Low labour mobility as well as high inflows of graduates will not allow reducing the unemployment rate. EU accession of Poland in 2004 may only worsen the situation in the short-time.

Public social expenditures. The consolidated public social expenditures (according to the IMF approach - IMF 1996) reveal their absolute and relative growth during the first half of 90ies (by several percentage points). After that their level has stabilised at around 30% of GDP.

Social insurance expenditures compose the biggest share in GDP; around 14%. Though their total share has kept decreasing (from 16% of GDP in 1996) they became a serious burden to the state budget. High transition cost of the old-age pension reform forced for rising the budget subsidy to the social insurance fund (FUS): from 3,6% to 5,7 % of GDP during 2000 - 2001. The requirement of higher subsidy will last for a long period of time (until most of the pensioners will be covered by the new system).

A growing tendency took place in case of the expenditures for education, which are characterized by a stable increase from 5.2% in 1995 to 6.3% of GDP in 2001. Nevertheless, in international comparison, they represent a very low level per student. The share of health care expenses in GDP at the level of just above 4% was slightly reduced during the second half of 90ies.

1.1.2 Demographic indicators

Size and structure of population. Poland ranks 8-th in the Europe population ranking, i.e. is a relatively big country. In the 1990-ties the demographic development in Poland experienced dramatic changes. Until the mid 80-ties Poland belonged to a group of countries characterised by high dynamics of population growth reaching 0,9 % per year, whereas in the 90-ties annual population growth reached nearly 0,2 %

Age Structure. The population of Poland is young if we compare it with other European nations. Median age stands at 37 years for females and 33,2 years for males. However, in the 90-ties we may observe already the process of ageing of the Polish population. The children group (less than age 15) declined during the last decade by more than 2 millions due to a dramatic decrease in the number of births. In the same time the number of persons at the post-working (retirement) age increased by 5 millions.

Fertility and reproduction rates. Total fertility rate stood at 1.366 – which was never observed earlier. The new generation of females not only give birth to less children, but also are older at the first birth, i.e. aged 25-29, while this was earlier in the age between 20-24.

Households and family structure. In the last quarter of the century the number of single-person households has been increasing, though at a slower rate than in the Western European countries. In the period between the population general censuses (1978 and 1988) the share of single-person households in the total number of households rose only slowly (by approximately one percentage point; from 17.4% to 19.7%). After that, the growth of these households was faster in the country, as a result of the more advanced ageing process of the rural population that is influenced by migratory movements of primarily young people from the country to the cities.

The number of single-parent families in Poland has been also growing steadily. In the 1980s the number of such families rose three times faster than the total number of families. In 1988 they represented 11% of all households and 20.1% of all families with children, whereas single-mother households accounted for about 10% (17.7% of families with children).

According to the population census data, the number of children in single-parent families represented 12% of all children brought up in families in 1988 and almost 13% in 1995.

Marriages and divorces. At the beginning of 1980-ties there were nearly nine new marriages per each 1000 thousands inhabitants, in the 1990-ties in average about six. It indicates, that the number of legally constituted marriages is decreasing.

Almost 4-5 per each 1000 existing marriages is dissolved by court. Such a tendency could be observed already for a long time. Divorce rate in Poland stands at 1,1% and is one of the lowest rates in Europe.

Life expectancy. From the beginning of the 1990-ties (exactly from 1992) life expectancy of males and females has been steadily increasing. The figures of life expectancy in 1999 against 1990 were extended by 2.3 years for males and 2.0 years for females. These positive changes testify to a certain stability.. Still, life expectancy in Poland remains to be 5-8 years shorter than in the western European countries.

Migration. The tendency in internal migration is significant declining. In the 1980-ties the balance of internal migration for permanent residence stood at about +130 thousands, and the figure for 1990-ties was at +60 thousands; two times less. A distinctive feature of several past years is a slight decrease in the number of urban population moving to big cities and an increase in the number of inhabitants of their neighbouring small towns-suburbs. The balance of migration between urban and rural areas continues to decrease also. In the years 1999 - 2001, it was the lowest in the entire post-war period.

Available GUS migrations surveys point to a decline in the number of international migrations for permanent residence in the last decade. It is a new tendency in Poland, which constituted an emigration country for about two centuries.

Demographic forecasts. The Central Statistical Office prepared demographic forecasts until 2030. The future developments are the following:

The number of total population will continue its slow declining trend until 2005 (down to 38 634 from 38 649 thousand in 2000) as a result of a smaller population growth (the number of children 0-17 diminishes). Within the next 10 years the population will grow slowly to just over 39 million in 2015. In the next 15 years the total number is expected to shrink by 1 million (38 million in 2030).

The polish society is relatively young as persons at age 0-44 equal 64% of the population. The share of young people will keep falling down to 50% in 2030. Ageing of the population will worsen the ratio between older non-working population (60/65+) and working population (18-59/64) from stable 23-25 until 2010 up to 41 in 2030. Such a burden was a main argument to support the pension reform. At the same time, the ratio of the total non-working population (0-17 and 60/65+) to 100 persons of working population will be diminishing from 63 in 2000 to 55 in 2010 due to a decrease in births. However, the increasing number of the elderly and children until the year 2020 together will push the ratio up again; it will continue to grow in

2020-2030 despite lowering number of children as it will reflect substantial ageing of the population.

Migration tendencies between city and rural area will be very stable. The share of the rural area population in total population (38.2%) is not expected to be changed until 2005. After that, the relative number of rural areas population will be slowly diminishing - to 35.9% in 2030.

1.1.3 Social indicators

Employment and Unemployment. The processes of transition left a very clear imprint on the labour market in Poland. In the early years unemployment increased (nearly 3 million people - 16% in 1993) and the employment numbers declined. This initial phase was followed by a period of increasing employment in the private sector, while unemployment declined to about 10% by the end of 1998. Since then unemployment has been climbing again and it has reached 17.8 % (November 2002). We can therefore speak of a second wave of unemployment growth. The strong element of the employment reduction was restructuring of the state owned enterprises. This together with privatisation led to substantial shift in the employment structure - private sector accounts for over 73 % of total number of working people (including self-employed, on average in 2001) from 61 % in 1995.

Among the unemployed population there are more young than elderly persons, women than men and unskilled than skilled workers. The scale of unemployment among people up to the age of 24, just starting their working life, is highly disquieting. The baby boom from the 1970-1980-ties will be responsible for a 1.2- million-person inflow of the new labour force by 2006.

Varying unemployment rates by gender is typical for countries in Europe. Currently about 54 % of the unemployed are women against 46% for men. But during the years of declining unemployment the share of women among those without jobs was higher, growing to 60%. This can suggest that even in the situation of economic growth, the employment of women encountered greater resistance (Boni 2002).

One of the more significant characteristics of the Polish labour market is the geographic differentiation of unemployment. This has been evident from the very beginning of the 1990-ties, and even economic development made little to weaken such disparities. The situation in large metropolitan areas, particularly in Warsaw, is much better than in rural regions and the small towns of northern and eastern Poland. In these Polish regions the unemployment rate is 2.5 times higher.

Labour market development forecasts. Short-term labour market forecast is based on the CASE outlook for Poland.

The CASE forecast of the labour market is based on the outlook for Poland, assumptions on structural developments as well as the GUS demographic forecast. Total average employment will continue to fall during 2003 as a result of the demographic wave of new graduates as well as mentioned before structural problems and low mobility of the labour force. Diminishing tendencies among the employed will be offset partly by slow recovery of the number self-employed and employees from small enterprises (up to 9 employees). Higher growth in 2004 should bring minor improvement of the labour market - increase in the working population by around 80 thousand and fall in unemployment from 18.2 % by the end of 2003 to 17.3 % by the end of 2004.

Poverty. There is a relatively rich scope of poverty studies in Poland which lead to the use of a number of poverty definitions, which are estimated by the Central Statistical Office and Institute of Labour and Social Studies.

Comparison 1: Poverty lines applied in Poland

Categories of poverty lines	Lines applied	Institutions and authors using given poverty measurement
Absolute poverty	Subsistence minimum (basket of goods defined by experts)	IPiSS, GUS
Relative poverty	50% of the average household expenditures per consumption unit (OECD equivalence scale)	GUS
Subjective poverty	Leyden Poverty Line	GUS (Podgórski)
Income threshold in the social assistance	406 PLN per consumption unit (OECD equivalence scale) in the family (2001)	Ministry of Labour and Social Policy (MPiPS); social assistance centres
Threatened with poverty	Social minimum; bundle of commodities essential for participation in social life (assuring integration)	IPiSS, GUS, trade unions

In the 1990s we can observe two periods with a significant increase of poverty. The first period, in which the poverty suddenly rise, was the time of the collapse of the communistic block and the beginning of the transition from the planning to the market system. Only in two years: 1990 – 1991 GDP fell by approximately 18 %[*]. The second period is the end of 1990s. Since 1998 the economic growth in Poland is smaller and unemployment rate is systematically higher.

[*] Estimation concerning the drop in GDP differ, even in the yearbook of GUS in subsequent year; generally, the later the yearbook, the smaller the decrease. The figure of 18% in 1990=1991 is the most widely used.

Highlight vulnerable groups. Statistical evidence helps us to answer who are the poor. Using socio-economic criteria to classify household groups in the sample of household-budgets surveys we can state that families living from non-wage sources are the most vulnerable household group. Non-wage sources means unemployment and social assistance benefits.

People who live in villages and have some links to agriculture (belonging to farmers and mixed worker- farmers households) are also poor more frequently than the average. Almost 40% of peasant with a small farming area(up to 10 ha) are poor (GUS 2000). It is important to mention that diversity of income among farmers is in Poland very big, bigger than among employees (Deniszczuk 1998)

Studies on poverty in Poland carried out in the 1990s showed fundamental changes in the income redistribution policy between generations. These changes turned out to be advantageous for older generations and much less advantageous for younger generations and children. The synthesis of results using various poverty lines and definitions (absolute, relative, and subjective) confirmed that households with the highest poverty risk are large families (Golinowska 1996). With each line applied, the poverty rate for families with three or more children is the highest, much higher than for average families, single-parent families, or pensioners. Poverty rates for families with four or more children are dramatic. In addition to their worse income situation, the health of 20% of persons in these families is endangered, and as much as 85% are below the social minimum.

1.2 Annex to chapter 1

Table 1.1: Economic growth

	1995	1996	1997	1998	1999	2000	2001
GDP in Euro (million)	-	-	-	-	145 521	170 762	196 695
GDP in DM (million)	182 126	216 421	249 683	278 339	284 613	333 981	384 702
GDP in PLN (million)	308 304	387 827	472 350	553 560	615 115	684 926	721 575
Exchange rate PLN/ Euro	-	-	-	-	4.2270	4.0110	3.6685
Exchange rate PLN/DM	1.6928	1.7920	1.8918	1.9888	2.1612	2.0508	1.8757
GDP - growth, %	7.0	6.0	6.8	4.8	4.1	4.0	1.0
GDP per head in PPS							
CPI, average % change	27.8	19.9	14.9	11.8	7.3	10.1	5.5

Notes: GDP in Euro was calculated on the base of the nominal GDP in PLN terms and the average central bank PLN/Euro exchange rate. In order to start the period of the analyses in 1995, PLN/DM exchange rate was used. GDP in DM terms more than doubled in 6 year-period from the level of DM 182 billion to DM 385 billion (or Euro 197 billion) in 2001. The PLN depreciation towards DM/Euro contributed only marginally to the increase in GDP value in DM terms - depreciation reached 10.8% between 1995-2001.

Source: GUS (1998, 2000, 2001) Statistical Yearbook of the Central Statistical Office, statistics on exchange rate of National Bank of Poland

Table 1.2: Macro indicators forecast 2002-2003

	2001	2002	2003	2004
GDP (change in %)	1.0	1.3	2.3	3.2
Domestic demand	-1.9	0.9	2.4	4.3
Individual consumption	2.1	3.2	2.6	3.5
Investment	-9.8	-6.6	3.0	9.7
Unemployment rate (%)	17.5	18.3	18.2	17.3
CPI (average, %)	5.5	2.0	1.8	2.1
Trade balance (USD billion)	-11.7	-10.2	-11.9	-13.6
Current account balance (USD billion)	-7.2	-6.8	-7.8	-9.0
Current account balance (% GDP)	-4.1	-3.7	-4.0	-4.5
Central budget balance (PLN billion)	-32.4	-43.4	-43.3	-51.3
Public sector balance (% GDP)	-5.2	-7.5	-7.6	-
Exchange rate (average)				
PLN/USD	4.09	4.09	4.03	4.15
PLN/Euro	3.67	3.86	4.00	4.17
Broad money supply M3 (change in %)	9.2	-1.1	4.6	4.1
Interest rate of NBP (28-day reference rate)	11.50	6.50	5.50	4.25
WIBOR 3M	12.30	7.30	6.51	4.86

Source: 2000-2001 - GUS, NBP; 2002-2004 - CASE (Polish Economic Outlook 3/2002 (15))

Table 1.3: Consolidated public social expenditures

Specification	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Consolidated public social expenditures, PLN million	93 700	120 176	145 332	163 025	181 085	197 781	221 279
- social insurance and other social protection benefits	63 811	80 057	97 487	108 505	119 105	128 150	144 939
- education	15 912	21 317	26 711	30 946	35 298	40 527	45 212
- heath care	13 977	18 802	21 134	23 574	26 682	29 104	31 128
Consolidated public social expenditures, % GDP	30.4	31.0	30.8	29.5	29.4	28.9	30.7
- social insurance and other social protection benefits as % GDP	20.7	20.6	20.6	19.6	19.4	18.7	20.1
- education as % GDP	5.2	5.5	5.7	5.6	5.7	5.9	6.3
- health care as % GDP	4.5	4.8	4.5	4.3	4.3	4.2	4.3

Notes: Consolidation is done according to IMF approach (IMF 1996)

Source: GUS (1998, 2000, 2001) Statistical Yearbook of the Central Statistical Office

Table 1.4: Social expenditure in cash as a % in GDP

Specification	**1992**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Old-age, invalidity and family pensions (ZUS + KRUS)	15.0	16.0	16.0	14.5	14.0	14.1	13.5	14.4
Family benefits*	2.5	1.2	1.2	1.1	1.1	1.2	1.3	1.3
Unemployment benefits	1.7	1.7	1.7	1.1	0.6	0.6	0.8	1.0
Social assistance benefits	0.3	0.4	0.5	0.4	0.4	0.4	0.4	0.4
Scholarships	0.01	0.01	0.01	0.01	0.02	0.02	0.02	n.a.
Total cash expenditures	20.0	19.9	19.7	19.2	18.4	17.7	17.1	18.2

*Family benefits cover also nursing allowances, from March 1995 financing direct from the budget

Source: Golinowska S., Hagemejer K. 1999, Golinowska 2002, own compilation based on MPiPS 2002

Table 1.5: Size of population: total and by gender (as of December 31) - in thousands

Population	**1990**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Total	38 183	38 609	38 639	38 660	38 667	38 654	38 644	38 632
Male	18 606	18 786	18 797	18 801	18 798	18 784	18 773	18 761
Female	19 577	19 823	19 842	19 859	19 869	19 870	19 871	19 871
Natural increase	157,4	47,0	42,7	32,5	20,3	0,6	10,0	5,0

Source: GUS and Eurostat

Table 1.6: Fertility and reproduction rates

Items	**1990**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Birth rate per 1000 inhabitants	14,4	11,2	11,1	10,7	10,2	9,9	9,8	9,5
Total fertility rate	2,039	1,611	1,580	1,508	1,431	1,366	1,337	
Net reproduction rate	0,967	0,765	0,748	0,720	0,682	0,654	0,640	
Average age of women at birth of first child	23,5	23,5	23,6	23,7	23,8	24,0	24,2	

Source: GUS and Eurostat

Table 1.7: Private households and families; size and structure

Specification	1970	1978	1988	1995
Households - in thousands	9 376 (100,0%)	10 948 (100,0%)	11 970 (100,0%)	12 508 (100,0%)
One person households	(16,2%)	(17,4%)	2 188 (18,3%)	2 468 (19,7%)
Non-family households	17,5%	18,2%	2 379 (19,9%)	2 664 (21,3%)
Families total - in thousands	100,0%	100,0%	100,0%	10 533
Marriages without children	20,5%	22,3%	22,8%	2 482 23,6%
Marriages with children	66,8%	64,3%	61,8%	6 278 (59,6%)
Mothers with children	11,3%	11,9%	13,6%	1 580 (15,0%)
Fathers with children	1,4%	1,5%	1,8%	192 (1,8%)
Average size of the households	3,39	3,11	3,10	3,06

Source: GUS after the population census

Table 1.8: Marriages and divorces

Specification	1990	1995	1996	1997	1998	1999	2000	2001
Marriages - in thousands	255,4	207,1	203,6	204,9	209,4	219,4	211,2	195,1
Marriages per 1000 of population	6,7	5,4	5,3	5,3	5,4	5,7	5,5	5,0
Divorces – in thousands	42,5	38,1	39,4	42,6	45,2	42,0	42,8	45,3
Divorces per 1000 of population	1,1	1,0	1,0	1,1	1,2	1,1	1,1	1,2

Source: GUS

Table 1.9: Life expectancy - in years

Life expectancy	**1990**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
at birth								
-males	66,5	67,6	68,1	68,5	68,9	68,8	69,7	70,2
-females	75,5	76,4	76,6	77,0	77,3	77,5	78,0	78,4
at age 60								
-males	15,33	15,84	15,93	16,13	16,38	16,29	16,72	
-females	19,96	20,52	20,52	20,80	21,04	21,13	21,51	

Source: GUS and Eurostat

Table 1.10: Internal migration - in thousands

Specification	**1990**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Inflow / Outflow	529,9	419,7	427,3	417,0	425,9	432,4	394,1	369,3

Source: GUS

Table 1.11: Foreign migration - in thousands

Specification	**1990**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Emigration for permanent residence	18,4	26,3	21,3	20,2	22,2	21,5	27,0	23,4
Immigration	2,6	8,1	8,2	8,4	8,9	7,5	7,3	6,6
Net	-15,8	-18,2	-13,1	-11,8	-13,3	-14,0	-19,7	-16,7
Job emigration – temporary	107,0	183,4	211,3	220,7	218,6	240,4	330,0	
Job immigration								

Source: GUS, LFS

Table 1.12: Size and structure of population according to GUS forecast

Specification	2000	2001	2002	2003	2004	2005	2010	2015	2020	2025	2030
Population in thousands	38648.8	38 642.9	38 639.8	38 639.0	38 638.0	38 634.5	38 788.0	39 005.4	39 003.0	38 656.5	38 024.8
men	18 776.9	18 768.0	18 760.5	18 754.6	18 748.9	18 742.9	18 813.0	18 931.3	18 942.4	18 771.6	18 445.4
women	19 871.9	19 874.9	19 879.2	19 884.5	19 889.1	19 891.5	19 975.0	20 074.1	20 060.6	19 884.9	19 579.4
0-17	9 304.4	8 985.2	8 687.2	8 414.6	8 185.2	7 985.2	7 440.3	7 515.8	7 713.8	7 530.5	6 897.5
18-59/64	23 664.8	23 933.0	24 198.0	24 445.8	24 647.0	24 819.4	25 076.5	24 276.9	23 074.6	22 270.6	22 015.2
18-44	15 539.1	15 557.4	15 559.6	15 550.8	15 540.1	15 527.0	15 589.7	15 315.4	14 341.7	13 119.9	12 030.0
45-59/64	8 125.6	8 375.6	8 638.4	8 895.0	9 106.9	9 292.4	9 486.8	8 961.5	8 732.9	9 150.7	9 985.2
60/65 and more	5 679.6	5 724.8	5 754.6	5 778.6	5 805.8	5 829.8	6 271.2	7 212.6	8 214.6	8 855.4	9 112.1
0-44 population as % of total population	64	64	63	62	61	61	59	59	57	53	50
non-working age population per 100 persons of working age population	63	61	60	58	57	56	55	61	69	74	73
60/65 and more population per 100 persons of working age population	24	24	24	24	24	23	25	30	36	40	41
urban areas	23 897.3	23 893.6	23 894.9	23 900.9	23 909.7	23 920.1	24 178.7	24 508.3	24 702.0	24 654.5	24 387.8
rural areas	14 751.5	14 749.3	14 744.8	14 738.2	14 728.3	14 714.4	14 609.3	14 497.0	14 301.1	14 002.0	13 637.0
% of population	38.2	38.2	38.2	38.1	38.1	38.1	37.7	37.2	36.7	36.2	35.9

Source: GUS (2000) Demographic forecasts

Table 1.13: Labour force participation (IV quarter of the year)

Specification	1993	1994	1995	1996	1997	1998	1999	2000	2001
Employment rate	52.1	51.0	50.7	51.2	51.5	51.0	48.0	47.4	46.0
Male	60.1	58.8	58.5	59.4	59.8	58.9	55.9	55.2	52.5
Female	44.8	44.0	43.7	43.8	44.0	43.9	40.7	40.3	39.0
At age 55-59/64	39.1	37.5	36.7	36.3	36.6	36.1	31.7	31.9	32.2
At age 60-64			24.0	23.8	23.4	22.6	19.3	19.1	18.1
male			31.5	31.4	31.1	29.7	26.3	25.5	24.4
female			17.7	17.6	17.0	16.9	13.5	13.8	13.0

Source: GUS - LFS

Table 1.14. Structure of employment by ownership sector, end-year

Specification	1995	1996	1997	1998	1999	2000	2001
Employment- in thousands	15 486	15 842	16 229	16 174	15 918	15 480	14 988
Private -%	61.4	63.6	67.9	69.4	71.3	72.2	73.2
Public - %	38.6	36.4	32.1	30.6	28.7	27.8	26.8

Source: GUS estimations

Table 1.15: Unemployment rate

Unemployment rate	1993	1995	1996	1997	1998	1999	2000	2001
by register	16,4	14,9	13,2	10,3	10,4	13,1	15,0	17,5
by LFS (IV quarter of the year)	14,9	13,1	11,5	10,2	10,6	15.3	16,0	18,5

Source: KUP (National Labour Office) and GUS - LFS

Table 1.16: Labour market development until 2004

Specification	2002	2003	2004
Employment (average), in thousand	14196	14162	14246
Employees from enterprises with > 9 employed)	7556	7517	7563
self-employed and employees of enterprises up to 9 employed	6640	6645	6683
unemployment rate	18.3	18.2	17.3

Source: CASE (Polish Economic Outlook 3/2002 (15))

Table 1.17: Poverty rate according to different poverty lines - % of persons living at the given poverty level and below this level.

Poverty lines	1992	1994	1996	1999	2000
Subsistence minimum	-	6,4	4,3	6,9	8,1
Relative poverty line*	12,0 (1993)	13,5	14,0	16,5	17,1
Income threshold in the social assistance scheme	-	-	13,3 (1997)	14,4	13,6
Subjective**	32,6 (1990)	33,0	30,5	34,8	34,4
Social minimum	32,4	47,9	46,7	52,2	53,8

Notes: * 50% of average expenditure per OECD consumption unit

** % of households at the level and under the level of poverty

Source: GUS and IPiSS

Table 1.18: Poverty rate among households by different socio-economic group in 1999 - 2000

Type of households-	**Subsistence minimum**		**Relative poverty lines**		**Subjective poverty lines**		**Income threshold in the social assistance**		**Social minimum**	
Year	1999	2000	1999	2000	1999	2000	1999	2000	1999	2000
Total	6,9	8,1	16,5	17,1	34,8	34,4	14,4	13,6	52,2	53,8
Employees	4,7	5,8	12,4	13,6	25,3	22,6	10,7	10,4	51,2	52,5
Farmers	13,3	12,9	29,9	26,2	44,0	43,6	26,8	21,3	68,9	68,5
Employees – Farmers	9,2	8,6	24,7	20,9	28,9	25,6	21,3	16,2	64,8	62,9
Self-employed	3,2	3,7	8,2	8,5	16,4	17,1	6,4	6,5	36,6	38,2
Old age and disability pensioners	6,1	8,0	14,3	16,6	-	-	12,5	13,3	44,0	48,3
old-age pensioners	3,6	5,1	9,6	10,8	34,9	38,2	8,6	8,4	35,2	39,0
Other – maintained from non-earned sources	28,4	30,4	46,9	45,5	78,6	72,5	43,8	30,4	78,4	80,3

Source: GUS 2000

Table 1. 19:Poverty rate in families with children - % of persons below applied line

Families	**Subsistence minimum**	**Relative poverty line**	**Income threshold in the social assistance**	**Subjective poverty line (Lyden Poverty Line)***	**Social minimum**
Couple without children					
1994	1,2	3,7		28,2	35,6
1996	1,1	4,0		19,8	19,8
1999	1,3	4,3		-	23,4
2000	1,5	4,1	2,9	22,7	26,2
Couple with children					
with 1 child					
1994	1,1	5,2		27,9	41,8
1996	1,6	5,7		22,0	31,6
1999	2,6	6,6		-	36,5
2000	3,4	8,2	6,3	27,5	40,4
with 2 children					
1994	4,0	9,4		35,8	56,4
1996	2,4	9,6		30,3	47,1
1999	4,3	12,0		-	51,9
2000	5,7	12,9	9,7	31,7	53,4
with 3 children					
1994	8,4	18,9		51,5	73,0
1996	5,3	19,8		39,2	63,0
1999	11,1	25,2		-	69,4
2000	11,0	24,5	19,3	38,6	68,8
with 4 children and more					
1994	20,4	37,9		60,0	85,7
1996	16,0	38,2		54,5	80,0
1999	22,3	44,1		-	84,7
2000	26,4	47,9	40,8	54,3	87,4
Single parents					
1994	6,0	12,8		54,4	56,5
1996	4,0	11,1		48,4	45,3
1999	9,8	19,2		-	57,4
2000	11,7	23,0	19,4	53,6	57,7

* Lyden Poverty Line concerns % of households

Source: Golinowska 1996, GUS 1997, GUS 2000

2. OVERVIEW OF THE SOCIAL PROTECTION SYSTEM

2.1 Organisational structure

In the Polish tradition of social policy and in the Polish social law rather categories of social security (zabezpieczenie społeczne) were used (and still are used) than social protection (Jończyk 2002). The social security system consists of:

- social insurance schemes (old-age, invalidity, work injuries, occupational diseases and survivors pensions),
- sickness benefits,
- health care services,
- maternity and family benefits,
- insurance allowances (care allowances, funeral allowances),
- non- insurance allowances (housing allowances)
- unemployment social protection,
- social assistance.

2.1.1 Overview of the system

Table 2.1: Social security in Poland – legislation and administration

Sectors of social protection	Ministerial responsibility	Legislation	Administration
Old – age pensions			
for employees	Ministry of Labour and Social Policy (MPiPS),	Law of 13th October 1998 on social insurance system and Law of 17th December 1998 on old-age disability and survivors pension from the Social Insurance Fund (FUS), Law of 20th December 1990 on social insurance of farmers and their families,	Social Insurance Institution (ZUS),
for individual farmers	Ministry of Agriculture (MR),	Law of 17th December 1998 - see above.	Social Insurance Found for Farmers (KRUS),
for soldiers and policemen's	MINISTRY OF DEFENCE AND MINISTRY OF INTERNAL AFFAIRS AND ADMINISTRATION		ZUS

continued Table 2.1

Sectors of social protection	Ministerial responsibility	Legislation	Administration
Invalidity			
invalidity pensions	MPiPS and MR	The act of June 28, 1996 (medical assessment)	ZUS and KRUS
		and Law of 17th December -see above,	
rehabilitation	MPiPS/ Ministry of Health (MZ)	Law of 27th August 1997 on professional and social rehabilitation and employment of the disabled,	ZUS and health founds (medical rehabilitation), PFRON (professional and social rehabilitation),
labour for disabled persons			
social assistance	MpiPS	Law of 11th November 1990 on social assistance	district and local self-government
	MpiPS		
Sickness	MpiPS	Law of 25th June 1999 on cash social insurance benefits in case of sickness and maternity	ZUS and employers
EMPLOYMENT INJURIES AND OCCUPATIONAL DISEASES	MpiPS	Law of 12th June 1975 on benefits provided in case of work accident or occupational disease	ZUS and employers
Family policy	MPIPS AND GOVERNMENTAL PLENIPOTENTIARY FOR FAMILY, WOMEN AND CHILDREN ISSUES	LAW OF 1ST DECEMBER 1994 ON FAMILY AND NURSING ALLOWANCES	Ministry of Finance and District Family Assistance Centres (PCPR)
PROTECTION OF UNEMPLOYED PEOPLE	MPiPS - Labour Office	Law of 14th December 1994 on employment and counteract unemployment with later amendments	DISTRICT SELF-GOVERNMENT
Social assistance	MPIPS – DEPARTMENT OF SOCIAL ASSISTANCE	Law of 11th November 1990 on social assistance	local self-government
Health care	Ministry of Health (MZ)	Law of 6th February 1997 on general health insurance with later amendments	health fund and self-governments: regional, district and local
Long-term care	MPiPS / MZ	Social assistance law	local self-government

2.1.2 Centralisation /Decentralisation of the system

In 1999, a further decentralisation of the public administration and inter alia also further decentralisation of the social protection system was introduced together with three social reforms (pension, health care and education) simultaneously. Further decentralisation in the Polish case meant the introduction of the district (powiat) level; which is below the regional and higher than the local (gmina) level. Main branches of the so called non –

insurance social issues, especially family protection, social assistance and unemployment protection are located at the district level.

Table 2.2: Overview of central and decentralised responsibilities

Sectors of social protections	**Governmental responsibilities**	**Social partners**	**Regional authorities**	**District / Local**
Old – age pensions for employees for individual farmers for soldiers and policemen's	Central level			
Invalidity invalidity pensions rehabilitation labour for disabled persons social assistance	Central level			DISTRICT AND LOCAL
Sickness	Central level	Employers		
Employment injuries and occupational diseases	Central level	Employers		
Family policy	Central level			District
Protection of unemployed people				District
Social assistance				District and Local
Health care	Central clinics and high specialised medical procedures	Occupational health care	Regional hospitals	District hospitals and local ambulatory health care
Long-term care				District and local

2.2 Financing of social protection

Table 2.3: Overview of the financial system

Sectors of social protection	Sources	Financial mechanism	Collecting means institutions
Old-age pensions			
for employees	contributions - 19,52% * (50% employers and 50% employee) of the basis for pension calculation** + subsidies (state budget compensatory subventions),	pay-as-you-go (11,22%) and funded pillar (7,3%)	ZUS
for individual farmers	state subsidies + contributions,		
for soldiers policemen's and prison employees	general taxes	pay-as-you-go	KRUS
Invalidity			
invalidity pensions	Contributions - 13% (50% employers and 50% employees).	pay-as-you-go	ZUS and KRUS
rehabilitation	Different sources: contributions for social and health insurance, and general taxes.	pay-as-you-go	ZUS and health funds
labour for disabled persons	Employers with more than 50 staff members are committed to employ disabled persons to 6% of their personnel. Employers who fail to employ the disabled or do not meet the identified quota are committed to pay 'a penalty' to the special found (PFRON), which finances sheltered workshops and other expenditure for disabled workers	pay-as-you-go	Quasi-budgetary State Fund for Rehabilitation of the Disabled (PFRON)
social assistance	taxes		
Sickness	Contributions - 2,45% (employee) and remuneration at 80% of salary during the first 35 days of sickness	pay-as-you-go	ZUS
Employment injuries and occupational diseases	Contribution - 1,62% (employer)	pay-as-you-go	ZUS
Family policy	taxes		
Protection of unemployed people	contributions - 2,45 % (employer) + state subsidies	pay-as-you-go	
Social assistance	taxes		
Health care	contributions - 7,5% of the PIT before taxation by employee and general taxes	pay-as-you go	
Long-term care	taxes		

Notes: * 1% is paid for Demographic Reserve Fund

**Pension calculation base is identified on the basis of an average calculation base for social insurance contribution through subsequent 10 calendar years, which the applicant can select from the past 20 calendar year preceding the year in which the application for pension was submitted. The period lasts 19 years for applications submitted in 1999. The percentage indicator of the calculation base may not exceed 250 %

2.3 Overview of allowances

2.3.1 Health care

Health insurance covers employees and self-employed persons, pensioners, recipients of other social benefits (unemployment insurance), students, farmers and family members of the insured. There is no qualifying period and medical treatment is granted as long as the insured is registered with a sickness fund. The insured has a free choice of the family doctor and certain specialists. No co-payments are due for basic treatment (defined by the Ministry of Health). There are certain co-payments for pharmaceuticals.

2.3.2 Sickness

Allowances for sickness-related absence for employees is financed by two sources: by the Social Insurance Institutions (ZUS) and by the employer. The ZUS provides a compensation for the lost earnings in respect of long-term incapacity for work caused by an illness or by the necessity of isolation due to a contagious disease - starting from the 36th day of the incapacity. For the first 35 days of the incapacity within the calendar year, a worker is entitled to a payment, not smaller than 80% of his salary, from the employer. Sickness benefits for farmers are financed by KRUS.

Table 2.4: Comparison - Sickness benefits

Scheme	Eligibility	Level of benefit	Length of provision
for employees	obligatory insured employees, waiting period: 30 days	80% of remuneration, may be granted as 100% of remuneration if the incapacity for work was caused by an employment accident or an accident on the way to or from work, an occupational disease, or collides with the pregnancy period, or continues the 91th day without interruption. 1999 a ceiling was introduced for the calculation base – 200% of the average remuneration during three last month	Basic payment is 6 month (9 month in case of tuberculosis). It may be prolonged by next 3 month on a doctor's request.
for self-employed people, hand-craft and agents	voluntary insured persons, waiting period: 180 days		

2.3.3 Maternity

Maternity allowances are provided by the Social Insurance Institutions. In the employee scheme the basic maternity benefit is 100% wage replacement which is paid for 16 weeks after the delivery of the first child, 18 weeks after the delivery of any subsequent children, and 26 weeks in the case of multiple births. Since the 1970s the maternity benefit is also granted to female family helpers in the private agricultural sector. In this case, it is paid

for eight weeks at the level of an average pension. All major principles related to the maternity leave and maternity benefits were maintained during the transition period.

The lump-sum birth allowance (introduced in 1936) became widespread in the 1970s when it was also granted to female family helpers working on private farms and to inactive women whose husbands were insured. The amount of the birth allowance was set at 12% of the average wage of women working in the non-agricultural sector and three times the lowest pension of women working in agriculture. In 1978 an additional universal birth allowance was introduced. From 1985 to 1990 only uninsured women received these payments. The birth allowance was maintained during the transition period, and in 1995 the amount of the benefit granted to women working outside the agricultural sector went up to 15% of the average wage. Just recently (2002) the birth allowance was abolished.

The unpaid parental leave was introduced in the 70s-ties and the paid parental allowance in 1982. It has failed to become a universal benefit. Entitlement was granted to mothers whose family income did not exceed 25% of the average wage. The allowance was paid for 24 months until the child reached the age of four. At the time of its introduction, the value of the benefit was 34.7% of the average wage and declined to 13.7% in the mid-1980s. In the subsequent years of recession the rate basically remained unchanged.

At the start of the transition period, under conditions of dramatic unemployment and inflation, the parental allowance was seen as an incentive for women to stay at home with their children. Consequently, the authorities took measures to prevent it from depreciating and the parental allowance was price-indexed every quarter. Since 1994, the duration of the allowance can be extended if both parents remain unemployed.

Subsequent changes took place in 1996. The amount of the allowance was based on an absolute value and was PLN 179.9, the equivalent of 21.3% of the average wage. The benefit was price-indexed, which had a negative effect on its value. Another major modification introduced in 1996 was an option allowing fathers to take parental leave and claim the allowance. Preferences for single parents (34.5% of average wages for 36 months) and parents raising disabled children (up to 72 months) were maintained. The parental allowance has thus become a benefit mainly addressed to the most economically underprivileged families with scarce chances to find employment. In the late 1990s, women with low-paid but permanent jobs tended to take parental leaves and claim parental allowance over four times less frequently than at the time the benefit was introduced (Kurzynowski 1995 and 1998).

2.3.4 Invalidity

Eligibility to the invalidity pensions for employees and self-employed people (ZUS)

Eligibility to invalidity pensions is determined by the three following criteria:

- actual incapacity for work
- minimum period of employment covered by contribution payments and non-contributory periods (periods of parental leave, caring for a dependent person etc.)
- occurrence of the incapacity for work during employment or within a period of time considered as employment
- Within the framework of the act on old-age benefits and pensions of SII (dated December 17, 1998) the minimum period of insurance is specified (similar to former provisions):
- 1 year prior to completion of the age 20,
- 2 years for the age of 20 – 22,
- 3 years for the age of 22-25 ,
- 4 years for the age of 25 – 30,
- 5 years for the age of over 30 years, whereas the incapacity for work should be determined within a ten-year period prior to the application.

Non-contributory periods should not exceed one-third of periods covered by contribution.

Table 2.5 Structure of assigned invalidity pensions by the degree of incapacity for work

Year	Total	Permanent incapacity for work and independent existence	Permanent incapacity for work	Partial incapacity for work
		In per cent		
1995	100.0	11.4	41.5	47.1
1996	100.0	12.0	41.3	46.7
1997	100.0	12.7	41.5	45.8
1998	100.0	12.9	40.9	46.2

Source: data of ZUS (1999, 1998, 1997, 1996)

Eligibility to the farmer's invalidity pension (KRUS)

In line with the act of 1990, the core eligibility criterion for an invalidity pension is long-term incapacity to work on a farm, which cannot be shorter than six months. the act specifies two conditions of incapacity - permanent and long-term incapacity. A permanent pension is granted to individuals whose permanent invalidity was officially assessed , and is granted automatically to pensioners who are five years below the legal retirement age as well as to persons with invalidity of the first category.

An additional condition of eligibility to an invalidity pension is the termination of farming activities. An individual who fails to cease his/her farming activities may be punished with partial or total suspension of his/her invalidity pension.

Rights to a separate pension are granted to both spouses working at the farm and other household members.

Invalidity benefits from ZUS

Invalidity pensions from ZUS are granted after the end of sick leave, during which an applicant was entitled to sickness benefit (see 2.3.2). If after expiration of sickness cash benefits an employee continues to be disabled for work, he/she holds the right to rehabilitation benefit, if medical examinations confirm that the individual will be capable to work again within 12 months. The amount of the rehabilitation benefit is an equivalent to 75 % of his/her remuneration.

If a medical doctor identifies a decreased capacity to work as a consequence of an illness, the employee acquires the rights to a compensation allowance. The allowance compensates for the difference between the amount of remuneration before the occurrence of partial incapacity to work and the actual remuneration received.

For an individual temporarily unable to work, having exhausted all benefits he/she is entitled to (sickness benefits and rehabilitation allowance) but still be unable to work, the invalidity assessment procedure determines whether the person is fully disabled or is unable to work in his/her current occupation.

New legal provisions (the act on invalidity assessment of 1996) provide a possibility to assess the ability to work in another profession. Applicants can acquire a right to vocational rehabilitation for the period of 12 months from the pension-granting body. The benefit period may be extended (for no longer than 30 months).

Having exhausted all the above-mentioned possibilities, an employee who is disabled acquires the right to an invalidity pension. The pension-granting body may grant a permanent pension, if permanent working disability is

medically determined, or a temporary pension, if assessment indicates temporary incapacity to work.

Invalidity benefit from KRUS

The social insurance system for farmers provides the same formula for calculating old-age - and disability pensions. Farmer's old age (disability) pension cannot be lower than the minimum employee old-age (disability) pension.

2.3.5 Old-age

Table 2.6 Comparison - Old-age pensions

Schemes	Coverage	Qualifying conditions	Level of benefits	Length of provision	Taxation of benefits
For employees	Universal - without exception	Two conditions: - at least 20 years of employment for women and 25 years for men, - retirement age* : 60 years for women and 65 for men	according to employee pension formula**	average contributory period: 36,9 years for men, 32 years for women	yes - PIT
For private farmers	For all cultivating more than 1 hectare. Those cultivating smaller areas can get insured on request	Retirement age for man 65 and for woman 60 years, and of Polish citizenship. Next: time of insurance is the same for men and women: 100 quarters time. There is an option of 5 years earlier retirement with some benefit reduction.	according to farmers pension formula***		
For soldiers and policemen, prison employees and clerks		at least 15 years of service	40% of assessment base. For years of service above 15 years the benefit is raised by 2,6% of assessment base for each year; 1,3% for other years of employment and 0,7 for non-contributory years. The maximum benefit equals 75% of the assessment base. (=last year remuneration).		
For self-employees	Polish citizenship				

Notes: Some professional groups and employees whose work involves special condition or is of special specific character are entitled to receiving a pension earlier

** Employee pension formula: P = 0.24S + (0.013N' + 0.007N")B

P = pension amount

S = basic lump sum (used to be average monthly wage in the previous quarter, it was lowered then to 91% and raised again to 93%).

N' = number of eligible years for which contribution payments were made

N" = number of eligible years for which no contribution payments were made

B = the individual assessment base

*** Farmers pension formula: P= B(0,01N +0,95)

P- pension amount

N- number of years in insurance (personal history variable)

B - basic pension equals minimum of employee pension (person independent variable)

0,01NxB is called contributory pension,

P - 0,01NxB is called supplementary pension

If the number of years in insurance is more than 20:

P = 0,01NxB + B (0,95 - 0,005d)

d = N-20.

2.3.6 Survivors

The survivor pension in Poland is called "family pension" because one survivor benefit is paid to all surviving relatives (widow / widower, children until 16 or longer when they attend schools and parents when they were living together) of the insured. Surviving widow or widower are entitled to family pension if they are fulfil one of four conditions:

- are more than 50 years old,
- have medical assessment about incapacity to work
- rise children until 16 years (if attend schools – until 18 years)
- take care of disabled child

If the widow/widower does not fulfil one of those four conditions and has no own earnings, she/he can receive temporary family pension – for 1 year, in case she is in training – for 2 years (only widow).
The amount of family pension is 85% of the benefit (old-age pension or invalidity pension) which would have been granted to the deceased for one person and then 5% more for second person and 10% more for three or more surviving persons; the maximum survivor's pension is than 95% of the benefit. Basically it is assumed that the deceased would have been granted

the invalidity pension with the medical assessment about permanent incapacity to work.
In the new pension system it is possible to inherit pension capital of the deceased in the second pillar.

2.3.7 Employment injuries and occupational diseases

Work accident invalidity pension is granted in case of the loss of health as a result of an accident at work, on the way to and from work, or as a result of an occupational disease. Loss of health is determined (since 1997, loss of ability to work) by a certified doctor (previously Medical Commissions). A special legal act of 1983 specifies occupational diseases which entitle applicants for "work accident invalidity pension". Beneficiaries of such pensions hold the right to nursing allowances, rehabilitation services, professional training benefits (as in the case of pensions granted through general insurance), and rights to retire five years before reaching the legal retirement age.

Work injury benefit is an equivalent of maximum 100 % of an individual calculation base for a fully disabled, and 75% for a partially disabled person. Calculation base for the benefit may not be lower than 1.5 of the minimum wage. Work injury benefits in case of total disability may not be lower than 80 % of the wage (individual calculation base), and 60% for partial work incapacity. Provisions (of 1975) also specify the relation between the minimum work injury benefit and disability benefit from the general insurance. Minimum work injury benefits must exceed minimum invalidity pension from general insurance by at least 20 %.

If an individual receiving invalidity pension granted due to an accident at work, reached the retirement age, he/she may choose to maintain the pension and claim 50% of due old-age benefit or 50% of invalidity pension and total amount of old-age benefit, depending on his/her individual choice.

2.3.8 Family benefits

Family benefits nowadays in Poland are mostly cash benefits. Price subsidies for children and family needed goods and different benefits in kind were abolished. At the same time the family benefits are very modest. The classical family policy instrument – the universal family allowance is now means-tested and its value is low.

Since 1995 the family allowance are granted exclusively to less affluent families. The value of the allowance was set at amount of 21 PLN, indexed once a year in line with the price increase index. Due to the fact that Polish wages have dramatically increased since 1994, price indexation of family benefits has had a negative effect on the benefit-to-wages rate. After two

years, the average value of the benefit had fallen to approximately 6% of average wages. The principles of the entitlement to family allowances were changed in 1998 and, as in the socialist era, it was based on the number of children in the family. At the same time, single parents raising disabled children were entitled to the double amount of the benefit. The relative value of benefits in the years 1999-2001 has again decreased considerably..

Table 2.7: Comparison - Family and children protection allowances

Type of benefits	**Entitled criteria**	**Target group and the aim of benefit; for whom and for what**	**Level of benefit**	**Duration of payment**
Family allowance	Income threshold – 50% of average wage per family member	For child up to 16-teen years old or 24 when the education is continued	42,2 zł to the first child (2 % of average wage) 51, 0 to the second 63,7 zł to the third and subsequent children	12 month and application can (must) be repeated each year
Nursing allowance	Medical assessment	For disabled or chronically sick children and old (after 75 years) family member	10% of gross average wage (136,0 zł in 2001)	According to medical assessment
Alimo-ny	Court assessment and income threshold - 60 % of average income	For abandoned children by family breadwinner	Individual determined by court, but no higher than 30% of average wage	Up to becoming independent but income threshold is checked each year
Grant for the start in inde-pendent life	Full age of children living in institutions	For children giving up institution due to majority	Determined in absolute amount (1546, 0 zł in 2001- about 75% of average wage)	Single
Nume-rous family allowance	3 or more children in the family, without income threshold	For the family before school beginning	Determined in absolute value – (160,0 zł. in 1999)	Once a year, paid only in years 1999-2000

Source: own compilation according to legal regulations

2.3.9 Unemployment

Unemployment benefits in Poland are flat rate and linked to the average wage for all workers (35% of the average wage). Those benefits are paid for a maximum of 1 year. Only 20% of the unemployed are eligible to receive benefits. To protect poor families with children, unemployment benefits for employees of a family with double unemployed family members have an extended eligibility of 18 month.

Table 2.8: Comparison - Allowances for unemployed people from the Labour Fund

Type of the benefits	**Entitlement criteria**	**For whom**	**Level of benefit**	**Duration of payment**
Basic unemployment benefit	Unemploy-ment status	Unemployed and registered in the employment office	476,7 zł (24% of average wage)	Depends on the unemployment rate in the territory* (6,12 or 18 months) and on the work record and family status (minimum 20 years of work and for the breadwinner)
Higher unemployment benefit	Unemploy-ment status and 20 years of work record	Such as at basic benefit	572,1 zł	Such as at basic benefit
Reduced unemployment benefit	Unemployment status and up to 5 years of work record	Such as at basic benefit	381,4 zł	Such as at basic benefit
Scholarships	Unemployed school-leavers up to 12 months after the school leave	Participated in vocational training Practised Continued education in the territory of high unemployment	60 % of basic benefit 100 % of basic benefit 60 % of basic benefit	12 month
Training Supplement	Unemployment status and order of training from the labour office	Unemployed participated in training	20 % of basic benefit	Time of training
Pre-pension allowance: Basic Higher	 Work record: 30 years for women and 35 years for men or 25 and 30 in case of special /difficult working conditions and leaving work place due to employer reason Residence in the territory with high unemployment	For the leavers of work place due to reorgani-sation or closing of firm	 120 %of basic benefit. Up to 160 % of basic benefit	Up to retirement

continued Table 2.8:

Type of the benefits	Entitlement criteria	For whom	Level of benefit	Duration of payment
Pre-Pension Benefit	Age limit: 58 years for women and 63 years for men or 55 i 60 and pension contribution record entitled to pension or only contribution record 35 (women) and 40 (men) years and leaving work place due to employer reason	For the leavers of work place due to reorganisation or closing of firm	90% of pension	Up to retirement

Note: * For using unemployment measure the polish territory was dividing into three groups: with average unemployment rate, with high unemployment rate: twice of average and with low unemployment rate: lower than average.

Source: own compilation according to legal regulation (as of IX. 2001)

For young unemployment people a special programme was introduced in 1997. This consists of short –term measures, generally at the local level, based on co-operation between employment services, education inspectorates and other labour market partners (particularly oriented to training and retraining). Young people participating in the programme receive a financial incentive amounting to 50 per cent of the minimum wage, which is paid up to 1 year. The grant can be used to finance training, which covers at least 50 % of working time. It can be also used to finance scholarship for combined training and education, training grants, and to stimulate voluntary work.

Due to the deep restructuring of the industry a special quasi-pension benefits (early retirement pension) was introduced in the late 1990ies (see table 2.8):
Pre-retirement benefit - an instrument for social protection of older workers. This allowance is targeted to older workers who fulfil the following conditions:

- they are unemployed and are entitled to the unemployment benefit,
- their employment record is 30/35, or 25/30 if they worked for at least 15 years in special or risky working conditions.

The pre-retirement allowance amounts to 120% of the average unemployment benefit, or 160% if the older worker lives in the area of structural unemployment (unemployment rate more than average in the country).

Pre-retirement pension – an instrument of the social protection of older workers. It is targeted to older workers who fulfil the following conditions:

- they are 58 (women) and 63 (men) years old and have the minimum employment record required by the pension law,
- they are dismissed due to employers' reasons and have the minimum employment record of 35/40 years.

A pre-retirement pension amounts to 90% of the potential old-age pension for the given person.

Active labour market policy (ALMP) would have special importance in the current situation (high increase of unemployment) but to date, it plays no significant role.

Table 2.9: Comparison - Active Labour Market Policy (ALMP) instruments applied in Poland

Active programmes	Actors	Method of financing	Duration	Comments
Public works	Local authorities organise public works for the unemployed people	Direct financing from local budget	Undefined	Not very much effective
Intervention works	Local authorities and employers make contracts to employ jobless people	Refunding costs of employed people	12 month	
Subsidised employment for young people (graduates)	Local authorities and employers make contracts to employ the graduates	Refunding wages of employed graduates	12 month	
Training and retraining	Labour offices and training schools/firms make contracts to train unemployed people	Covering costs of training	For the period of training	
Loans to support self-employment and job creation	Labour offices giving loans for employers or/and for unemployed with initiative to be self-employed	loans at the level of 20 times average salary with the possibility of partial remission	-	

Source: own compilation based on decrees of the Minister of Labour and Social Policy

2.3.10 Minimum resources/social assistance

According to the social assistance law two conditions must be met at the same time to claim social assistance benefits. One is obviously the low income level. The Polish social assistance system does not address aid to individuals but to the entire family. The income criterion is therefore related to the level of income per family member. Since 1996 income per family member is no longer calculated as a simple quotient of total income and the

number of family members, but according to the OECD equivalency scale (consumption unit), which largely limits the possibility to claim funds from social assistance programmes. Despite an increase in the statistical evidence of poverty, the number of social assistance recipients has not increased. The income threshold in the social assistance amounts 406 PLN per consumption unit (according to OECD equivalence scale) in 2001.

The second condition is connected with ”dysfunctionality” in the family. It means that an eligible person must belong to one of 10 groups of this dysfunctionality like:

- unemployment,
- orphancy,
- homelessness,
- physical or mental impairment,
- alcohol and drug addiction,
- maternity protection,
- chronic disease,
- parental immaturity and helplessness in the large and one parent families,
- adaptation difficulties after releasing from prison,
- ecological catastrophe and other elemental disasters

Table 2.10: Comparison - Social assistance allowances

Type of allowances	**Entitlement criteria**	**For whom; targeted person and for what**	**Level of allowance**	**Duration of payment**
Social pension for disability	Medical assessment and lack of entitlements to disability pension or old-age pension. No income threshold required	For disabled persons (disabled since birth, childhood or youth).	Determined in quota: since VI 2001 – 406 zł (ca. 20% of average wage), indexed 1 or 2 times a year, depending on increase of the CPI level	According to medical assessment; allowance is abolished when other income exceeds the level of social pension for disability
Permanent allowance	Double level of income threshold required.	For not working persons due to permanent caring of the disabled child (including adults).	Determined in quota; since VI 2001 – 406 zł	Till 16 years of age, of till 24 of child continues her/his education

Continued Table 2.10

Type of the benefits	Entitlement criteria	For whom	Level of benefit	Duration of payment
Compensatory permanent allowance	Income threshold and total disability to work (age for M > 65, F > 60 years of age, or status of disabled) and loneliness	For persons totally disabled to work with low income	Minimum 18 zł and maximum 447 zł (the level of income threshold for one person)	Systematically adjusted in accordance with the income level
Guaranteed temporary allowance	Single parent, expiring of entitlement to unemployment.	For single parents, caring for children till 15 years of age, who lost entitlement to unemployment benefits	447 zł for 12 moths, 80% of this level for the next 24 months	For 36 moths or initially only for 12 moths and late for 24 months
Temporary allowance	Income threshold (in special cases no threshold) and deprivation of basic needs	According to social risks defined in the social assistance law: chronic illness, disability, unemployment	Minimum 18 zł up the level of income threshold	Not obligatory, since 1999 problems with payments due to financial shortages
Focused (earmarked) allowances	Income threshold (in special cases no threshold) and deprivation of basic needs	Covering the costs of medicines medical treatment, caring for children, funeral costs etc..	Up to the level of income threshold in a given family	Not obligatory, often paid only once, also in form of benefit in kind

Source: own compilation according to legal regulations (as of IX 2001)

2.4 Main principles and mechanisms of the social protection system

The social protection system has been anchored in a merger between government responsibilities and the very initiatives taken by local communities and regional policy makers. Nonetheless, in addition to beneficiaries of change and development, the transformations have led to the emergence of social groups on the brink of exclusion. One of the most important distinctions of social status now is having a job. This factor became the key determinant of Polish poverty.

The social protection system provides rather poor benefits for unemployed and poor people.

Table 2.11. Level of the main kinds of social benefits

Kind of social benefit	**2000**		**2001**	
	in PLN (monthly)	relative	in PLN (monthly)	relative
Pension on average, ZUS (non-farmers' system)	875.46	55.7% a.w.	971.80	57.2% a.w.
old-age pension	1000.07	63.6% a.w.	1106.04	65.1% a.w.
disability pension	716.73	45.6% a.w.	794.15	46.7% a.w.
family pensions	859.51	54.7% a.w.	949.18	55.9% a.w.
Pension on average, KRUS (farmers' system)	601.57	38.3% a.w.	678.52	39.9% a.w.
Unemployment benefit	406.42	25.9% a.w.	441.16	26.0% a.w.
Pre-retirement benefit	594.80	37.8% a.w.	635.67	37.4% a.w.
Pre-retirement pension	985.47	62.7% a.w.	1092.07	64.3% a.w.
Family benefit on average	40.27	2.6% a.w.	41.38	2.4% a.w.
of which farmers	45.04	2.9% a.w.	44.48	2.6% a.w.
Nursing benefit on average	117.9	7.5% a.w.	130.43	7.7% a.w.
of which farmers	121.15	7.7% a.w.	132.15	7.8% a.w.
Child-care benefit	314.96	20.0% a.w.	347.40	20.4% a.w.

Notes: a.w. - average gross wage in the economy after deducting the obligatory health contribution. Minimum wage - 760 PLN in 2001

Source: GUS 2002, Statistical Yearbook.

The relative well developed system of social protection is social insurance, which provides pensions for old-age and disability employees. In 1999 a pension reform was introduced with the objective to create a funded pillar in the employees scheme. The transition costs of the pension reform are high. The consequence of that is the limitation of the other social expenditure, especially on family protection, social assistance and health care services. It leads to the selection of public expenditure focused on so-called indispensable social needs or only for the poor target groups. Means testing is the widening principle to claim social protection in Poland.

3. PENSIONS

3.1 Evaluation of current structures

3.1.1 Public-private mix

A fundamental pension reform (called further also ”the 1999 reform”) was introduced in Poland starting on January 1st, 1999 (see chapter 3.3.1). It is therefore necessary throughout the report to differentiate between the current situation, resulting from the previous pension system and the completely new pension scheme which will clearly change the public-private mix .

At present, for the present and in the nearest future ”coming” retirees, the public pension scheme is an absolutely predominate source of income security in old age (Table 3.1). For the previous employees and self-employed outside agriculture it is the pension from ZUS (Social Insurance Institution), for the previous farmers – KRUS (Social Insurance Institution for Farmers). Occupational pension schemes are almost non-existent, apart from some group life insurance schemes. Only a slight proportion of elderly have income from private sources, like life insurance.

Table 3.1: Sources of income of households of retirees (1) 2000 in %

Total available income per capita in household	**100.0**
Income from retirement pensions	78.2
Income from other social benefits	8.0
Income from hired work	8.0
Income from a private agricultural farm	1.1
Income from self-employment	0.8
Income from owning and leasing buildings and structures not connected with conducting economic activity	0.3
Other income (2)	3.7

(1) Households of retirees – households in which retirement pensions are exclusive or primary (predominate) source of maintenance.

(2) Other income includes, i.a.: gifts (i.a. private alimony), insurance indemnities, winnings from games of chance and lotteries.

Source: GUS 2001, p. 190; own estimates.

Poland, relying on its social insurance tradition, does not have a universal system for the whole population. A person in old age without a pension entitlement can apply for social assistance. There are no specific means/income-tested transfers especially for older people. On the other

hand, both social insurance systems for employed persons are, after the major unification of pension law in the latest reform, quite universal for all categories of employed.

The role of family within the old-age security system has been decreasing in Poland, as in other countries with formal social security systems, throughout the years of the development and maturing of the pension system after the Second World War. However, the family relations in Poland are still often tighter than in Western Europe, and the elderly more often rely on support of their children. But also a vice versa happens. As the income position of younger people (if unemployed, with children, or in agriculture - compare chapter 4) is often not better than that of their parents, the pensioners support their children.

The pension reform in Poland has replaced a ”one-pillar scheme” by a multipillar one. This change has not however concerned farmers who are still covered by the separate KRUS scheme. The new system which covers all employed persons outside agriculture, consists of two obligatory parts (”pillars”). The first pillar is pay-as-you-go and administered by ZUS and the second one fully funded and privately managed. Additional sources of income security, among them the ”employees pension programmes” (occupational pension schemes) constitute the third, voluntary pillar. There are no tax incentives to participate in a voluntary scheme. There is, however, an incentive to create an employee pension programme, as the contributions to that scheme, paid only by employer, up to 7 % of earnings of the participant are exempt from social insurance contributions.

In the new system the risk of old-age has been separated from the risks of invalidity and death of breadwinner. There are two separate social insurance branches and contributions: retirement insurance (and contribution) and ”pension” insurance, covering invalidity and survivors.

The introduction of the new pension system with its obligatory funded part was only possible after the capital market and the banking sector had developed to a level according to standards of a market economy.

Table 3.2: Main old and new pension system characteristics

	Old system	**New system**
Pension formula	**P = 0.24 W + W*I*0.013*L + W*I*0.007*S** W – national average wage for previous quarter I – individual wage index L – total length of service S – additional years accepted for insurance	P = K / G K – pension capital of insured, composed of imputed, registered old-age contributions G – life expectancy coefficient at pension allotment
Eligibility criteria		
Length of service	20 years for women, 25 for men	Any contributing periods
Normal retirement age	60 for women, 65 for men with many exceptions	60 for women, 65 for men
Early retirement	Many different categories, including generally women at 55 with at least 30 years of contributing	No early retirement possible
Indexation of benefits	Since 1986 – at least prices. The real growth defined annually in the state budget law	From 1999: mixed price-wage formula, with 20 % of wages At present: defined annually in the state budget law
Taxation of pensions	Taxed as other income	Taxed as other income
Minimum pension	In nominal terms, indexed as other pensions for every pensioner that worked for a qualifying period, paid from the Social Insurance Fund. In 1998 – approx. 70 % of minimum wage	Minimum pension guarantee: In nominal terms, indexed as other pensions for every pensioner that worked a qualifying period (20 years for women and 25 for men), topping up pension from first and second pillar and financed from the State Budget
Maximum pension	Maximum: replacement rate not higher than 100 %, individual's wage factor not higher than 250 % of average wage	No maximum pension

continued Table 3.2

	Old system	**New system**
Contributions		
Financing	Paid by employer, not divided into different risk categories	Paid partly by employer and employee, divided into: retirement, disability, sickness and work injury contributions, contributions tax exempt
First pillar	Mandatory PAYG system – 45 % of wage	12.22 % contribution to PAYG old-age fund, 17.07 % - other benefits (disability, survivor and short-term benefits) Note: Wage increased in 1999 by 23 % to compensate for the split of contributions
Second pillar	n.a.	7.3 % of wage
Ceiling and floor levels	Minimum base: minimum wage for workers, 60 % of average wage for self-employed; No maximum	Minimum base: minimum wage for workers, 60 % of average wage for self-employed; Maximum: 250 % of average wage
Administration		
Contribution collection	Social Insurance Institution (ZUS)	ZUS collects contributions for all social insurance branches, including 2nd pillar
PAYG pillar	Social Insurance Institution	Social Insurance Institution
Second pillar (accumulation)	n.a.	Open-ended pension funds and pension fund societies, supervised by the State Supervision Agency
Special systems	Armed forces (army, police, border guards, firemen), farmers, judges and prosecutors	Farmers, judges and prosecutors, armed force in force prior to January 1, 1999

Source: Chlon, Gora, Rutkowski 1999, pp 63-64.

3.1.2 Benefits

The 1999 reform has changed completely the basic rules concerning pension benefits (Table 3.2).

The new system has covered wholly the younger insured: those under 30 at January 1, 1999. Those between 30 and 50 at that point had the right to decide, until the end of 1999, whether they would take part in the new funded second pillar or would stay in the new PAYG system. Older persons,

over 50, have not been covered by the new system – they will receive pensions according to the old rules.

The old ZUS pension formula in Poland, still used for calculating pensions of all persons retiring in the coming years (see chapter 2.3.5) is a defined-benefit formula, the new one – defined-contribution:

$$P = C / G$$

P – pension amount
C – capital (in the first pillar "notional") the sum of contributions paid, indexed
G – average life expectancy at retirement age in the calendar year of retirement.

The same defined-contribution formula (in the first pillar NDC) is used in both obligatory parts of the new system.

Pensions should have been indexed to at least consumer prices increased by 20 % of real wage growth, but are now indexed at a rate defined in the state budget law.

Replacement rate of pensions has been decreasing since 1995 (Table 3.3), mainly as a result of indexing the pensions to prices, during the time of dynamic economic growth and increasing of real wages. In 2001 an average ZUS retirement pension was some 62 % of average wage (in gross terms – wages and pensions are taxed in the same way). Some 60 % of old-age pensioners received a pension lower than this average[1].

Whereas the legal retirement age has not been changed in the reform and has remained on the level 65 for men and 60 for women, many early retirement possibilities in the old system have resulted in a much lower effective retirement wage. Among the retirement ZUS pensions newly granted in 2001, only 29.6 % of men were above 65 (with the average age of 59.4) and only 16.2 % of women were above 60 (with an average of 56.0) (ZUS data). In the new system, all early retirement possibilities have been abolished.

A new retirement pensioner, i.e. with a pension granted in 2001, had covered on average 36.6 years of insurance (men) or 33.0 years (women).

---

[1] Some 5 % of ZUS old age pensioners receive minimum pension. The share of invalidity pensioners who have to rely on the minimum pension only is much higher and exceeds 20 % - ZUS data.

Table 3.3: Data about the pension system in Poland 1989 - 2001

	1989	**1995**	**1998**	**1999**	**2000**	**2001**
Insured (ZUS) in 1000	14 696	13 206	12 737	13 271	13 060	12 851
Insured (KRUS) in 1000	.	1 452	1 419	1 428	1 452	.
Pensioners (ZUS), including	5 471	6 779	7 184	7 231	7 217	7 156
Retirement pensioners (ZUS)	2 264	3 046	3 303	3 333	3 365	3 401
Invalidity pensioners (ZUS)	2 152	2 602	2 702	2 704	2 640	2 526
Pensioners (KRUS)	1 356	2 049	1 969	1 929	1887	.
Average retirement pension as % of average national wage (ZUS)	58.1	69.2	65.0	62.3	59.9	61.8
Spending on pensions (ZUS and KRUS) as % of GDP	6.5	15.6	14.1	14.1	13.5	.

Source: www.zus.pl/statyst; ZUS 1992, pp. 8,19,29,31,40; GUS 1992, pp. XIII,203; GUS 1995, S.157; GUS 2001, pp.XLI,173; 541; own estimates.

The old pension system in Poland used to try to combine both functions: securing an income related to that from earnings, through linking the benefits to the insurance career, and preventing poverty, through an extensive redistribution within the system (minimum pension and social element of every benefit). The above data show that the first aim has been reached to a high degree. The pension system in Poland has been also relatively successful in preventing poverty in old age as the income poverty among pensioners has been lower than in other categories (see chapters 1 and 4). Whereas the explicit objective of the new system has been making the pensions even more earnings-related, there are fears concerning the new system as far as its consequences for the poverty in old age are concerned (see chapter 3.2).

Pensions are considered low in terms of their earnings capacity which is, however, more a result of the generally lower income level in the country than of the pension system solutions (replacement rates). The thesis is supported by the fact that the average replacement rates in the new system will be lower.

According to the reform programme, the average replacement rate from both obligatory pillars should sink to 50-60 % (Chlon, Gora, Rutkowski, 1999, pp.37-41). The level of pension will also include a much higher risk, typical for defined-contribution scheme, carried by the insured.

3.1.3 Financing of the pension system

The pension system is financed mainly from contributions and additionally from subsidies.

In the old ZUS system there was a general contribution for the whole social insurance: in the last period it was 45 % of contribution base, without any upper limit. For employees it was wholly paid by the employers.

In the present system there is a separate retirement insurance contribution 19.52 % of contribution base, paid for employees half by employees and half by employers.

The reform introduced in 1999 has caused severe transitional costs of the ZUS system, resulting mainly from directing part of the contribution for the pay-as-you-go scheme to the newly created funded pillar (Table 3.4). The deficit of the Social Insurance Fund from which pensions are financed has grown both as a consequence of directing part of contributions previously financing the PAYG system to pension funds as well as a consequence of limiting the contribution base to 250 % of average wage. The two elements as well as increased administrative costs of ZUS, thus the whole consequences of the pension reform have been estimated as 0.8 % of the GDP in 1999, 1.4 % of GDP in 2000, 1.4 % of GDP in 2000, 1.8 % of GDP in 2001, 2.2 % of GDP in 2002 and 1.8 % of GDP in the years 2003-2004 (Krajewski 2001).

Problems of ZUS with its new computer system have caused big delays in directing the contributions to the open-ended funds.

Table 3.4: Sources of revenues of the Social Insurance Fund 1995-2001 (billion of Zloty)

	1995	**1998**	**1999**	**2000**	**2001**
Total revenues (billion of Zloty)	42.0	72.0	73.7	81.3	91.7
= 100 %	*(100.0)*	*(100.0)*	*(100.0)*	*(100.0)*	*(100.0)*
Social insurance contributions	35.2	62.8	64.1	65.6	69.9
as % of total revenues	*(83.8)*	*(87.3)*	*(86.9)*	*(80.7)*	*(76.3)*
Systematic subvention for non-insurance benefits	1.8	2.7	3.2	3.3	3.7
as % of total revenues	*(4.3)*	*(3.8)*	*(4.3)*	*(4.0)*	*(4.0)*
Additional subvention covering the deficit of contributions	4.2	5.6	6.2	12.1	17.5
as % of total revenues	*(10.0)*	*(7.8)*	*(8.4)*	*(14.9)*	*(19.1)*
of which:					
subvention to cover the deficit resulting from directing contributions to pension funds	-	-	2.3	7.5	8.7
subvention to finance the reduction of contribution base (250 % of average wage)	-	-	1.7	2.8	3.1
subvention to supplement means to finance benefits	4.2	5.6	2.2	1.8	5.7
Other revenues	0.8	0.4	0.2	0.3	0.6
as % of total revenues	*(1.9)*	*(0.5)*	*(0.2)*	*(0.4)*	*(0.7)*

Source: www.zus.pl/statyst; ZUS 1997, p.29.

3.1.4 Incentives

One of the major tasks of the 1999 reform was to change incentives set by the pension system with regard to labour market participation.

The old system gave quite strong incentives to retire as early as possible rather than to stay in employment longer. There were many early retirement possibilities and each additional year in employment, i.e. an additional contribution year was credited with only 1.3 % of individual assessment base. This resulted in early retirement decisions and effective retirement age much lower than the official one (see chapter 3.1.2). The old system was also accused of being one of the causes of unemployment and shadow labour market, to avoid paying contributions which had only a limited link to future benefits.

In the new system there are no early retirement possibilities. Pensions are very clearly dependent on contributions paid and the redistribution has been limited. The new pension formula gives strong incentives to postpone retirement decision which should result in increasing pension by several percentage points for every year, depending on retirement age[2].

These "microeconomic" advantages of the new system are claimed by the reform's authors to be one of its biggest achievements. The fact is also stressed that both obligatory pillars: pay-as-you go and funded, with the same defined-contribution pension formula, create the same positive incentives.

3.1.5 Coverage of the system

The present system introduced in 1999 covers all employed outside agriculture with the exception of lawyers who "escaped" from the general scheme to a special civil servants' scheme financed from taxes just before introduction of the new system. These "good risks" are thus in a privileged position not only in comparison with employees and self-employed but also with other groups of "state servants" like soldiers or policemen who were integrated in the general scheme as far as newly starting service after January 1, 1999 are concerned[3].

All persons self-employed in agriculture as well as their family members are covered by the unchanged KRUS system. The two systems together cover thus all employed persons. There is no possibility of 'opting out'.

The second funded pillar is also an obligatory scheme, with no possibility of leaving it before retirement (Table 3.5). In the starting year of the reform 1999 the choice was only given to the people aged 30 to 50 at January 1, 1999 to join the funded pillar or to remain wholly in the reformed pay-as-you-go scheme. The time to make the choice was however restricted until

---

2 As the benefit formula is actuarially adjusted, replacement rates increase with retirement age. The marginal increase in replacement rates depends on the retirement age and may be higher than 5 per cent. Chlon, Gora, Rutkowski 1999, p.39.

3 Those serving at that moment remained in the old tax-financed state system with higher pensions.

December 31, 1999, and the choice made is not reversible. The only choice which will remain for all (obligatory) members of the funded scheme concerns the open-ended fund. It is possible to switch from one fund to another – after two years membership in one fund without, and earlier with some fee.

Gender equality is still a problem in the Polish pension scheme. The authors of the reform proposed to replace the various retirement ages for men and women (65 and 60 respectively) with a unique minimum retirement age at 62. It proved however to be politically impossible. Given the defined-contribution pension formula, the lower retirement age for women will lead to much lower pensions for them.

Table 3.5: The open-ended pension funds in Poland 1999-2001

	1999	**2000**	**2001**
Number of open-ended pension funds (at the end of the year)	21	21	17
Members (in 1000) (at the end of the year)	9 666	10 423	10 637
Members in 3 biggest funds as % of all members (at the end of the year)	56.60 %	56.15 %	55.70 %
Average rate of return from 30.9.1999 till 28.9.2001	.	.	18.1 %
Inflation from 30.9.1999 till 28.9.2001	.	.	16.2 %

Source: UNFE

3.1.6 Public acceptance of the system

The old pension system in Poland was generally criticised and seen by an absolute majority of people as unsustainable. Partly the critique was objectively not right: pensions were considered as very low, which was however a result of their low earnings capacity and so of the general income level rather than of replacement rates offered by the pension system and so the pension system itself. Nevertheless the reform team could refer to the fact that most of the public wanted a replacement of the old system by a new one. For example in October 1997 66 % of interviewed labelled the pension system of that time as ”bad or very bad” and 9 % as ”good or rather good”. The critique of the old system was one of the factors enabling the radical pension reform in Poland.

On this background, the reform programme was an attractive alternative to the old system. The reform concept *“Security through Diversity”* (by the way, a very good title) presented a comprehensive project which combined the politically difficult reform of the old system with creating of new, expected with hope, institutions of old age security. Former reform attempts

had not been successful also because they had been restricted to the first element only. The questionable idea of an obligatory second pillar could also be explained by the fact that in that case many people would take advantage of the new institutions and not only those with higher earnings, like with a non-obligatory scheme. The reform people referred directly to the opinion polls in which people showed clear wish to have individual accounts and funding. The separation of retirement pensions from other social insurance benefits was also presented as an answer to the popular view on pensions as deferred wage rather than a social benefit.

To sum up, the solutions of the new system have been based on a wide public support which has led also to a wide political consensus on the issue (see chapter 3.3.1).

The surveys conducted after the introduction of the reform, in 2000, have not however shown such a clear picture (Szumlicz 2001). First, the rules of the new system are not known or not understood by a significant part of society. 55 % do not know that the new system has made pensions strictly dependent on previous contributions. 53 % of respondents do not know whether the system gives them feeling of security for the future, 25 % think it does and 22 % that it doesn't. Only 49 % of respondents know that private institutions managing money for retirement had been introduced into the new system.

Among all respondents almost as many (22 %) judge the new system as better as well as worse (20 %) than the old one. A clear majority does not have any judgement on this issue. Exactly the same are the answers on the question whether the new system is more just than the old one.

The knowledge of the system and its positive judging is generally higher among persons who are younger, better educated, taking higher professional positions and earning more.

Especially negative has been the assessment of the implementation of the new pension system. 17 % see it as "very ineffective" and 31 % as "rather ineffective". Only 1 % view it as very effective and 14 % as "rather effective". 37 % of respondents do not have any judgement. The main reason for such a critical assessment of the reform implementation has been certainly the issue of introducing the new computer system in ZUS to identify insured and collect records on contributions as well as the outstanding contributions not directed by ZUS to the open-ended funds, partly because of the IT problem and partly because of the problems with financing the transition period (see chapter 3.1.3).

3.2 Evaluation of future challenges

3.2.1 Main challenges

The reform of 1999 should have been an answer to demographic, economic and social challenges facing the Polish pension system.

As pointed in chapter 1.1.2, the ***demographic situation*** is in Poland very beneficial for the pension system at present, as the country has a relatively very young population. It will change however clearly in the next 30 years which can be illustrated by increasing the ratio between those older than 60 (women) or 65 (men) and those between 18 and 60/65 from 24 in 2000 to 41 in 2030. That was one of the main justifications for the pension reform. The new pension formula of both obligatory pillars has an explicit demographic factor built in which should help to deal with the ageing process.

The ***economic situation*** will remain the main challenge for the pension system. Economic growth leading to an increase in income can be the only source of improving the living standards of pensioners. In a lively discussion in Polish media in the beginning of 2002 the issue of replacement rates in the new system has been raised. The argument of the authors of the reform has been that even a lower pension as expressed as percentage of average earnings will enable a higher standard of living provided the general level of income will be clearly higher. In the whole period of transformation Poland experienced a dynamic growth which was slowed however dramatically in 2000 (see chapter 1.1). One of the consequences is the growing unemployment with all the known consequences for the pensions finance and future pension claims.

The issue of high rates of contributions to the pension system with their consequences for labour costs, competitiveness in the opened economy is likely to be raised again in future especially as incomes have continued to close the gap between Poland and high income countries. It must be noted that the reform has not decreased the overall level of contributions which has been considered as very high in international standards[4]. High transition costs will make it rather more difficult than before to decrease the level of contributions.

The situation on stock exchanges has a clear impact on the rate of return of pension funds which itself is decisive for the level of future ”funded” pensions. The difficult situation on the capital market in the first 3 years of

[4] The retirement contribution is 19.52 % of contribution base, the pension contribution further 13.0 %.

the functioning of the new system had an influence on the rather poor performance of the funds[5].

Also the ***social situation*** will remain a challenge for the pension system. The new system should have been an answer to social changes towards individualisation of life, decreasing the scope for solidarity, increasing self-reliance and responsibility for own life. The increased scope for responsibility for one's own future incomes in old age is necessary taking into account the lower replacement rates from the new system. The awareness of that is rather high: 47 % of respondents see the necessity to supplement the retirement pensions from the obligatory system by some additional retirement income schemes (Szumlicz 2001). The effective participation is much lower however, because of limited incomes and should increase with improvement of the income position.

A challenge for the future of the new pension system will result from the increased contribution-pension link and restricted redistribution. This will lead to growing differences in pension level and a growing scope of "underprovison" in old age.

A separate issue remains the pension age for women. As pointed out earlier, given the defined-contribution pension formula, the lower retirement age for women will lead to much lower pensions for them. The growing awareness of that problem may lead to growing support for equalising the age which may also be supported by the gender equality issue in connection with the ***EU accession***, dealt with in chapter 3.2.3.

3.2.2 Financial sustainability

To make the pension system financially sustainable has been the major reform aim of the 1999 pension reform in Poland.

In the long run the open-ended pension funds should contribute to the relieving of the State Budget. The authors of the reform estimated that between 2010 and 2012 the PAYG old-age pension fund would reach a balance (Chlon, Gora, Rutkowski 1999, p. 49).

In the short and medium perspectives the reform has made the financial situation of the Social Insurance Fund worse, especially because of higher participation in the second pillar of people aged 30 to 50 (Table 3.4).

---

[5] The average rate of return during the first two years of functioning of pension funds was 18.1 % or 1.9 % in real terms – Table 5. The best fund achieved 28.3 % and the worst only 1.4 % - UNFE.

3.2.3 Pension policy and EU accession

Direct impact of EU accession will be related to including Poland into the EU system of ***coordination of social security systems***. This will lead to transfers of pensions from Poland to countries to which people from Poland will emigrate. The additional financial cost will be limited, also because Poland already has social insurance agreements based on similar rules with many EU-countries (Markowska, Zalewska 2000)[6]. As employment of EU-citizens in Poland is a very new development, the scale of transfers of pensions earned during their employment in Poland will remain negligible in the nearest future. Joining the coordination system will also cause organisational and thus financial costs related e.g. to training, translation or information systems.

Additional organisational costs will result from Poland's joining the newly started "open method of co-ordination" in the area of pensions in the EU. Even more important, the process can influence in future, as in the case of all member states of the EU, the pension policy in Poland.

An indirect influence of the EU-law outside the area of pensions on the pension system in Poland can concern the issue of retirement age. It seems likely that the different retirement age for men and women will be assessed as being incompatible with equal treatment according to gender. It seems even more likely taking into account the consequences for pension level of women, resulting from the new pension formula.

3.3 Evaluation of recent and planned reforms

3.3.1 Recent reforms and their objectives

Poland has a long tradition of a social insurance which was still present under socialism, although with some important elements of a state redistribution system. The Polish pension system was in a sense between the traditions of "Bismarck" and "Beveridge" (Zukowski 1994).

The transformation process influenced the pension system clearly: number of contributors fell and number of pensioners, also as a result of special early retirement schemes connected with unemployment, rose. This, together with an increase in pension levels, led to a financial crisis (Table 3.3). These were costs of a successful policy preventing incomes of retirees in the difficult time of an economic and social destabilization.

Several reform plans met with political resistance and changes introduced concerned only some parameters of the system, without a structural reform. Unlike many other areas, pension system was reformed only in the "second

[6] The scale of export of pensions to EU countries is estimated to be between 229 and 256 million in 2005. See Markowska, Zalewska 1999.

wave" of the reforms[7]. There are several explanations of the fact that the pension reform was made only some 10 years after the beginning of transformation. First, Poland had inherited from the socialist time an old-age security which was able to function under the changed circumstances, unlike many other areas which had to be built from the beginning, like taxes, banks, capital market or – in the social policy area – labour market policy. Second, exactly for the above reasons, at the beginning of the transformation some important preconditions for functioning of pension funds, which were an element of almost every reform concept, were absent (capital market, banks, insurance). Third, a political consensus necessary for such a deep reform was absent in Poland for a longer period. Still, however, with time the understanding of the problem, especially of the systematic burden of the system, has been growing.

Only work which started in 1996, on the reform concept *"Security through Diversity"* (Office of the Government Plenipotentiary for Social Security Reform, 1997) led to a success. The first plenipotentiary became the Minister of Labour and Social Policy Andrzej Baczkowski. After his sudden death professor Jerzy Hauser took the post (at present Minister of Labour and Social Policy). Between 1997 and 2001 Mrs. Ewa Lewicka held this position.

The main objectives of the reform were both microeconomic and macroeconomic (Gomulka, Styczen 1999). The first microeconomic concern was to create far tighter link between contributions and pensions, thus strengthening the incentive to work and the disincentive to evade (see chapter 3.1.4). The other microeconomic objective was to lower – in the longer term – social insurance contributions paid by the employer, in order to reduce labour costs and to increase employment. The key macroeconomic aim was to lower the level of public expenditures on pensions, as a proportion of the GDP, to relieve public finance for other aims towards growth. The other aim was to induce people to save more voluntarily.

In 1997 the Parliament with the left majority enacted two first acts on the reform, concerning the second and the third pillars of the new system. The centre-right government coming out of the elections in September 1997 completed the work on the reform, through enacting in the end of 1998 two major acts on the system of social insurance and on pensions from the Social Insurance Fund. The new system could come in force, as originally planned, on January 1, 1999. The start of the pension funds (second pillar) was postponed however until April 1, 1999.

---

[7] Alongside the pension reform, in 1999 also three other structural reforms were implemented: the health insurance was introduced, the educational system was restructured as well as the structure and constitution of the state was changed, through the introduction of the second (powiat) and third (voivodship) levels of self-governance.

Several reasons can be pointed out which enabled such a structural change in the old age security system. The first was the critique of the old system, the second one: the reform concept (see chapter 3.1.6). The reform concept was a prerequisite of the laws on the reform which however had to be enacted. This was achieved through an appropriate organisation of the work on the reform and the political consensus.

Especially important was the creation within the government of the Plenipotentiary with a team of experts who were considered as "independent". This helped a lot to reach the political consensus. The reform could therefore be realised as a common work of the two following coalitions in Parliament. An important factor of political acceptance was the stressed fact of excluding the previous retirees and older workers from the reform.

Among actors who played an important role for the reform introducing privately managed pension funds, of course especially representatives of financial institutions should be mentioned. The role of Minister of Finance was important, although it is open whether this is to be explained by the concern about the deficit in the old system: the reform would rather not relieve the public finance in the short and medium term. The engagement of the Minister of Finance can rather be explained by the expected influence of the new system on the economic growth.

The role of the World Bank is often stressed very much in the context of the pension reform in Poland. This role should certainly not be underestimated. Certainly the famous World Bank report did have a big influence on the direction of the reform (World Bank 1994). At the beginning of the reform, the reform team was headed by a Polish expert working for the World Bank (Michal Rutkowski). Nevertheless, the reform concept in Poland differed from the "World Bank concept", especially as far as the first pillar is concerned. Questionable is also the explanation of the role of the World Bank by the high foreign debt of Poland (Müller 1999). It seems that it was also the "modernisation" of the economy and the country which played the main role here (Golinowska 1998).

3.3.2 Political directions of future reforms

The "big reform" has been made in Poland in 1999. As this reform resulted from a political consensus, there are no political pressures on a structural change in that area. There are still, however, some issues discussed at present in Poland which will be described briefly. Unlike in some other areas, like health care, it is difficult to state a clear political partition as far as separate issues of pension policy are concerned.

The new government has changed the structure of the supervision of open-ended funds. The separate agency functioning from the beginning of the reform – UNFE – has been on April 1, 2002 replaced by an integrated Commission on Supervision over Insurance and Pension Funds, responsible for the whole field of insurance and pension funds. This change was seen as politically motivated, as the old UNFE had been headed by persons clearly belonging to the old, right coalition. On the other hand, it has been a solution of a longer dispute between UNFE and the reform team, concerning mainly the consolidation process among the open-ended funds. The authors of the reform, supported by the pension fund lobby, wanted to see the regulation on this issue relaxed, arguing that consolidation of funds should take place and can be beneficial to the insured. UNFE, on the other hand, opposed it, arguing that higher competition means higher security.

Other still open issues are rules on investment of open-ended-funds. Pension funds would like to have the rules relaxed, including increasing the present limit for investments abroad – 5 % of all assets. It has been however opposed both by the Ministry as well as the Supervisory Agency. The whole issue of regulations concerning functioning, especially investment policy of the funds, will however certainly be raised in the future. Pension funds managers have argued that relaxing these regulations, motivated by the security considerations, can be an important way to improve efficiency of the funds, and in that way increasing future pensions.

The lively discussion at the beginning of 2002 on the issue of future pension levels has often led to the conclusion about necessity of development of additional, voluntary old-age security. The Ministry of Labour and Social Policy has announced plans for introducing tax incentives to participate in the ”third pillar”. However reasonable it seems, it will be extremely difficult because of the state budget deficit, also because of additional burden related to the transition costs of pension reform.

Certainly an open issue for the future will remain pensions for women.

An even more difficult question, reaching far beyond the area of social security, concerns the KRUS system of individual farmers. For political reasons, to reach support of the strong party representing the electorate in the agriculture (PSL), this system has remained outside the pension reform issue. It seems unlikely that this will change in the nearest future, taking into account the role of agricultural pensions in supporting incomes of people living in the country, the participation of PSL in the present coalition and difficult negotiations concerning agriculture with the EU.

3.3.3 Conclusions

Poland has a completely new pension system which has been functioning since January 1999. An assessment can therefore only concern the reform

concept and the start of the system, and should be very provisional, taking into account the long-term character of an old-age security system, especially of a funded system.

Provided the old pension system in Poland was unsustainable, its removal through the reform is a success, although of course only if the new system is more efficient than the old one. The new system seems to have some clear ***advantages*** over the old one.

First, the system has introduced a risk diversification because it is partly based on pay-as-you-go and partly on funding, and through this it partly relies on the labour market and partly on the capital market. An obligatory funded scheme is not a part of the European tradition of social security, but funded pension systems, on a voluntary basis, have been developing in many European countries for decades. The situation in Poland used to be different, and the reform can be considered as a method to accelerate the process of risk diversification in the old age security.

The new system acknowledges the self-responsibility and self-provision for one's own old age. It is clearly to be seen in the voluntary third pillar which has been presented in the reform programme as an important element of the old age security. A choice, even if very restricted, is also included in the second pillar (free choice of a fund). Also, in the first year of the reform, the 30- till 50-year-old could choose between an option with and one without pension funds.

Rather unquestionable are the microeconomic advantages of the new system in the first pillar, which are also directly related to the problems of the old system. Through a strict link between contributions and pensions, the new system should create, other than the old one, positive incentives to contribute and to stay in employment longer.

A key role in the reform was played by the concept that the new pension funds would contribute to economic growth, through savings and investment. These advantages, theoretically debatable, can of course not yet be analysed empirically. From the point of view of security, the first experiences with the new pension funds are rather positive which can be attributed to legal regulations and state supervision.

There are, however, also ***disadvantages and risks*** of the reform programme. They concern mainly the second obligatory pillar. These doubts, well known from the international pension debate, concern mainly: level of future pensions, profitability and security of investments of funds, coverage of contributors and, last but not least, transition costs.

Pensions from the new system will be lower than those from the old one and there is a much higher risk as far as the level of pension is concerned, and the risk should be carried by the insured which is an element of the

defined-contribution scheme. The above mentioned stronger link between contributions and pensions will lead to bigger differences in pension level which will lead in many cases to underprovision. Unemployment will also lead to low pensions.

The new system makes the level of pensions clearly dependent on the developments on the capital market and the moment of retirement. The problem is already at the start of the system very clear, because the first results of investments of pension funds are rather poor (Table 3.4).

A questionable element of the new system is the obligatory character of the second pillar. In this way the new Polish pension system combines a pension based on contributions (and through them: earnings) from a pay-as-you-go system with a defined-contribution annuity from the pension fund. This solution differs from the pattern according to which a second pillar is combined with a universal minimum pension from the first pillar. The reform was based on the idea to strengthen the self-responsibility and consumer choice in the old age security. However, the total scope of the obligatory old-age security has not been reduced by the reform. Furthermore the state obliges the insured to a high degree to insure or to save for their old age, although now with a partial self-escape from the direct responsibility of the state. The furthermore large scale of the obligatory system is probably also the main reason for the poor development of the voluntary third pillar. For example, till the end of May 2002 only 164 employee pension programmes have been registered.

The fact that many more people having the choice have decided in 1999 to join pension funds can, on the one hand, be seen as a success of the reform. On the other hand the question arises whether the reform was not ”too successful”. The transition costs and their influence on the public finance are probably the biggest weakness of the reform (see chapter 3.1.3). High transition costs will make it difficult for a longer period, to decrease the contributions to the old age insurance which was one of the aims of the reform.

The implementation of the reform was very weak, especially of the new information system. This has to a large extent contributed among the public to a negative picture of the pension reform. Partly this was caused by the extremely short time between enacting of the last acts in October and December 1998 and the start of the reform on January 1, 1999. Secondly, the leadership of ZUS at that time is responsible for the delay of works at the information system. But also, thirdly, the authors of the reform are responsible for underestimation of the problems of implementation, as if the work on the reform had been completed with the enacting of the acts.

To conclude: ”With some exaggeration, one can say that the pension reform introduced in Poland is an instrument of capital building and of the economic growth rather than a solution of future social problems”

(Golinowska, 1998, p.24). Whether the expected aims of the brave reform will be reached, will however be seen only in future.

Certainly the new system is better than the old one as far as its inner rationality is concerned. Open are however its future consequences for the level of pensions and therefore for fulfilling the main function of the system. In the medium term, high transition costs and their influence on public finance are a big deficit of the reform.

The reform programme can awake interest from outside. Transition costs and implementation should be rather a warning.

4. POVERTY AND SOCIAL EXCLUSION

4.1 Evaluation of current profiles of poverty and social exclusion

The period of transition from the central planed economy to the market together with opening of the economy brought about considerable problems for agriculture and rural population. The profitability of rural production decreased radically, and prior to that ”insatiable food market” had shown its limitations. The improvement of material condition was primarily tied up with the exit from agriculture into non-agricultural economy. Yet, it became far more difficult than in previous years. Internal migrations directed from the countryside to the city stopped, and two-occupational population (farmer-worker population) limited its activity. At the initial stage of transformation process (until 1993) the number of persons working in agriculture had decreased, among other reasons due to using possibilities of gaining pension benefits by elder farmers. However, since 1994 the number of the employed in agriculture has been recorded to grow, due to changes on the labour market outside agriculture and due to some institutional changes on this market. The non-agricultural economy absorbed surpluses of labour resources very slowly and, at the same time, eligibility to benefits for the unemployed was limited by a legal act. Accordingly, the farm of the individual farmer became a ”storeroom” for persons not finding work outside agriculture and, simultaneously, not receiving a status of the unemployed. The result of this situation is a relatively high hidden unemployment in the individual agriculture, by some estimations reaching 900 thousand persons (Kryńska, 1999).

At the same time, mainly due to the collapse of state farms, high open unemployment appeared among rural population not possessing land and not connected with the individual agriculture. As a consequence, poverty appeared in the countryside. Yet, the rural poverty differentiates a lot from the urban poverty. It endangers subsistence to a much lesser degree and to a much bigger extent it is a cultural poverty. Today it is hard to imagine that people possessing even a small piece of land can suffer hunger, but at the same time the phenomenon of limiting to subsistence economy is commonly known. Cash became a deficit and it is the basis of mobility and accessibility of non-food consumers’ goods. Poverty in the countryside has become a larger phenomenon since 1997. At present it affects considerably also farmers’ households. Previously poverty concentrated basically in the circles of former state farms’ employees.

Industry was affected by equally strong changes. Here, restructuring of traditional branches, called the post-Ford transformation (Mingione, 1996) is accompanied by indispensable ownership changes, which, however, makes the process more difficult for coordinated control and social adjustment. Changes in the structure of industry, from the point of view of

consequences for employment has been recently described as a process of creation and destruction of workplaces (Work Bank - Rutkowski, 2001)
In the years 1997-2000 restructuring process in economy were intensified. The characteristics of these processes is their asymmetry, since we deal with a considerable dominance of destruction of workplaces over their creation. In the years 1998-2000 the number of the employed decreased by approx. 360 thousand (estimation – Witkowski 2001).

New workplaces have been up till now primarily created in the private sector and in the services. In the recent years both creation of the private sector and the growth of services have significantly slowed down. In the period 1998-2000 over 80% less workplaces had been created than in the years 1994-1997 – the period of their dynamic growth. The decrease in growth of workplaces in the services had been even bigger – it exceeded 90%. It can be explained by the decrease in the employment in the public sector of social services accompanied by smaller dynamics of growth in the whole private sector.

The growth of labour productivity is the result of restructuring. In the industry, where the decrease in the number of the employed was the biggest (over 550 thousands people in the period 1998-2000) the labor efficiency only in the year 2000 increased by 14% (Witkowski, 2001). This growth of labor efficiency in the industry is a sign of desired modernization of economy; it forecasts higher efficiency of management in the whole economy. However, without the growth of workplaces in other sectors, compensating the decline in workplaces in the industry, this growth brings about disadvantageous effects for the labor market – a dramatic growth of unemployment and poverty.

In general - Polish poverty remains related to the structural backwardness of the economy – relatively high in agriculture and deterioration in industry, as well as to the high regional disparities. The restructuring process of the economy intensified in the second half of the 1990s and brought many difficulties in living conditions, especially for those groups most strongly affected by the changes. At the same time, a large number of threats potentially affecting young people emerged on the labour market. This high labour supply at the end of the 1990s and beginning of the 2000s is not being met sufficient by available jobs. This in turn makes young people susceptible to poverty. However, the rate of poverty among children depends to a large extent on social policy measures. Social policy in Poland today does not give priority to children's well-being.

4.1.1 Social exclusion and poverty within the overall social protection system

At the beginning of the 1990s the existence of poverty phenomenon as a serious social problem was neglected by policy makers. Not till than the

World Bank (1994 - 1995) and IPiSS with GUS (1993-1997) researches have shown the development of inequalities and the increase of poverty scope in the society, policy makers took some decisions about anti-poverty programmes, like for example focused on workers from the ex state farms or on the homeless people.

Combating poverty is not defined as an aim of the social policy *explicitly*. Objectives of social policy are defined in a positive way, for instance - to satisfy important social needs, especially for the so called weak group's of the population: pensioners, young people, *et cetera*.

The term 'social exclusion' is not yet officially defined in Poland. It is however used in the some quality analysis and sociological research.

Views on social changes in the living conditions are surveyed in public opinion polls. One result of such public opinion research on societies perception about individual income pauperisation is presented in Table 4.1.

Table 4.1: Public opinion about the personal income level development (Answer to the question - How is your income in comparisons with the average income?)

Specification	1992 (April)	1995 (April)	1996 (April)	1997 (October)	1998 (Mai)	1999 (Juni)
the same	33	36	34	37	37	27
less	33	34	34	31	28	33
very much less	28	22	19	19	22	25

Source: CBOS 2001 (Falkowska)

4.1.2 National definitions of poverty and social exclusion

In the first half of the 1990s an official criterion of poverty could be derived from the category of the minimum pension, which was defined as 35 % of the average wage. This minimum pension was never officially named the poverty line, but in social policy regulations of that time minimum pension was used as a screening device: to divide applicants who should be helped from those who should not. It means that in practice minimum pension determined an entrance to the social assistance and housing allowances (Topińska 1997). Therefore the World Bank poverty studies in Poland were made on the basis of the minimum pension as the official poverty line (World Bank 1994 and 1995).

The World Bank report ”Understanding poverty in Poland” (a quantitative and very comprehensive study about income poverty on Poland) tried to give the answer who the people with the lowest income are and how their situation has evolved under the first years of the transition, how important

growth is for reducing poverty, how the labour market enables the poor to lift themselves, and to what extent social transfers are targeted to the poor and how they can –given a tight budget constraint- be restructured to reduce poverty (World Bank 1995). Findings of the study based on the HBS individual data gave somewhat a new picture about poverty in Poland. The biggest surprising was that older people are not very poor. The first group of the poor people was the group of the unemployed in the relative young age (more than 1/3 of cases), than people lining in villages, especially peasants and people living in large families (30% of cases). Only 5% of the poor are elderly. The second very interesting conclusion from this study was that Polish poverty is ”shallow”. It means that average income (in the study – households expenditure) of the poor people are only 12-15% less than given poverty line. At that time (1993) shallowness persists also with the use of higher poverty lines. This was an argument that there were no identifiable ”underclass”.

The second important study about poverty in Poland was done by the research institute – IPiSS (Institute of Labour and Social Studies) - loosely affiliated with the Ministry of Labour and Social Policy. 1995/1996 this institute together with the Central Statistical Office (GUS) has been producing the data and quality research about poverty (Polish Poverty I and II). Those studies have contributed to the systematic monitoring of poverty rates according to different poverty lines and different dimensions.

Since 1996 an income threshold, which entitled to claim social assistance benefits, was defined explicitly in the law of social assistance. From that time defining this income threshold we can recognise it as an official poverty line. The level of this income threshold was given as the value of 35% of the net minimum wage as the starting point (1996) and over the time this amount (in zlotys) was indexed by price increase.

Table 4.2: Rate of poverty according to various poverty lines - % of people living on the level and below the level of a given poverty line

Poverty Lines	1992	1994	1996	1999	2000
2 USD per day – the line applied in cross-country researches by the World Bank				1,2 (1998)	
Subsistence minimum	-	6,4	4,3	6,9	8,1
Relative poverty*	12,0 (1993)	13,5	14,0	16,5	17,1
Income threshold entitling to social assistance allowances	-	-	13,3 (1997)	14,4	15,0
4 USD per day – the line applied in researches by World Bank		10,0 (Milanovic 1993-1995)		18,4 (1998)	
Subjective poverty**	32,6 (1990)	33,0	30,5	34,8	
Social minimum	32,4	47,9	46,7	52,2	54,0

* 50% of average expenditure per one consumption unit according to OECD equivalence scales

** % of households, and not persons

Source: GUS, IPiSS, World Bank (2000)

Vulnerable Groups

One of the factors gaining more and more importance as a determinant of the social status, including the material conditions of an individual and the family, is the position on the labour market. Poverty risk mostly affects the people excluded from the labour market by unemployment. Since about the 1980s most new evidence from household surveys suggests that unemployment is playing an increasingly important role as the main cause of poverty, overtaking low incomes (Lipton 1995), primarily across the industrialised countries. In CEE countries unemployment appears to have even graver consequences than in EU countries (Klugman, Micklewright, Redmond 2002). In Poland an unemployed member of the households increases the risk of relative poverty about three times and the risk of extreme poverty - about four times (GUS 2001).

The second group, most affected by poverty and correlated with unemployment in the family, are families with 3 or more children.

Table 4.3: Poverty among vulnerable groups of population in 2000 - % of persons below poverty line

Specification	Relative poverty line	Official poverty line - social assistance threshold
Average of the population	17,1	13,6
Living from unemployment and social assistance benefits	49,1	43,1
Households with at least one unemployed person	36%	-
Low education of the head of household - primary and incomplete primary	28,9	23,9
Rural areas	25,8	20,6
Couple with		
3 children	24,5	19,3
4 and more children	47,9	40,8
One parent family	19,2	15,3

Source: GUS 2001 according to HBS

The older population in Poland is not the most threatened group of the society with respect of poverty, as it is the case in some other post communistic countries. Only subjective poverty of older people is higher than in other groups of the population. This, in fact, is quite understandable taking into account that the health status of older people is often worse and influences their subjective assessment independent from material stress.

Evidence for conclusion appears in all studies of the past years. According to the new GUS estimates low poverty rate for retired people are not different if the old OECD equivalence scale (1; 0,7; 0,5) is used, in comparison with the new equivalence OECD scale (1; 0,5; 0,3) – (see Eurostat 2002 - The Laeken indicators of monetary poverty).

4.1.3 18 EU Indicators of Social Exclusion

The Polish Statistical Office (GUS) has already undertaken co-operation with Eurostat to calculate the EU poverty and social exclusion indicators. The information basis for creating those indicators exists and will be developed. The main information sources for it are: households budget surveys (HBS) and labour force surveys (LFS), which make any differences to the EU appropriate information standards.

By the end of this year (2002) the GUS will prepare the EU social indicators as a first approach.

Table 4.4: EU - Primary indicators

Specification	**Explanation**	**Data**	**Comments about sources**
Low income rate after transfers	Below 50 % of households expenditure using the old OECD equivalence scale	1999 – 17,4 2000 - 18,0	It is systematically calculated based on the HBS data
Distribution of income	S80/S20 Ratio between the national equivalised income of the top 20 % of the income distribution to the bottom 20%	1999 - 4,9 2000 – 5,3	according to households budget survey (HBS)
Persistence of low income	Persons living in households where the total equivalised household income was below 60% median national equivalised income in year n and (at lest) two years n-1, n-2, n-3, by gender		A new panel data of HBS must be created for these indicators. The last one dates from the period 1993-1996
Relative median low income gap	Difference between the median income of persons below the low income threshold and the low income threshold, expressed as a percentage of the low income threshold, by gender	in 1997 - poverty rate at the poverty line as 50 % of median income in 1997 - 13,1%	according to HBS
Regional cohesion	Coefficient of variation of employment rates at NUTS 2 level		A new regional classification must be created according to the NUTS 2 level. By the end of this year it will be prepared.
Long term unemployment rate	> 12 month as proportion of unemployment in the given group	in 2000- total - 41,1 male - 36,4 female - 44,4	according to LFS (IV quarter of the years)
Persons living in jobless households	Persons aged 0-65 (0-60) living in households where is working out of the persons living in eligible households	In 2000 - there were 7% jobless households of the total amount of the households	It is possible to calculate this indicator according to the LFS
Early school leavers not in education or training	Share of total population 18-24 -years olds having achieved ICCED level 2 or less and not attending education or training,		It is possible to calculate this indicator.

Specification	Explanation	Data	Comments about sources
Life expectancy at birth	Number of years a person may be expected to live, starting at age 0	male - 68,8 female - 77,5	GUS - demographic data
Self defined health status by income level	Ratio of the proportions in the bottom and top quintile groups (by equivalised income) of the population aged 16 and over who classify themselves as in a bad or very bed state of health on the WHO definition , by gender	health status good or very good - 44% bad and very bad - 22%	Special research conducted in 1996 by GUS

Table 4.5: EU Secondary indicators

Indicators	Definition	Data	Comments about sources
Dispersion around the low income threshold	persons living in households where the total equivalised household income was below 40, 50 and 70 % median national equivalised income	Not available at the moment	
Low income rate anchored at a moment in time			
Low income rate before transfers	Relative low income rate where income is calculated as follows; -- income excluding all social transfers, -income including retirement pensions and survivors pension, -income after all social transfers (=indicator 1)	h in cash before social transfers including pensions 1999 – 47,7 2000 – 48,8 excluding pensions 1999 – 30,5 2000 – 31,4	GUS - HBS
Gini coefficient	The relationship of cumulative shares of the population arranged according to the level of income, to the cumulative share of the total amount received by them	1995 - 0,321 1997 - 0,334 1999 - 0,334	GUS -HBS
Persistence of low income (below 50% of median income)	Persons living in households where the total equivalised household income was below 50% median national equivalised income in year n and (at lest) two years of years n-1, n-2, n-3, by gender	data for the period: 1993-1996 24 % at lest 1 year in the relative poverty	GUS - HBS panel data 1993-1996

continued Table 4.5

Indicators	Definition	Data	Comments about sources
Very long term unemployment rate	Total very long-term unemployed population (>24 month) as a proportion of total active population, also by gender		It is possible to calculate on the LFS basis
Persons with low educational attainment	Educational attainment rate of ISCED level 2 or less for adult education by age groups (25-34, 35-44, 45-54, 55-64) by gender	Employment rate by primary and incomplete primary education 1995- 36,0 2000- 28,1	GUS- LFS

Main problems of adapting the EU Indicators of social exclusion in the Polish statistics consists of:

- Developing in Poland panel HBS research similar to other EU countries
- Using also income in-kind when defining income of the households
- Using a new OECD equivalence scale, which is not adequate to real situation in consumption of different households members by age and sex. This problem was already earlier explained by some statisticians (for instance Szulc 1998).

The EU indicators are not yet deeply discussed in Poland. A special conference is planed on the end of 2002.

4.2 Evaluation of Policy Challenges and Policy Responses

4.2.1 Inclusive Labour Markets

In Poland is the labour market situation especially difficult because is faced with a huge labour supply for demographic reasons and the intensive restructuring of the economy: heavy industry and agriculture. More noticeable employment difficulties concern the so-called groups sensitive to unemployment. The youth belongs to such groups. The second group is constituted by persons of low qualifications. Raising their qualifications and readiness to be employed is one of most difficult tasks of social policy at the present stage. It is a group the most endangered by poverty and social exclusion.

Table 4.6: The rate of unemployment among groups vulnerable to unemployment differently than on average

Groups vulnerable differently	1993 XI	1996 XI	1997 VIII	1999 II	2000 1st quarter	2001 1st quarter
on average	14,9	11,5	10,7	12,5	16,7	18,2
young (15-24)	31,6	26,2	23,5	28,5	37,9	41,2
female	16,9	13,4	13,5	13,5	18,5	19,8
persons at immobile age (over 45 years)	8,5	6,5	6,5	6,3	10,6	11,9
Poor qualifications (basic and lower education)	15,0	12,9	12,9	11,7	22,1	22,9
in towns	16,9	12,0	11,5	12,9	17,1	19,2

Source: GUS (Central Statistical Office); based on the individual data of LFS

An active job creation would be the best measure to counteract poverty in the current situation in Poland. An upswing in the demand for labour is likely to generate the demand for employment and will affect their income situation.

Active labour market policy (ALMP) would have also certain importance in the current situation but its role is only a complementary. Unfortunately in the last few years there was no emphasis given to active labour market policy.

The national employment strategy (linked to the EU methodology) declared in Poland is now implemented trough the adoption of a specific action program and includes:

- work for young people (the first job programme – implemented 2002),
- labour market flexibility (implemented 2002),
- development of the entrepreneurships (old programme but the realisation rather weak)

Action to improve employment for young people is focused on:

- better educational preparation and adjustment of graduates to labour market conditions,
- differentiating minimum pay for persons just starting their employment to increase job opportunities,
- reducing the employment cost of the graduates by subsidizing their social security contributions

The flexibility of the labour market programme is focused on changes in the labour law:

- to receive greater freedom in firing and hiring,
- to have space in labour law for more sensitivity to different ways of operation in small firms,
- to recognise new forms of labour adapted to the new economy and new technology,
- to improve the definition of forms of self-employment

It is too soon for evaluation evidence to come from these programmes.

The second group of the inclusive labour market state programmes is connected with the rural unemployment and hidden unemployment in the individual agriculture, which according to some estimations reaching about 900 thousand persons (Kryńska, 1999). Those programmes are focused on: (1) to find and to create employment for the unemployed people and (2) to help in changing the transition from the work in agriculture to the non-agriculture work.

In 1998 the Minister of Labor introduced so-called ”special programs” which were targeted at, among other groups, unemployed villagers (including former state farm employees). The target groups for these programs are ones identified as being at high risk of not being able to find employment and also include, for example, persons unemployed for periods of over 12 months, unskilled persons or persons without skills for which there is no demand on the local labor market, and women. These programs are implemented by powiat (district) labour offices and financed from the Labor Fund.

The National Labor Office has been monitoring these programs and estimates that through the end of 2000 449 programs were carried out in all 16 voivodeships (regions) (the largest number was carried out in the Warmia-Mazuria region, which has the highest unemployment rate). Rural participants accounted for 44% of the total number of participants.
The programs are differentiated in character. While the most common consist in the subsidization of the costs of employers who hire unemployed persons, there are also many training programs designed to retrain the unemployed. One such program, called ”A New Occupation – Employment of Villagers”, has been successful in the Lower Silesian voivodeship. The effectiveness of these programs is high; they result in employment for 80 to 100% of the unemployed participants. The problem with the programs is their largely specialized character and the small numbers of participants. Only 20% of the monies at the disposal of the Labor Fund in 2000, for example, were used to support Active Labor Market Policy measures (and only 2-3% of those monies supported training), in spite of the high effectiveness of these programs (Lewitas, Golinowska, Herczyński 2001).

The acquisition of skills useful for non-farm employment for the Polish peasants is a big problem. They are generally relatively poor qualified and there are no appropriate institutions for that because this function is an entirely new one in the Polish adults education system. Vocational retraining for farmers now is carried out by numerous special institutions acting under the supervision of various ministries. The most important is the Agency for Restructuring and Modernization of Agriculture – ARiMR (under the supervision of the Ministry of Agriculture). Although the agency's main purpose is to support small business through the provision of loans, the support of training programs also constitute an important part of its activity. It does so by subsidizing training carried out in agricultural vocational schools. In 1996, for example, around 50% of Polish agricultural vocational schools organized training courses for adults financed by this agency.

4.2.2 Guaranteeing Adequate Incomes/Resources

Income development and income distribution

Beginning of the transition was associated with a dramatic fall of the income of the population due to production crisis connected with the abolishment of previous economic cooperation within COMECON and due to difficulties in the appropriate and quick adjustment to the market mechanism. Some times is this income declining in the transition beginning interpreted as a replacement of the shortage of the consumers goods with shortage of the money.

Table 4.7: Development of the GDP and disposal income in the transition period. Previous year=100

Items	**1999**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
GDP	88,0	102,6	103,8	105,2	104,3	103,3	108,3	106,0	104,8	105,2	102,6
Gross disposal income	80,0-85,0	106,0	99,6	99,4	103,5	106,9	104,8	107,1	104,6	102,8	101,4

Source: Zienkowski 1998, Deniszczuk 2002 on the basis of the national account

The biggest losers group in the decade of transition is the group of the rural people living from the agriculture. People employed in the state farms lost their job "for ever" and they are the candidates for the Polish underclass (Tarkowska 1998). Private peasant due to very weak adjustment to the strong competition in the open agricultural market (huge import of the cheep agriculture product from the West) proved unprofitable. The majority of the peasant population with a small farms (average 7 ha) produce only for the own needs (subsistence economy).

Table 4.8: Ratio of the average disposable income of peasant and other households to the average income of employed households (=1,00)

Economic group of households	1989	1993	1994	1995	1996	1997	1998	1999	2000
Peasant	1,16	0,89	O,87	0,94	0,87	0,83	0,76	0,69	0,69
Self-employed	n.a.	1,24	1,27	1,28	1,23	1,23	1,22	1,21	1,21
Pensioners	0,73	1,05	1,05	1,04	1,02	1,04	0,99	1,01	0,94

Source: Deniszczuk 2002 on the basis of the HBS data from the GUS (Central Statistical Office).

Income differences among the socio-economic group of households are different. The most differentiated group are peasant group, then self-employed. Income of pensioners are not very much differentiated, however there is a significant increase of it. The reasons of that is the pension reform from 1991, which introduced a new pension formula with some equivalence elements and mainly due to dependency of the benefit from the earnings of the finally 10 best years in the individual employment record.

Table 4.9: Gini coefficient within the socio-economic group of households

Group of households	1990	1994	1996
Employees	O,26	0,31	0,33
Peasant	0,34	0, 46	0,47
Self-employed	n.a.	0,37	0,35
Pensioners	0,20	0,27	0,27

Source: Topińska 1998 on the basis of the individual data of HBS produced by GUS

According to quantitative research carried out redistribution of income in Poland has the 'classical' intended effects; taxes take away more from the richer groups of households and transfers (in cash and in kind) give more to the poorest group of them (Wiśniewski /Górecki 1998).

However there is another problem related to redistribution; it is the concentration of cash transfers on only almost one target – pensions (80% - see the table below) and rather limited means for other needs and groups of transferees. As a consequence there are only very selected groups, which receive social benefits other than pensions. For instance less than 20% of unemployed people receives unemployment allowances.

Table 4.10: Structure of cash transfers %

Items	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
cash transfers, including	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
old-age, disability and family pensions	76.5	75.0	75.0	77.2	78.8	80.5	81.2	75.8	76.3	79.5	79.2	79.3
family benefits	15.5	14.7	12.5	10.3	8.6	6.2	6.0	5.7	5.8	6.9	7.5	7.3
unemployment benefits	3.1	7.8	8.3	8.7	8.8	8.8	8.4	5.7	3.0	3.6	4.9	5.5
social assistance benefits	1.3	1.4	1.5	2.5	2.0	2.1	2.5	2.3	2.2	2.3	2.2	2.0
Scholarships	1.3	0.10	0.06	0.05	0.05	0.05	0.05	0.07	0.09	0.09	0.12	n.a.

Source: own compilation (Golinowska / Hagemejer 1999), for the years 1999 - 2001 based on data from MPiPS 2002

Social institutions does not promise to guarantee the benefits or certain level of benefits to anyone. The debate on introducing a minimum income guarantee (MIG) indicates that it is not yet the appropriate moment for that. At the current stage of development costs of the introduction of a minimum income guarantee in the social security system would amount to about 4 % of GDP. Another argument against such a MIG is connected with negative incentives of this measure to escape from social dependency. Any realistic MIG would leave practically no room between the MIG and the minimum wage.

4.2.3 Combating Education Disadvantage

There are two big problems concerning education and poverty in Poland. The first one is related to the poor education of the rural population. The second one refers to a big scale of the basic vocational education based on traditional skills of workers.

(1) The educational problems of the Polish countryside are in turn compounded by the gap in the educational attainments of rural and urban adults. Despite its egalitarian rhetoric, communism did little to equalize the educational chances of rural and urban children, as can be seen from table 4.11. Particularly striking is the fact that in 1988 more than 60 percent of rural adults had completed no more, and often less, than primary school education.

Table 4.11: Level of education of rural and urban adults in 1988 and 1995 - %

Items	**1988**		**1995**	
	Urban	Rural	Urban	Rural
University	9,4	1,8	9,8	1,9
Post secondary and secondary professional	22,6	10,5	24,6	12,5
Liceum	9,3	2,6	9,6	3,0
Basic Vocational	23,2	24,2	24,6	28,0
Primary and Incomplete or no primary	35,2	60,9	31,4	54,6

Source: GUS 2000, Rocznik statystyczny (Statistical Yearbook)

Social survey data also consistently show that rural adults place considerably less importance on education than their urban counterparts and even regard advanced education with some suspicion. Worse, a international survey conducted by the OECD on adult literacy (OECD 1995) revealed that 70 percent of Polish adults could not comprehend simple texts as compared to 32 to 45 percent of adults in other OECD countries. This was in large part due to the poor performance of farmers and people whose education did not advance beyond basic vocational training. Indeed, the test scores of Polish farmers were 40 percent less than those of other occupational groups, as compared 10 percent lower for farmers in other OECD countries (UNPD/CASE 1998)

(2) Rural low educational attainment of rural adults place rural children at a severe disadvantage because so much of children's educational performance depends on the education and income of their parents.

The legacy of educational policy of socialist Poland is the dominance of basic occupational education. The accelerated industrialization of the country lasting three decades (1949 – 1978), with the exceptionally intense phase of the first half of the 1950s, demanded mass increase in the number of high-qualified workers. The model of the basic occupational school and then its mass growth was the answer to this demand. Accordingly, today, among working population of the medium generation the dominance of persons attained only basic occupational education (over 50 % - Cichomski 1998). Politicization of this group (trade unions participation), incomplete acceptance of the market system, especially of its efficiency requirements, as

well as lack of qualification adjustments to the present situation on the labor market currently constitute one of noticeable barriers to better development.

The situation of the current educational process creates also problems of the inequality of chances among the young generation. It begins already at the preschools.

Preschools

In Polish society children were still mainly brought up in their families. Such public institutions as créches and kindergartens were developed in a relatively weak (in compare with other socialistic countries) scale. The share of children attending these institutions never exceeded 50% of the total child population of a relevant age.

Table 4.12: Preschools and Preschool Enrolment in Urban and Rural Areas 1990-99

Items	**1990**	**1995**	**1999**	**2000**	**% Increase /Decrease in compare with 1990**
Number of Preschools	12308	9350	8733	8501	-31
Urban	7009	5625	5453	5386	-25
Rural	5299	3725	3280	3115	-41
Preschool enrollment	856,600	823,200	719,600	688,600	-20
Urban	665,800	661,800	574,700	551,300	-17
Rural	190,800	161,400	144,900	137,000	-28
Children attending preschools per 1000 children aged 3-5	295	272	328	331	+12
Children attending preschools per 1000 children aged 6	952	973	967	954	+0,2

Source: GUS appropriate Statistical Yearbooks

Table 4.13: Percent of 3 to 6 year olds receiving pre-school training

	1990	1993	1995	1997	1999
% Of 6 year olds in zero classes	95,3%	94,9%	97,3%	97,1%	96,7%
Urban*	98,3%	98,0%	102,2%	103,2%	103,5%
Rural	90,8%	89,4%	90,8%	89,7%	88,5%
% Of 3-5 year olds in preschools**	31,0%	25,5%	28,7%	31,3%	34,0%
Urban	40,5%	34,7%	40,1%	44,9%	49,3%
Rural***	17,8%	13,6%	14,1%	15,2%	15,7%
% Of 3-6 year olds in preschool	48,2%	43,6%	45,3%	49,0%	50,8%
Urban	56,3%	51,6%	56,5%	60,6%	63,9%
Rural***	36,6%	33,1%	33,4%	35,0%	35,2%

* some of the above 100% figures for 6-year-olds in urban preschools come from children residing in rural (suburban) districts but going to urban preschools. Some is the result of the enrollment of 5- and 7- year-olds.

** included all of the forms of kindergartens (e.g. part-day care)

*** some of the growth of preschool enrollment in rural areas probably comes from suburban communities that are legally characterized as rural gminas but in fact resemble urban ones in per capita income.

Source: MEN Materials for Sejm, 1996, 1997, 1998, 1999, 2000.

During the transformation era kindergarten evolved into an elite educational establishment because the fees increased dramatically. Kindergartens became a competency of local authorities (*gmina*) (previously they were under the Minister of Education). If a *gmina* was poor and failed to subsidize a kindergarten and parents could not afford the fees, kindergartens were establishments operating on a totally commercial basis or were offered by non-profit and church organizations with a differenced standard or were simply closed.

However the percentage of children receiving preschool education actually rose (see table) despite the closures and after the steep demographic decline of the decade is taken into account. The growth came, however, only in urban areas which were able to simultaneously streamline the delivery of pre-school services and meet the increased demand for them coming from urban workers[8].

In the socialistic period kindergartens were rarely formed in the countryside; the only exception was villages where state farms (PGR) were located. In typical Polish villages dominated by individual farmers, kindergarten groups were sometimes formed at schools. These groups were

mainly active in the harvest season. Such kindergartens were often transformed into zero-grades (preparing children for the proper school) for six-year-olds. Now, in the transition time, this heritage together with the dramatic fall of the income from agriculture production determines the low access of the rural children to the preschool education.

The low level of access of rural children to early childhood education, the poor qualifications of pre-school teachers, the lack of well developed curricula and teacher training programs and the poor state of existing infrastructure (for the evidence see the study of (for the evidence see the study of Levitas, Golinowska Herczyński 2001) ll suggest that there is a crying need to improve pre-school education in the Polish countryside. Indeed, this need is particularly dramatic given the large body of international research (see *Pre-school Education in the European Union: Current Thinking and Provision* – http://www.eurydice.org/documents/preschool/en/1cpren.htm) which suggests that investment in early childhood education is of critical importance in improving the life chances of culturally and economically disadvantaged social groups.

The Ministry of Education has recently begun to recognize this need and to make modest investments in improving the curricula and teaching skills available in rural preschools. The last decision concerns obligation to attend the zero class for six –years-olds and recognize it as a first step of compulsory education.

Primary and secondary schools

Statistically available measures of the effect of educational policy and school system performance are the school careers of graduates once they finish primary school. The following table 4.14 summarizes the choices made by the graduates of primary schools over the time:

Table: 4.14: Structure of further education of primary school graduates-structure %

Type of schools at the secondary education level	**1960**	**1970**	**1980**	**1990**	**2000**
Lyceum general	30	23	21	23	38
Secondary professional (”technicum”)	26	27	36	34	40
Basic vocational	44	50	44	43	22

Sources: own accounting based on the GUS data – Statistical yearbook from appropriate years

From above table we see a great change over transition period in the structure of education after graduating primary school. Almost 80% of

students (lyceum and secondary professional) attend secondary level schools, which grant maturity certificates (*matura*) and thus allow their graduates to enter the higher education system[9], when in the seventies only 50%.

The social problem in this matter consists in rare attending full secondary education of the rural children in compare with their urban colleges. The differences in further school careers between the graduates of urban and rural schools are very clear. Indeed, only 25% of rural children go on to general education lyceum, the most popular school type in the cities (attended by over 45% of urban pupils). On the other hand, over 35% continue their education in basic vocational schools. In contrast, only 20% of pupils in the cities attend such schools. We can thus conclude that rural primary schools equip their graduates rather poorly for the competitive world of general education, either in the areas of self-assurance and education aspirations, or simply in the scholastic skills sphere (or, most likely, both). The performance of rural primary schools must be judged as very inferio (Levitas, Golinowska, Herczyński 2001) r.

Interestingly, most of the primary school graduates who do not continue their education come from urban schools. This shows that the non-continuation phenomenon is related to social pathologies prevalent in the cities and much less apparent (with the exception of alcohol abuse) in the rural areas. The main factors leading to lower participation of the graduates of rural primary schools in the full secondary schools (i.e., schools leading to the maturity certificate) and later in tertiary schools according the mentioned research results (op cit.) are following :

(1) Low level of education of the rural population. It is a well-established fact that a large part of a child's school success is attributable to parental influence. The educational attainment of Polish countryside is extremely low, and can be called catastrophic in comparison to Polish cities.

Another source of such data are the international studies in functional literacy (Białecki 1997) and in (OECD 2001), which put Poland well below the OECD average, mainly because of the low performance of Polish farmers in the functional literacy tests and rural children . In practical terms, this difference translates into additional difficulties that rural students face when they start their school careers. Their homes have very few books and they cannot expect much help from their parents in preparing for school. The difference is exacerbated by inequalities in access to computers at home. The Household Budget Survey (GUS Statistical Yearbook 2000) shows that

[9] However from the formal point of view attending basic vocational school gives some possibilities to continue a education, mainly in the "technicum", but because the different curricula and weak quality of teaching in the most basic vocational schools don't allow be up to requirements of the full secondary school (with matura certificate), such continuation was met rather very rarely.

in 1999, in households with 4 family members, there were, on average, 4.7 computers per 100 farm households. In contrast, there were 32 computers per 100 households headed by white-collar employees and 34 computers per 100 households headed by self-employed persons (Levitas, Golinowska, Herczyński 2001).

(2)The educational aspirations of rural families are much lower that those of their urban counterparts. The child in rural areas is often seen by his parents from an early age as a valuable resource for working on the family farm. The low education aspirations and much lower standards of living are the main contributing factors to the difference in parental expenditures on school aged children. For instance, in the cities 59% of parents pay for additional courses of their children, while in rural areas only 22% do so (CBOS 2000). The willingness to pay for additional educational services is also extremely strongly correlated with parents' education level. It can thus be seen that low educational attainment and poverty in rural families reinforce each other in a vicious circle.

(3) Another aspect of low performance by rural primary school is their low level of academic excellence. For instance, the participation of rural children in various Olympics (in history, mathematics, etc.) is traditionally low, and the rural schools do not encourage their students to compete.

(4) Last but not lest - poverty is also a major factor in school failure. Since the Polish countryside is so much poorer than the cities, the impact on rural students can be very significant. For instance, the school textbooks have become so expensive that often the parents find it hard to buy the full set of required manuals. Whenever the child needs special assistance, the basic condition for seeking it is paying for transport to the nearest cities. Thus, for instance, dyslexia and dysgraphia are very rarely diagnosed and treated in rural schools, although the cities have a nearly universal system of early detection and referral. Children with learning disorders can find support in the cities, but have to travel a long way if they live in villages. The travel costs become a major obstacle.

Policy response

Education was one of the four domains which was deep reformed in 1999. Main element of this reform was the introduction of gymnasiums, a new lower secondary school, and appropriate changes in curricula. The primary school was shortened to 6 years; gymnasium lasts for 3 years, and the new upper secondary schools, the lyceum and the vocational school, are to last 3 and 2 years respectively. Thus the reform left the total teaching time (6+3+3 in place of 8+4 for lyceums, 6+3+2 in place of 8+3 for vocation schools) unchanged, and in fact reduced it for some technical schools (where the students were taught for 8+5 years).

The main aims in introducing the gymnasiums are:

- The modernization of school programs, improvement of teaching quality and of school equipment. The programmatic change related to the introduction of gymnasiums stresses a closer connection between the periods of individual student development and the phases of school career.
- The creation of larger and better-equipped schools in the countryside. It was decided that while shorter primary schools may remain somewhat smaller, the older children (after the age of 13) should attend larger schools, which it will be easier to equip well, for instance in computer laboratories or language classes. Initially, it was assumed that a gymnasium should have at least 150 students, but this and some other requirements had to be abandoned as gminas grappled with the problems of creating the new schools. Nevertheless, as discussed in the main report, the gminas were very successful in creating a rational network of gymnasiums.
- The separation of the young children attending introductory grades from teenagers in the last grades of the previous, 8-year primary schools.

The newly created gymnasiums were assigned to the gminas. Thus, the gminas are responsible for 6+3 years of obligatory schooling. Correspondingly, the number of school years in the powiat-run (district) schools decreased by one year. This shift of one year means that a certain redeployment of teachers should take place between the two tiers of local government. However, it seems that no such transfer is taking place: the gminas are using the additional year to secure work for their teachers, threatened with redundancies as the numbers of students fall. The district (powiat) schools, on the other hand, seem to be generally quite prepared for the structural change.

The first graduates of the gymnasiums will enter secondary schools already in this year - 2002. From 1999 until 2002 should be completed the second phase of the reform, namely the preparation of new curricula, new programs and textbooks. This work is still under progress. Of special importance is the place of vocational and career training in the lyceums. The lyceum students are expected to choose one of the five available profiles: academic profile (identical to the earlier lyceum), technical and technological profile (chemical, electrical, and other trades), agricultural and environmental profile (agriculture, environment protection and similar trades), social and service profile (economic, trade, service trades) and cultural and artistic profile. In addition to the general knowledge necessary for taking the maturity examination, each profile will also contain a number of professional skills.

It is important to realise that the new post-gymnasium schools, which will be established by the self-government at the district level (powiats), will

have to conform not only to the general design of upper secondary schools as formulated by the Ministry of Education, but will also have to take into account the actual situation facing each school. Indeed, there is significant evidence that quite independently of the centrally mandated reforms, and largely on their own initiative, the secondary school directors have for the last few years been engaged in massive redirection of the resources of their schools in an attempt to adapt to local labour market demands. This has resulted in an increase in the number of general academic lyceum students, a decrease in basic vocational schools and many shifts in the trades taught in the schools. Although record numbers of primary school graduates move now to the secondary schools, there is intensive competition for students, and directors reacting slowly to these ”market signals” often find themselves with few potential students interested in what their schools have to offer. This pressure may in the end prove much more significant in shaping Polish secondary education than the overall reform plan of the Ministry of Education.

Education for adults

Education is very sensitive factor influencing unemployment and poverty.

Table 4.15: Structure of unemployment according to the level of education and age.

Education level	Average	Mobility working age	In-mobility working age
Academic	3,8	3,5	3,8
Full secondary	33,1	34,0	30,7
Basic vocational	43,9	45,8	38,4
Primary and incomplete primary	19,2	16,6	26,9
Average	100,0	77,4	21,6

Source: own accounting based on data from LFS; GUS 2001

Table 4.16: Poverty rates according to the education oh the family head 2000, %

Education level of the family head	Used relative poverty lines	Used social assistance threshold as a poverty line
Academic	1,2	0,8
Full secondary	8,2	6,3
Basic vocational	20,9	16,2
Primary and incomplete primary	28,0	23,9

Source: GUS 2001, p. 185

The overwhelming majority of issues related to education for adults are provided under the Education Act (1991) and The Labour Code (1996), whereas education for the unemployed is governed by provisions of the Employment and Unemployment Prevention Act (1994).

The Education Act stresses that the system of education provides adults with the possibility of enhancing their general education as well as acquisition of new professional qualifications and retraining. The Act specifies the definition of recurrent education and points out to diversification of this form of education. Recurrent Education Centres are public establishments focused on providing education to adults. In line with the Education Act schools and private education establishments for adults are also entitled to pursue educational activities, provided they are entered into the registry of the School Superintendent General. The Act also provides terms and conditions for carrying educational activities (excluding schools and educational institutions) which draw on principles specified by provisions on economic activity.

The Education Act commits the Minister of National Education and the Minister of Labour and Social Policy to issue a decree providing principles for enhancing professional qualifications and general education of adults. The decree was issued in 1993 and constitutes an addition to the Education Act and the Labour Code. The decree specifies, *inter alia*, benefits for employees who take up studying. Benefits are much more favourable in case of employees delegated to a school or training by the employer. An employee delegated, for instance, to a school or training, is entitled to obligatory free training leave (in selected cases the employee is also entitled to a several-hour long exemption from work).

Education of adults is also subject to selected provisions of the tax system (from 1991). Natural persons hold the right to deduct scholarship assistance from their income. The scholarship is granted by individual persons as a donation for scientific, technical and educational purposes. Tax relieves related to education taken up by the taxpayer and/ or purchase of scientific aids or books required for work performed by there of are yet another type of facilitation. It should be noted, however, that Polish tax regulations are highly unstable.

The possibility of financing activities related to education of adults for specific target groups is provided under the Act on Incorporation of the Agency for Agricultural Restructuring and Upgrading of 1993 as well as its integral decree. Goals of the Agency include provision of support for agricultural education, agricultural consulting, implementation and promotion of accounting among farmers as well as communicating information and provision of agricultural training courses delivered by state administration, self-government and non-government organisations. Competencies of the Agency particularly include provision of financial

assistance for activities related to enhancement of professional qualifications and retraining as well as practical acquisition of professional skills.

Education for the unemployed and individuals threatened with the unemployment is provided under The Employment and Unemployment Prevention Act. State policy within the scope provided under the act is pursued by a network of labour offices incorporated in 1993. The network constitutes special state administration reporting to the Minister of Labour and Social Policy and consists of the National Labour Office (KUP) as well as voivodship and district (powiat) labour offices (and before the administrative reform - regional labour offices). If labour offices are unable to offer the unemployed jobs which would match their qualifications they are committed to launch and finance training venues for the unemployed as well as grant and pay training allowance. Special programmes (with training included) as well as training courses held at labour clubs are a measure aimed at activation of the unemployed.

Labour offices are entitled to cover the cost of training of persons seeking for a job who do not fall into the 'unemployed' category. The group includes persons who were made redundant, individuals employed by employers facing bankruptcy, individuals entitled to social benefits for miners or receiving temporary guaranteed social security benefit. Training events financed by labour offices should last no longer than six months, although in cases justified by the training curriculum they may be extended to 12 months. The Act also gives a possibility to reimburse 50% of the cost of training to the employees, provided that upon completion of the training employment offered to them will match the subject of the training. Another type of assistance is the possibility of providing the unemployed with a loan to cover the cost of training if the training will make an individual able to take up a job which requires specific qualifications. The labour office may also refund a major portion of the cost of the training or consultations to person who has already drawn a loan from the office to start-up an economic activity.

Training venues and reimbursements of training costs are covered by resources of the Labour Fund.

Provisions on training of the disabled are provided under **the Act on Vocational and Social Rehabilitation and Employment of the Unemployed** of 1997. In line with the act, training for the unemployed disabled or the disabled seeking for a job and being unemployed are organised by district (powiat) labour offices. The cost of the training is covered with resources derived from the Powiat Fund for Rehabilitation of the Disabled. Duration of the training may come up to 36 months. Persons who have lost their capacity of performing their current profession are entitled to training pension throughout the retraining period (1998).

Reorganisation of labour offices is to follow changes introduced by Poland's administrative reform - in 1998/1999. Acts on voivodship self-governments (at regional level) and powiat self-governments (district level) of 1997 imposed new goals on both bodies. Self-governments were committed to undertake activities aimed at unemployment prevention and activation of local labour markets. In accordance with the act on the public administration reform, on 1 January 2000 labour offices become an element of the self-government administration, voivodship labour offices become a part of the marshialship office (voivodship self-government), whereas the remaining labour offices become a part of the integrated powiat administration. This way, also competencies of labour offices related to training for the unemployed become competencies of self-governments.

The evidence of success in such programmes has a modest scale. Some evaluations were made by the National Labour Office (KUP) and MPiPS with the assistance of the World Bank.

4.2.4 Family Solidarity and Protection of Children

One of the factors traditionally correlated with poverty risk in Poland is a large family .

Table 4.17: Poverty rates according to the family type

Family types	**Used relative poverty line**	**Used income threshold in the social assistance 2000**
Marriages without children	4,0 (1996) 4,1 (2000)	2,9
M with 1 child	5,7 (1996) 8,2 (2000)	6,3
M with 2 children	9,6 (1996) 12,9 (2000)	9,7
M with 3 children	19,8 (1996) 24,5 (2000)	19,3
M with 4 and more children	39,2 (1996) 47,9 (2000)	40,8
One parent family	11,1 (1996) 23,0 (2000)	19,4
Average of the households	14,0 (1996) 17,1 (2000)	13,6

Source: GUS based on HBS data

With each line applied, the poverty rate for families with three or more children is the highest, much higher than for an average family and also single-parent families. Poverty rates for families with four or more children are dramatic. The situation of large families become significant worse last years. 40% are living below social assistance threshold income.

In addition to families with many children, single parent families are at poverty risk on a slowly increasing scale. However in the group of those families there are 8% of lone mothers with 3 or more children, which situation is extremely difficult. The comprehensive monograph concerns social policy towards lone mothers in Poland (Rymsza 2001) confirms that single parent families in Poland are not the special vulnerable group in terms of poverty and social exclusion. That group is strong supported by the big families[10] and public policy towards one parent family is relatively very friendly. There are at taxes splitting system for single parent and children. Than payments for some social benefits are longer or higher. There is also possible to receive payment from the alimony funds when the partner don't pay to maintenance their child or children.

According to the population census data, the number of children in single-parent families represented 12% of all children brought up in families in 1988 and almost 13% in 1995.

Social problems exist in the case of abandoned children, especially difficult poverty exists in the case of children in institutions. The main fact is concerns with the growing number of children living without own families. In the transition period the number of children living outside own families is increasing above 10% (Kolankiewicz 1999).

Child welfare institutions are not financed sufficiently by the territory self-government. However at the same time it was developed wide acceptance of new form of rising abandoned children, namely in the foster families, which form are strong supported by the state. In the1990s the number of children in foster families was increasing above 40%. On the contrary the number of adoption is still decreasing (op cit). .

Family policy in 1990s offered very modest benefits. Family allowances were systematically reduced over the last decade. Since 1995 the family allowance were granted exclusively to less affluent families (changing from universal benefits to the selected one). The value of the allowance was set at amount of 21 PLN, indexed once a year in line with the price increase index. Due to the fact that Polish wages have dramatically increased since 1994, price indexation of family benefits has had a negative effect on the benefit-to-wages rate. After two years, the average value of the benefit had fallen to

[10] Typical single parent family in Poland is lone mother, originating from town, living together with own parents or other big family members; sisters or brothers (Rymsza 2001).

approximately 6% of average wages. The principles of the entitlement to family allowances were again changed in 1998 and, as in the socialist era, it was based on the number of children in the family. The relative value of benefits in the years 1999-2001 has again decreased considerably. Family allowance reaches actually about 3% of the average wage.

Table 4.18: Family benefits development

	Recipients (family in 1,000)	Value of the benefit	Relation to the average wage	Expenditure on family benefits in mln PLN
1992	5260	32,2	9,3	
1993	5017	34,7	8,9	
1994	4893	36,1	6,9	2142
1995	3749	44,0	6,4	2174
1996	3827	47,3	5,4	2425
1997	3672	55,2	5,2	2744
1998	3445	63,9	4,9	3044
1999	3049	76,4	4,5	3172
2000	3376	75,3	3,3	3454

Source: own calculations based on data from Ministry of Finance and GUS

Other family benefits focused on family or children are strong targeted: on family with disabled children, single parent family and rarely - large families.

In short - the whole family protection in Poland is changed in the narrow focused assistance. Only families with disabled children have a better protection, however, the needs of public social services for those children are very modest. On the contrary, in this field, we can find a pretty well developed movement of non-profit and self-help organisations.

Table 4.19: Cash allowances for children from different systems of social provision in Poland.

Type of allowance	Conditions of entitlement	Reason or need covered by the allowance	Allowance level	Duration of entitlement
Family allowance	Income threshold - below 50% of average salary per person in family.	For children up to 16 years (or to 24 years, if education is continued)	Determined in fixed sum: Since VI 2001: - 41,2 zł for the first child, - 51 zł for the second, - 63,7 zł for subsequent children.	Maximum for 12 months. Annually reassessed.
Child-care allowance	Medical assessment. No income threshold required.	For permanent care of invalid child, up to 16 years, or to 24 years, if continuing education.	Defined as 10% of average gross salary, since VI 2001 - 135,96 zł per child.	Depending on changes in state of heath of child.
Allowance for children not living under care	Children under care becoming adult. No income threshold required.	For children leaving care (children home or foster family) to become independent.	Determined in fixed sum: Since VI 2001: 1.546 zł.	-
Alimony allowance	Court decision. Income threshold - 60% of average salary per person in the family.	For child upkeep, due to abandonment by parent(s) who is breadwinner.	Individually assessed by court, not higher than 30% of average gross salary.	Annually reassessed.
Allowance for those in families with more than 3 children	Families with more than 3 children, no income threshold required.	For child upkeep at school.	In 1999 r. 160 zł per child.	One-off annual payments during 1999 - 2000 before commencement.

Source: Golinowska / Topińska 2002

4.2.5 Accommodation

Homelessness

Social exclusion as a visible fact has become a phenomena in the 1990s. Homeless people and beggars could be noticed nowadays at railway stations, bazaars and on the streets of large cities. A few very interesting quality researches on those groups were carried out in Poland, mainly on homeless persons (f.e. Przymeński 2001) and long-term unemployed under special circumstances (ex workers from the ex state farms - Tarkowska 2000 and Tarkowska / Korzeniewska 2002 or passivity in the small cities - Frieske 2000) Those studies identify main characteristics of homeless people in Poland. First of all they are any family roots or they were rejected trough own families due to alcohol/drug abuse or violence towards family members. Second – they have abandoned institutions such workers hotel (special homes in communistic epoch for workers from countryside), children homes, psychiatric hospitals or prisons. Those two groups of characteristics occur very often together. . Until now there is noquantitative evidence of homelessness and social exclusion. However MPiPS (Ministry of Labour and Social Policy) is building up a special data base – (POMOST)- about different group of social assistance beneficiaries *inter alia* homeless people. This database is not yet complete.

Accommodation of the poor

Poverty researches conducted by GUS take into consideration evidence about the quality of accommodation of poor households. Such information and analysis is published regularly in the GUS studies and analysis. However, it is difficult to show on the GUS evidence basis that a bad quality accommodation is a factor of poverty and social exclusion. It would be rather easier to show that a long persistence with low income leads finally to poverty and social exclusion.

Table 4.20: Acommodation of the poor households in 1999

Specification	**In the families living lower than relative poverty line**	**In the families living lower than official poverty line**
Average surface of the flat in square meter per 1 person	14,4	14,4
Average number of persons per 1 room	1,8	1,8
Endowment - % of persons living in the poor households with:		
Water-pipe	89	88
Hot water	63	61
Bathroom	67	65
Telephone	33	30
Central heating	45	44
Washing-machine	44	41
Refrigerator	96	96

Source: GUS 2000 – Living condition of the population

Policy response

Housing policy as anti-poverty policy in the 1990s was provided different over the time. On the beginning of transition it was offered a relatively generous but only temporary in the social assistance institution operated programme of the housing allowances, which was introduced for the poor families. 1992 about 1,4 millions people used those benefits. Additionally the government kept still a few years on subsidising housing cooperatives to maintain existing apartments and prevent an excessive rise in rent prices. From the second half of the 1990s the local self-government is responsible to provide housing allowances. 1998/1999 the low about entering criteria of housing allowances was changed with the aim to make a better access for receiving help. It was connected with the negative social consequences of the introducing 1996 the low about eviction if the people don't pay rent.

Table 4.21: Housing allowances

Items	1996	1997	1999
Expenditure on housing allowances as % of GDP	0,1	0,1	0,2
Value of the housing allowance as % of average wage	9,5	9,5	10,3
Recipients	631,4	647,2	729,0

Source: Golinowska / Topińska 2002, p. 47

At the same time new private housing construction in the form of significant tax relief was supported by the state (focused on the middle class). Luxury private housing construction was developing. Estimations of the state support for the private housing construction in form of tax relief and in the form of subsidies for the flat and housing co-operatives amounted 1,9% –1, 2 % of GDP in the years 1994-1998 (Ministry of Finance 1998). Later housing tax relief's were reduced and 2001 abolished.

4.2.6 Ethnicity

Compared to other European countries, Poland is a very homogenous country in terms of nationality. It is estimated that no more than 3 % of the total number of the country's residents represent national minorities include Ukrainians Byelorussians, Lithuanians, Slovaks, Germans and Gipsies. The biggest national minority groups are Ukrainian and Germans. The numbers of those groups can only be estimated (about 3000 thousands each group). The results of the population census 2002 expected by the end of this year will improve the information on the number of national minorities.

Ethnic groups in Poland are rather small but relatively well organised (with exception of Ukrainian probably due to displacement (action Vistula) to the northern part of Poland after the second WW.

The 1990s were characterised by a rapid development of special education opportunities for some national and ethnic groups on the primary and secondary level (UNDP/CASE 1998). Some of the schools for national minorities with native language are even better endowed than Polish one (for instance for Germans). Only the Gipsies don't have own schools (eventually only separate classes) with native language due to communistic legacy and also due to their well known specific cultural attitude towards raising own children. A special assimilation policy towards Roma was provided in the communistic epoch and from that time they use also Polish

as common language and their children attend Polish schools. However about Gypsies (25 thousands according estimation of the Office for the Immigration and Foreigners) we can say that they are somewhat excluded from the society because they are living in a relatively closed ethnic group. Thanks them they have observed their customs and national identity. The last study concerning Roma in the CEE countries showed that a material status of Polish Roma are very differentiated in comparison to the Hungarians or Slovaks. In Poland we can meet very rich Gipsis as well as poor ones. From the quality sociological study of Laskowska- Otwinowska (Laskowska – Otwinowska 2002) we can image Roma attitude towards work. It is probably true that they are discriminated on the labour market but at the same time they rarely look for regular jobs.

Table 4.22: Institutions of ethnic groups in Poland

Minority population group	**Number of national and ethnical associations in Poland**	**Members**	**Number of schools with native language**	**Number of students**
Byelorussian	1	5 190	40	2 904
Kashubian	1	4 700	2	32
Lithuanian	2	2 390	13	636
German	39	311 570	252	23 050
Slovakian	1	3 260	13	471
Ukrainian	3	880	75	2 255
Gypsies	3	13 756	Only classes	
Jewish	4	4 870	(strong assimilated)	

Source GUS 2001 – Statistical Yearbook, p. 118 and GUS 2000

There is one more aspect of ethnicity and immigration in Poland. The closed Polish society in the communistic period developed sometimes unfriendly behaviour towards foreigners looking different than Poles. However the dynamic of the tolerance development in the 1990s according a very comprehensive and famous study of Nowicka and Łodziński (2001) is rather significant.

Table 4.23: Acceptance of foreigners with a different skin colour as Polish citizens - % of respondents

Answers	**Year of research**	
	1988	1998
Yes	70,0	80,6
No	19,0	13,6
I don't know	12,0	5,8

Source: Nowicka, Łodziński, 2001, p.91

Generally speaking there is no evidence of ethnicity as a significant factor of poverty and social exclusion in Poland. In comparison to other factors ethnicity is a very marginal one.

4.2.7 Regeneration of Areas

Poland is characterised by a relatively high degree of regional diversification. This is produced by divergent economic developments of various parts of the country, which had been developing under different historical conditions and dynamics of industrialisation processes. In contemporary Poland one may still find traces of the policy pursued by the partitioning states in the 19th century - the time when Poland was divided by Prussia (later the German Empire), Austria-Hungary and Russia.

The transformation of the economy has born a new territorial diversity. It is connected with the decline of agriculture production and especially the collapse of collective (state) farms. Unemployment indicators illustrated those new differences. The problems of the poor regional development were transferred from eastern part of the country to the northern and northwestern regions. However poverty indicators show the traditional regional diversity also. It is connected with the industrial underdevelopment (in the co-called 'eastern wall' of the country).

Table 4.24: Unemployment and poverty rate by regions in 2000

Regions (woivodship)	**Registered unemployment rate**	**Poverty according to official poverty line**
Dolnoslaskie	18,4	15,5
Kujawsko-pomorskie	19,2	18,5
Lubelskie	14,0	19,2
Lubuskie	21,3	12,0
Lodzkie	16,3	10,6
Malopolskie	12,2	11,6
Mazowieckie	10,8	9,1
Opolskie	15,7	11,3
Podkarpackie	16,2	18,7
Podlaskie	13,8	17,9
Pomorskie	16,6	15,5
Slaskie	12,9	8,8
Swietokrzyskie	16,6	18,3
Warminsko-Mazurskie	25,8	16,7
Wielkopolskie	12,5	13,6
Zachodnio- pomorskie	20,8	14,7
Average	15,1	13,6

Source: GUS 2001

Another "territorial" factor significantly influencing poverty is the urbanisation. The poverty rates is definitely the lowest in large cities with at least 500 000 inhabitants.

Table 4.25: Poverty rates in 2000 by place of residence

Place of residence	Poverty rate according to official poverty line
Average	13,6
Urban areas	8,9
500 000 and more	2,8
200-500 thousands	6,8
100-200 thousands	8,1
20-100 thousands	9,6
20 thousands and less	15,0
Rural areas	20,6

Source: GUS 2001

Territorial diversity was the reason to introduce special instruments in the ALMP framework to equalise employment opportunities. In 1991 the process of supporting communes threatened with high structural unemployment was launched. Structural unemployment was defined as unemployment occurred as a result of concentration and monopolisation of obsolescent industry, liquidation of state farms and major enterprises in a given area. The instruments applied to assist the indicated communes were concerned mainly with providing incentives to investors to create new jobs. In the initial period the incentives mainly included tax breaks under which companies could deduct from their income investment outlays, then regulations allowing for accelerated depreciation and finally - subsidies allocated to communes for investments into infrastructure.

It must be admitted that initially the instruments provided for by legislation were utilised to a small extent in communes threatened with structural unemployment. The learning process was slow and every year a number of communes determined as administrative limits threatened with high structural unemployment was growing.

The interest shown by local centres in being categorised as threatened by high structural unemployment was growing. It was also owing to the fact that the unemployed in these areas became eligible to unemployment benefit for 6 months longer.

4.2.8 Other factors influencing poverty and social exclusion

According to qualitative research about poverty we can state that the main features of the exclusion process is long-term unemployment and passivity towards job seeking and/or inability to work in the demanded sectors of economy. The reason of low employability is not only one. It is a syndrome of a number of common features, like: low human capital, living in a non-urbanised area, alcohol abuse or chronic illness and some times disability. If we are looking for instance only at the social assistance recipient group, which have alcohol dependency problem, we can observe additional exclusion-born problems: loneliness and rejection by families due to imprisonment or a long-term absence from family life, for example due to job migration (internal and foreign). A big majority of those people are men (Frieske 2000, Sowa 2002).

The MPiPS during the mid of the 1990s tried to set up some policy instruments focusing on the so-called critical unemployment cases ("hard-to place" groups). The Ordinance to the MPiPS Act from 1995, for instance, provided special measures in such critical cases. Funds from the Labour Fund in the amount of 10% of total expenses on ALMP are allocated to employers to encourage them to employ: long-term unemployed, with low qualifications, single parents, persons from families where both spouses are unemployed, unemployed graduates, ex-prisoners, army leavers (ex-soldiers)

and those who remained jobless after the liquidation of state farms. Now, in a period of high unemployment, there are not sufficient means for such instruments.

Quite interestingly, the Polish research does not confirm the often used thesis about feminization of poverty. However in the latter case there is evidence that in some backgrounds the phenomenon occurs. From that point of view Polish women are in a worse situation than women from other countries of the region (Domański 2002), but it cannot be yet verified on a general scale.

There is more and more evidences about violence against women and children in the families which can be cause of the falling into poverty and exclusion situation. Statistics of the violence facts are not sufficient because in Polish very traditional society from the point of family values, women rarely claim violence facts and the acceptance of the claiming behaviour is rather weak, also in the public institutions. Numbers in the below presented table show a relative decreasing of the ascertained crimes in complete preparatory proceedings refers family violence but it can not to evidence the declining of the family violence phenomenon. It rather reflects the known institutional difficulties of treatment with this problem in Poland, which have strongly occurred in the end of 1990s.

Table 4.26: Ascertained crimes

Ascertained crimes in completed preparatory proceedings by type	**1990**	**1995**	**1999**	**2000**
(1) total	883 346	974 941	1 121 545	1 266 910
(2) of which cruelty to family member or to other dependent or helpless person	12 838	21 775	22 710	23 308
Relation (2) to (1)	1,45	2,2	2,0	1,8

Source: GUS 2001

The most important problem in the Polish family live is alcohol abuse. In summer 1998 on the sample of citizens over the age of 18, alcoholism is seen as the fourth of the most important problems affecting the country (Sierosławski, 1998). Alcoholism (9,9% of answers) is behind the violence on the streets (20% of answers), unemployment (18,4%) and decrease in living standards (10,2%). Respondents were also asked of the problems they evaluate as the most important for their local community. In the local community context alcoholism is assessed as the second (15,1%), behind unemployment (22,7%) of the most important problems.

Alcohol abuse is a main reason of the violence in the families. According to estimation of the State Agency for Prevention of Alcohol-Related Problems (PARPA) about 2 millions people (mainly women and children) are victims of the alcohol abuse (www.parpa.pl)

Social policy towards alcohol abuse and violence in the families is concentrated on supporting different activities of the civil society. One of this activities consist of the establishment of homes and shelters for the victims of family violence. There are some spectacular example of those activities of a few NGOs and church organisations in this fields but the needs are much bigger than possibilities of the social organisations.

4.2.9 Administration, Access to and Delivery of Services

In the Polish social security system there are developed tree branches of institutions with the aim to alleviate poverty. The first of those institutions is the Protection of the Unemployed. It was built assuming that unemployment is only a temporary phenomenon.

The second one is family protection. Previous universal family policy in the 1990-ties was transformed into policy of poor family protection. The third one is Social Assistance, which was created as a final safety net. All those institutions are decentralised. Most of them were decentralised in the period 1998/1999. It means that at territory self-government level (exactly district level) it is possible to co-ordinate the anti-poverty policies. Monitoring and evaluating the effectiveness of the anti-poverty policy at the powiat level has, however, not yet been completed.

4.3 Evaluation of future challenges

4.3.1 Main challenges

The main challenge for social inclusion policy in Poland is to create work for the younger generations. It needs not only a higher economic growth but also many actions to improve employment for young people, for instance: better educational preparation of graduates, motivation instruments for the mobility, flexible combination of job and education, et cetera.

The second challenge for social inclusion policy in Poland is to create job opportunities for the so-called "hard-to-place". To introduce appropriate programmes for such groups is not easy. Such programmes are rather expensive and in the current situation with very strong budget constraints, it is difficult to receive political acceptance for actions focused on "hard-to-employ" groups.

4.3.2 Links to other social protection policies

Reforms in the pension system and health care, which lead to privatisation of the social insurance to a certain scale, will influence the difficult social

situation of the people excluded from employment. Probably in the future the old generations will experience problems with poverty and social exclusion, what is not the case now.

The new pension system based on the defined contribution principle could have disadvantages for all groups of people having low earnings and breaks in the employment record. Women are a typical group with such features. According to the simulations of the Institute on Market Economy Studies (IBnGR) in Danzig the average old-age pension for women in the new system will be about 50% lower than for men, if the wage and employment record differences between men and women remain the same (Wóycicka 2002). One aspect of those differences is connected with the lower statutory retirement age of women, which has been kept also in the new reformed system. In the future, this situation can lead elder women into poverty risk. Understanding the consequences of new regulations in the pension scheme as disadvantaging for women is not common. For instance trade unions were against the equal statutory retirement age principle for both sexes. The explanation for that is connected with the role of women in the Polish family. In the circumstances of underdevelopment of many care institutions an elder women is a good "nurse" at the same time for her (or her husbands) old parents and grandchildren.

4.3.3 Political directions of future reform

The main political and social purpose at present is a significant improvement of the labour market situation. In order to achieve this aim the Polish government prepared a few programmes which will be discussed in turn: first job for young people, reducing barriers for the enterpreneurship and to make the labour market more flexible. Among them there was a project to reformulate some articles of the labour code to create more possibilities for employers to employ and to hire people in accordance with the needs of the enterprise, which was latest enacted (Summer 2002). This programme has born an opposition from the trade union side, but finally a compromise with the employers organisation and government was achieved.. In the new labour low there is some articles which allow first of all to use more flexible forms of employment than earlier.

4.3.4 Social exclusion, poverty and EU accession

EU Accession brings hope and risks. Expectations are connected with the implementation of the European social model. Another element evaluated as positive is the free movement of labour. However, it will be not implemented just after accession, but civilised European labour market development (without illegal jobs and discriminating behaviours towards foreigners) seems the biggest expectation in the opinion polls about accession in Poland.

Risks are connected with the higher unemployment as a consequence of the open international competition in the economy and with the strong requirements of healthy and safety conditions at work places.

5. HEALTH CARE

Twelve years after the initiation of political system transformation, Poland's health care does not at all resemble the post-war system, fashioned after Siemaszko's Soviet model of a service that was centralized and served the creation of a new "socialist society". The disintegration of the socialist order in the 1980s significantly affected the health care system. Growing discontent of the public with the level and quality of care created not only a necessity, but also an opportunity for discussion. Various ideas were offered for curing the "sick" system, either through limited reforms or through a radical modification.[11] The process of working out a new health care system started even before Poland officially disposed of the socialist political and economic order. One of the first steps in this direction was the passage by the Polish parliament of the Physicians' Chambers Act of May 1989, which, along with the Pharmacists' Chambers Act and the Nurses' and Midwives' Self-Government Act of 1991 provided the foundations for an internal organisation of self-governing bodies and professional organisations of medical personnel. The Nurses' and Midwives' Act and the Medical Profession Act of 1996 determined formal requirements for medical professionals serving within the health care system, but more importantly, they also established the conditions for private practices, also known as individual practices. The administrative system reform changed and defined anew the responsibilities of individual levels of central government and local governments regarding health care. New legal provisions were introduced for in-company health care provision, mental care, transplantations and blood banks.

The key factor in the forthcoming evolution of the health care system was the Health Care Institutions Act of August 1991, which introduced a formal separation into service providers and fundholders, emphasizing the right of different, not only public, institutions and organisations, to create health care units and increased the range of independence of integrated health care units, even those that formally remained under the control of public authorities. The crowning effort of the reform process was to be the introduction, as of January 1, 1999, of universal health insurance stipulated by the act of parliament dated February 6, 1997.

5.1 Evaluation of Current Structures

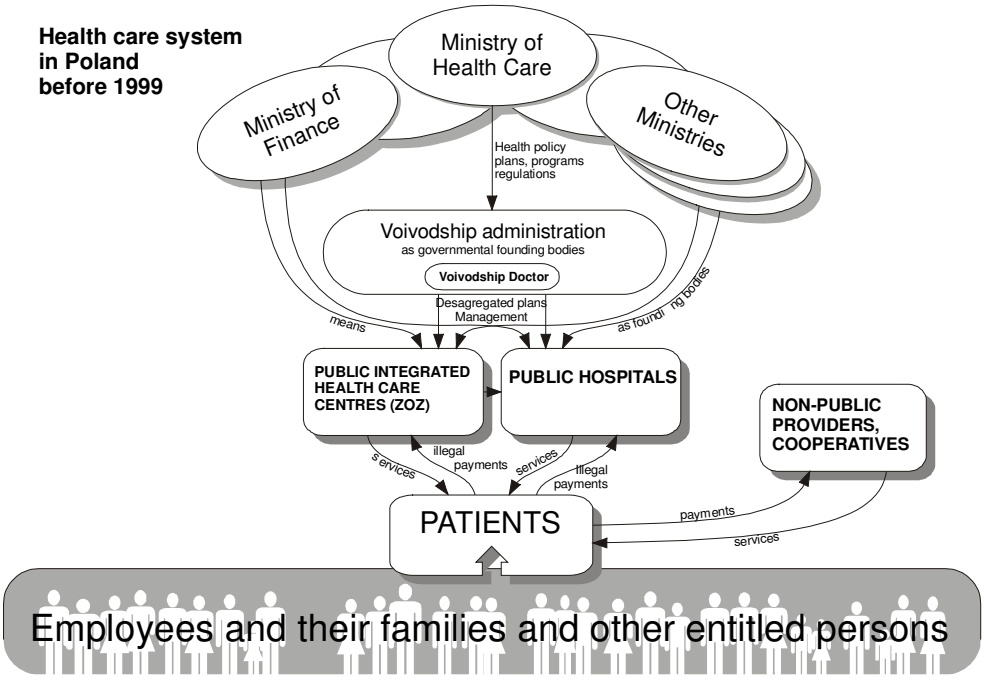
Till 1999 the Polish health care system was dominated by the state on the central level (government). Health services were financed in general out of taxation. Medical treatment was not always free of charge. Especially of drugs for most patients operated a sliding scale of charges. Because of the low level of services and the shortages in respect to health services in the

[11] For a more detailed account of debates concerning health care system reforms in the 1980s and 1990s see Włodarczyk (1998), pp. 121-313.

official sector under-table-payments to have the access to services of a good quality were common feature of the system.

The Ministry of Health Care provided health care however, there were a number of other state agencies as well, e.g. Ministry of Education run the school medical service, Ministry of Defense provided the treatment for military. The production of services was dominated by state institutions. Primary health care and outpatient specialist care was organized in special state centres called Integrated Health Care Centres (ZOZ) acting on the local level. They were built of several Local Health Care Units (przychodnie rejonowe). Some large state enterprises provided health care for their employees. The hospital care was organised by Ministry of Health, other ministries (sectoral hospitals) and the voivodship doctor as regional agents of the central administration. Private and physician co-operative practices were existed legitimately, but only on a limited scale.

Figure 5.1: Organisation of Health Care System in Poland before 1999

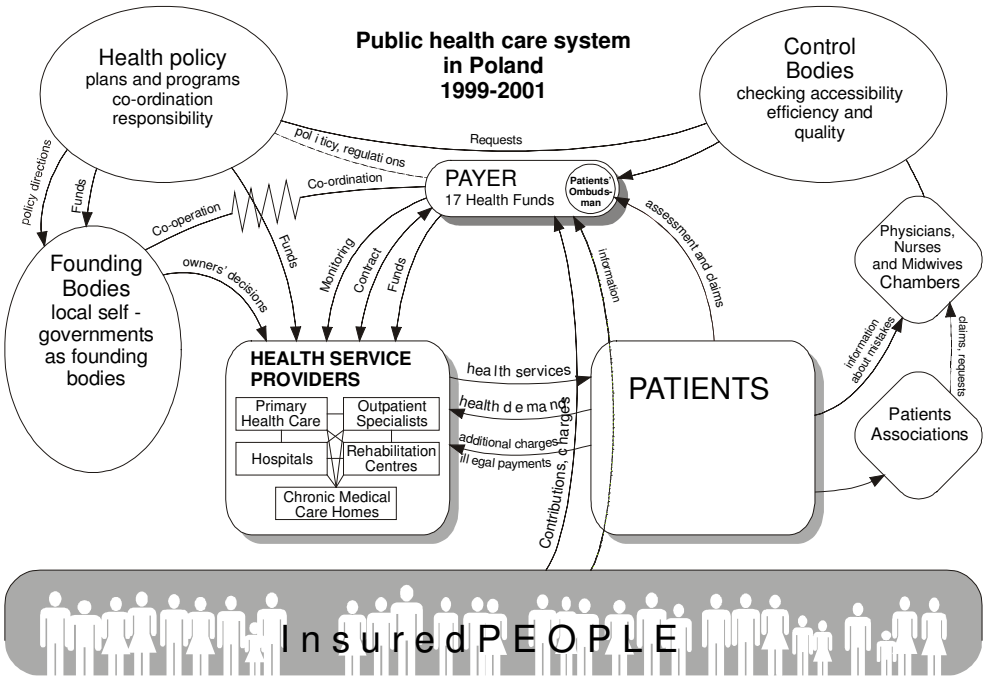


*) As founding bodies ministries, voivodships and another public administration bodies are setting up and running public health care institutions (e.g. public integrated health care centres and public hospitals).

5.1.1 Organisation of the Health Care System

The present structure of health care in Poland is a combination of the German system (social health insurance), the so-called internal market model (contracting for services at provider level) and the market model (purchasing health services by patients), with a number of elements of state regulation. In a theoretical classification of health care systems, Poland's organizational scheme can be described as a "mixed three-side system".

Figure 5.2: Organisation of Health Care System in Poland



The first side, in very general terms, involves Polish citizens, who perform four roles essential for the functioning of the health care system:
patients to whom health care is provided,

- direct payers obliged to pay for a number of services themselves,
- insured individuals and insurance contributors, and
- voters who have a say in deciding as to the further developments in the system.

Service Providers

The second side of the system is made up of service producers/providers organised into thousands of private and public health care units, medical and nursing practices as well as other operational forms. In the outpatient sector and in the area of provision of medicines, private property dominates the market, whereas the inpatient sector is dominated by public health care

institutions founded, in a technical sense of the term, by local government agencies, voivodes (local representatives of central government), Polish Rail management, ministries or state administration agencies. For the vast majority of hospitals, their founding bodies are local government agencies at various levels: voivodship, powiat (county) or gmina (district). Most public health care units are managed as independent entities with a separate legal status. Independent health care units are self-financing, but in the event of an operating loss, their founding bodies are obliged to cover it. But the actual poor economic standing of the majority of founding bodies makes the help for the providers rather unrealistic. Independent health care units own their movable property. As regards land and buildings, they enjoy an inalienable right to use them. Independence also involves the right to appoint unit management, the right to follow independent employment and remuneration policies, as well as the right to make autonomous decisions regarding the distribution of profits.

Primary Health Care

The first pillar of health service provision is made up by the so-called primary health care ensured by individual and group practices of first-contact physicians, as well as nurses' and midwives' practices. Primary health care physicians, also known as first-contact physicians, or family doctors, should, by definition, be the gateway to the health care system. Their main responsibility, above and beyond providing primary aid and the treatment of simpler conditions, is to guide the patient through the health care system as such, i.e. to refer the patient, whenever necessary, to specialists and hospitals.Many PHC doctors are self-employed, but most of them are employed by Public Integrated Health Care Centres. The PHC doctors are paid on the base of per capita financing model (see chapter 5.1.3.).

Increased importance of primary health care was to be the answer to the qualitative and quantitative disparity between specialists and general practitioners who were able to provide wide-ranging care to patients, which was widely perceived until 1998. Comprehensive primary care faces many difficulties, owing, among other things, to the absence of qualified family doctors. The deficit at present is estimated at around 14.5 thousand out of the 20 thousand needed.[12] Without raising the profile and professional status of family doctors, this gap is unlikely to fill quickly. Besides, the gatekeeper function of family doctors in the system has been reduced over the recent years by extending the list of specialists whose services can be used by the insured without referrals from their first-contact physician.

[12] It was assumed that each family doctor should have about 1900-2000 patients under his/her care.

Outatient Specialist Care

The second pillar of health service provision is the so-called outpatient specialist care that provides specialized services, diagnostic services, specialized outpatient treatment and dental services through individual and group practices as well as through integrated health care units. All insured persons have direct access to some of those specialists, to others they need referrals from other physicians working within the health insurance system, such as first-contact physicians. Many specialists are self-employed, but most of them are employed by Public Integrated Health Care Centres. The dominating method of payment here is fee for service (see chapter 5.1.3.).

Hospitals

The third pillar of the health care system is made up by inpatient care, mainly hospitals. Following the Minister of Health's decree, Poland's hospitals were divided into three reference levels. The theoretical categorization standard was the range and type of services offered. In practice, the reference level of a given hospital was usually decided by the status of the its founding body: a vast majority of gmina, city and powiat hospitals were classified as the first reference level, voivodship hospitals - as the second reference level, whereas hospitals whose founding bodies were agencies at ministerial level, such as University hospitals and hospitals affiliated with research institutions, were established as the third reference level. Such division plays an important role in the overall system since it determines the rates that each hospital obtains from the sickness funds for each admission or a service provided. Nonetheless, the reference level is not synonymous with the quality and level of services provided. Only about 30 hospitals of more than 800 are private hospitals. The dominating method of payment in the hospital sector is the fee-per-admission method (see chapter 5.1.3.).

Health care reform forced the inpatient sector to carry out a far-reaching programme of restructuring the ward system, which manifested itself, among other things, by the division of inpatient care into acute care, long-term care, day-care hospitals, nursing houses and palliative care centres. At the same time, the number of hospital beds was reduced, especially in paediatrics, gynaecology/obstetrics and surgical wards (see tables 5.16-5.21 in the Annex to chapter 5). Likewise, foundations were laid for the introduction of external quality control conducted by the Centre for Monitoring Health Care Quality in Kraków, which grants accreditation to hospitals. Gaining accreditation, subject to the fulfilment of a series of requirements and standards, which, among other things, comprise the structure and partly the quality of treatment, may be considered as a certain

indication of the level of services provided.[13] Regrettably, obtaining such accreditation by hospitals is not obligatory. Optional external quality control causes that assessed are only the "better" hospitals, i.e. those that have undertaken appropriate actions geared towards improving the quality of their services.

Other Providers

Apart from the three above-mentioned pillars, the system contains a broad range of institutions and units providing health services. They are, among others, emergency aid units, especially ambulance units, the Central Airborne Rescue Group and other entities (including units that belong to non-public providers), pharmaceutical wholesalers and pharmacists that enjoy an exclusive right to trade in medicines and medical supplies,[14] health spas and sanatoriums, as well as emergency care services usually operating as part integrated health care units.

The Third Side

The third part of the health care system in Poland involves institutions entrusted with the fundholder function, central government agencies and local governments.

Sickness Funds

The mainstays of the system of financing health care are universal health insurance institutions - sixteen regional and one branch sickness fund gathering first of all but not only professional soldiers, policemen and their families.[15] Sickness funds are independent of central authority quasi-fiscal institutions that operate on the principles of self-government and self-financing. They are not profit-oriented, but they have to implement the standards of economy and goal-oriented activity. Their most important mission is to finance health services for patients insured in them. Sickness funds cannot, by law, manage their own health care institutions.

On the basis of relevant information concerning the health needs of the insured populace, the funds contract for services by entering into agreements

---

13 As at January 1, 2002, CMJ accredited 51 hospitals, i.e. around 5% of all hospitals in Poland.

14 Only pharmaceuticals and medical supplies entered in the Register of Pharmaceuticals and Medical Materials can be sold by pharmacies, unless a special authorisation on the part of the Minister of Health has been obtained. Establishing a pharmacy or a wholesale pharmaceutical outlet requires a concession. Some pharmaceuticals can also be sold, by way of an exception, by herbal shops, cosmetic outlets, specialised medical provision outlets and trading networks.

15 The area of operation of individual Sickness Funds basically overlaps with the administrative division of Poland into 16 voivodships.

with individual producers of those (regulated market). The process of contracting for services starts with competitive tenders, which are supposed to ensure public funding to service providers. Competition on the market is, in principle, geared towards an optimal allocation of limited public funds to ensure highest possible quality combined with the lowest unit price. However, it is the individual fundholders that decide as to the level of provision of health services, even though, legally speaking, they should be following, for example, voivodship guidelines as to the minimum levels of outpatient service provision.

Sickness funds are obliged to balance revenues against expenses. The sources of revenue are health insurance contributions, incomes from bank deposits and government bonds, interest on back contributions, donations, endowments and other funds provided as compensating income (see also chapter 5.1.4.). Their expenses include, for the most part, the costs of health services for the insured populace, the funds' own operating costs and those of its branch offices (especially the upkeep of real property), salaries, overheads on salaries, allowances and reimbursement of travel expenses, provisions for the reserve fund, compensations, refunds of services supplied by other sickness funds or institutions in cases set by relevant legal provisions and funds earmarked for compensating income.

Sickness funds report to the Office for the Supervision of Health Insurance (Urząd Nadzoru Ubezpieczeń Zdrowotnych, UNUZ). The Office, as a central agency of government administration, oversees the activity of funds from the standpoint of legality, purposeful activity, economy and integrity of records kept. The Office also reviews and accepts statutes of individual funds, resolutions taken by their governing bodies, financial plans and reports on plan execution. In individual cases, the Office may place a given fund under receivership effectively depriving it of its independence. The Office does not coordinate, however, the activity of individual funds. Such coordinating activity was performed by the National Union of Sickness Funds until its dissolution in June 2001.

Central Government and the Ministry of Health

The absence of coordination in the area of ensuring health care to the public and vaguely defined political responsibilities for its implementation appear to be the most significant flaws in the present system. Although the Constitution provides that political responsibility for ensuring health care is borne by the state, in 1999-2001 Polish government withdrew not only from coordinating the activity of individual parts of the system, but also abandoned all forms of active promotion of any health policy, leaving the latter at the discretion of individual sickness funds. Nonetheless, the official legal scope of responsibilities of the Ministry of Health and Social Welfare is extraordinarily comprehensive. It includes the determination of main health issues and needs of the populace by planning, contracting and

overseeing the implementation of health care programs, including the National Programme for Health, determining standards for the provision of health services, overseeing professional medical training, the development of new comprehensive solutions, the development and implementation of restructuring and privatisation programs, the review of the contracting process, the monitoring of health services with a view to encouraging desirable features of the health care system, and many others.[16] In addition to their political functions, central government agencies other than the Ministry of Health, perform the roles of fundholders in the system and founding bodies for a number of health care institutions.

Local Government Agencies

The concept of a third side also includes local governments. As provided by legislation, local governments perform primarily organisational functions in the area of health care. As founding bodies for a majority of public units, they oversee and control their activity, as well as create, transform and disband them. In addition, local governments participate in financing health care through covering insurance contributions and paying for services provided to people not legally obliged to be insured, for the organisation and financing of the sanitary inspection authority, ambulance services, trade medicine and many other activities.

5.1.2 Financing Health Care

Public Funds

Universal Health Insurance

The most important public fundholders in Poland's health care system are the sickness funds. Revenues of those funds in 2001 were estimated at PLN 26.7 bil (as per financial plans). 95% of the amount, i.e. around PLN 25.3 bil, the funds planned to spend on financing health services provided to entitled individuals. 96% of total sickness fund revenues come from health insurance contributions. At present, the rate stands at 7.75% of taxable income. For individual taxpayers the contribution can be deducted from the tax due.

Broadly speaking, insurance contributions are based on gross income of the insured, which is also subject to personal income tax and social insurance contribution. Taxable incomes for social and health insurance, respectively, are not identical, though. For health insurance contributions, taxed are all sources of income that entail an obligation for such insurance.

---

[16] A detailed schedule of responsibilities of individual departments of the Ministry of Health is quoted by Dercz and Izdebski (2001).

Likewise, health insurance contributions are not quantitatively limited (without ceiling), which is the case with social insurance.

For old-age pensioners and recipients of incapacity benefits, taxable income equals basically the amount of pension and the benefit, respectively, excluding entitlements, other benefits, direct payments and allowances for utilities. Taxable income for the unemployed equals the amount of their unemployment benefit. For undergraduate and graduate students who are not insured contribution-free by their families and for the unemployed ineligible for the unemployment benefit, the tax base is assumed to equal the amount of a relevant social welfare benefit. Self-employed pay the health care insurance contributions on the same rules as employees. For individuals insured optionally (a very small group of about 1-2% of inhabitants, see chapter 5.1.4.), the tax base is their declared income, which cannot be less than the average salary in the entire economy.

Special regulations apply to non-specialising farmers. Farmers' contributions vary by the area of cultivated land, soil class and the price of rye. Unlike the rest of the insured public, legislators provided for a ceiling in individual farmers' health insurance contributions at the standardized level of income obtained from 50 reference hectares. Other than that, social insurance contributions for farmers are entirely financed from the state budget.

Central Budget Funds

The second public fundholder in the health care sector is the central (governmental) budget. Budgetary provisions for 2001 contain several expenditure items directly related to health care. In the chapter of Ministry of Health Care the biggest individual ones are designed to cover the costs of highly specialized medical procedures (around PLN 550 mil), financing of health programs (around PLN 507.5 mil), expenditures on university and general care hospitals (total PLN 114 mil), blood banks (close to PLN 88.5 mil) as well as expenses related to AIDS treatment, drug abuse and alcoholism prevention (almost PLN 44 mil). In other chapters of the budget (e.g. in National Defence and Internal Affairs) planned expenditures on health care exceed PLN 50 mil.

Reserve budget funds are not directly earmarked for financing health care, but are intended for restructuring the health sector and health care units (almost PLN 400 mil), for transforming health care facilities into social welfare units and for ensuring the continuity of services (around PLN 28.5 mil). Over PLN 200 mil was earmarked for financing physician probation practices, and over PLN 650 mil on teaching-related activities in medical universities. Some of those funds eventually flow into the health care sector, especially to University hospitals.

On the basis of the budget account it can be estimated that the total health care expenditures of the central budget amount to PLN 2-2.5 bil. (around 1.5% of state budget expenditures, about 4,7% of total health expenditures and 0.25% of GDP).

Local Government Funds

Another public source of financing of health care are the budgets of local governments. Health expenses of local budgets for the year 2000 totalled PLN 2.698 mil. Most expenses of local governments involve property maintenance, with a relatively small portion being spent on financing services for the uninsured part of the populace and those people who cannot meet the service costs themselves.

The organisation of available data related to the allocation of local government health care spending does not allow for a precise determination of what part of those funds was used to finance health care directly. However, on the basis of individual budget account numbers it can be estimated that the total amount exceeds PLN 2bil. (about 4,7% of total health expenditures).

Private and Other Funds

The most recent calculations available based on household expenses polls conducted by the National Statistical Office date back to 1999 and estimate the total of private expenses of patients at around PLN 13.4 bil.[17] The index of financing health care directly from patients' pockets reached the level of 51 % in 1999, but it must be borne in mind that the index tends to underestimate the true volume of those expenses as it does not take account of persons living outside households and people from the highest income brackets who, traditionally, use only private health care.

Apart from direct purchases of health services, private funds tend to finance various kinds of foundations whose statutory activity includes supporting individual health care facilities. It is estimated that in 1999 alone contributions of Polish patients by way of semi-legal extra payments for services obtained especially during in-patient treatment totalled at least PLN 1.6 bil. In the same year, informal and illegal payments described as "proofs of gratitude" and straightforward bribes were estimated, in inpatient sector alone, at over PLN 3 bil. (Czapiński, Panek 2001).

Yet another source of financing health care is the units' own business activity that involves the sale of services to payers other than sickness funds, institutions connected with the central and local budgets and private patients, such as companies that purchase services related to specific

[17] Cf. Golinowska et al. (2001).

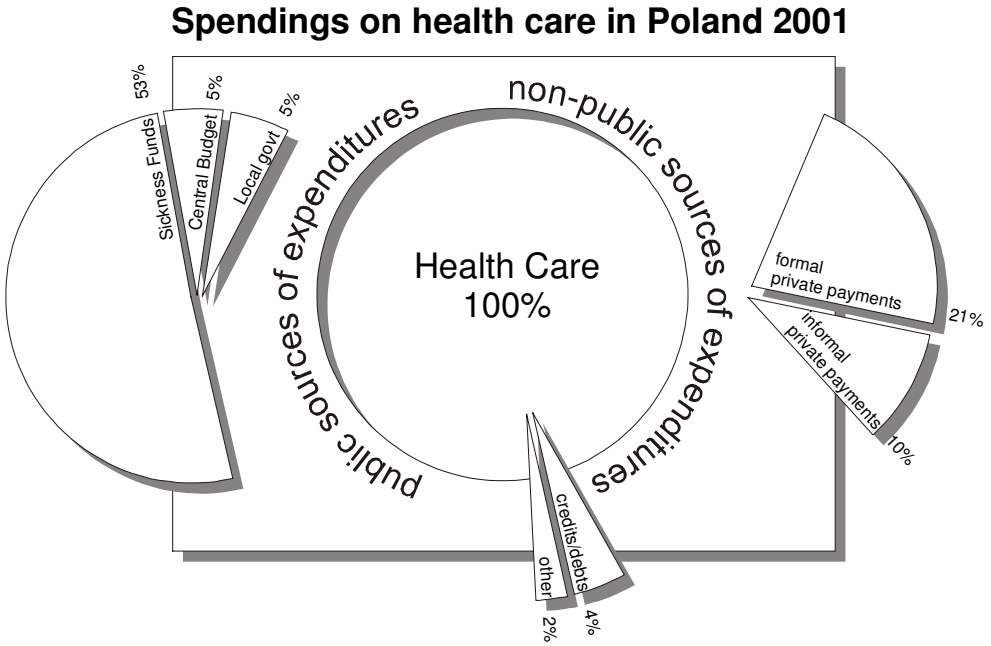
professions. On the basis of polls conducted in 2001, this source of financing can be estimated at over PLN 1 bil in the hospital sector alone. Moreover, the health care sector is a recipient of funds from domestic and foreign charities, such as Caritas, the Red Cross, and various public actions, such as Wielka Orkiestra Świątecznej Pomocy (a fundraising musical event).

Lastly, there is debt financing, such as unpaid liabilities to suppliers of medicines, equipment, utilities, etc. The debt level of public health care units exceeded in 2001 the level of PLN 5 bil, of which around 40% was incurred only in 2001.

Total Spending on Health Care

Let us try to estimate the total public expenditure on health care in Poland. Public spending on health care in 2001 reached the level of around PLN 30 bil (sickness found +central budget +local budget). If we assume that official individual expenses of Polish citizens on health care still total 51% of public expenditure, they would have exceeded PLN 15 bil in 2001 (legal and semi-legal and illegal). Further, if we add extra credit financing (around PLN 2 bil) and other sources of financing (PLN 1 bil in the hospital sector alone), the total spending on health care exceeds PLN 48 bil and constitutes over 6.6% of GDP. On the other hand, public expenditure totals around 4.15% of GDP.

Figure 5.3: Approximation of total spendings on health care in Poland 2001



Directions of Spending in Health Care

The most significant portion of health care spending on the part of sickness funds - PLN 11.7 bil (46.2% of total spending on health care) - is consumed by inpatient care.[18] Second comes spending on refunding the cost of medicines, which exceeds PLN 5.2 bil (around 20%). Slightly above PLN 3.1 bil was spent by the sickness funds on financing primary health care (12.3%), while less than PLN 2 bil (7.9%) was assigned to specialized outpatient care. But, since some sickness funds (e.g. the Pomeranian Fund) transfer part of the funds earmarked for financing specialized care to first-contact physicians, who subsequently finance some consultations and diagnostic procedures from their own budgets (system fundholders), it is impossible to accurately isolate those two spending routes solely on the basis of financial plans developed by the funds.

In 2001, sickness funds planned to spend somewhat more than PLN 900 mil on financing dental care (3.6%), spa resorts were granted around PLN 400 mil (1.6%), while emergency aid received around PLN 1bil (3.9%).

The presence of sources other than sickness funds that finance health care in Poland causes that total spending on individual types of services is different from expenses sustained by the funds themselves. On the basis of information from those funds as well as polled hospitals, total official revenues of the hospital sector in 2001 can be estimated at PLN 13.5-14 bil. This amount does not include the debts incurred by hospitals throughout 2001 or unofficial payments (the so-called "proofs of gratitude" and bribes).

If we assume that the structure of individual spending on health care in 2001 did not differ significantly from the spending structure in the last quarter of 1999, to the expenditures of sickness funds on medicines we can add almost PLN 8.3 bil from patients' own pockets. Thus, the total spending on medicines used outside the hospital sector exceeds PLN 13.5 bil and constitutes almost a quarter of all spending on health care in Poland (excluding spending on medicines by hospitals).

In the area of dental care, private spending estimated at PLN 2.6 bil, and significantly exceeds public spending by sickness funds. In the last quarter of 1999, private consultations, usually with specialists, cost Polish patients 10.7% of all private spending on health care. Extrapolated onto 2001, this yields an extra PLN 1.6 bil. The amount needs to be augmented by around PLN 400 mil spent by individuals on laboratory tests, imaging and other diagnostic procedures. All quoted figures, apart from those related to sickness funds, remain estimates. Given the present state of statistics and data-gathering mechanisms it is impossible to determine them more accurately.

---

[18] All data quoted in this chapter comes from 2001.

5.1.3 Incentives

In the domain of primary health care, all sickness funds have adopted the per-capita financing model. For each registered patient on the so-called active list, first-contact physician practices are paid a pre-determined amount. Additionally, since 2000, sickness funds have broadly adopted the principle of diversifying the per-capita rates in line with patients' age. For elderly persons and children of up to six years of age, the rates are higher. Some funds have also broadened the range of services financed from funds designated for primary health care to include specialized services. Each fund calculates its rates independently. The rates differ not only among the funds themselves, but also between individual physicians contracting for services with the same sickness fund.

The per-capita financing mechanism in general does not entail the danger of increased medically unjustified demand for medical services. As a rule, low rates paid out by the funds, do not motivate the providers to produce higher quality services. In the case of sickness funds that oblige primary health care to finance some specialized services, access to the latter is made significantly more difficult, as first-contact physicians refer patients to specialized consultations and diagnostics with exceptional reluctance. On the other hand, first-contact physicians who cover only their own operating costs from their budgets, demonstrate a tendency to refer patients to specialists and hospitals all too quickly.

As regards specialized services, sickness funds usually pay for each individual visit or service provided (fee-for-service system). This mechanism, although under ordinary circumstances encourages inflated demand for services instigated by the providers, in Poland has not posed a significant threat to the financial standing of the funds, as they have imposed quantitative limitations on visits and/or services sometimes so drastic that the waiting period for some specialized services exceeds six months.

In inpatient care, the prevailing mode of financing is the fee-per-hospitalisation system. A majority of sickness funds diversifies the rates depending on hospitalisation time, ward type and hospital reference level, but not on diagnosis type. Occasionally, admission limits payable at full rates are introduced, and admissions that exceed a given limit are reimbursed at reduced rates. The fee-per-admission system motivates hospitals to increase the number of hospitalisations over and above medically justified levels, especially that advance restrictions announced by the funds concerning non-payment for exceeding the limit of admissions or reduced rates for the latter are not always followed up in practice. Only in 1999, the number of admissions increased on average by 6,5% on the previous year. 2000 saw yet another increase, almost by 6%. Every ex-post increase of limits by the funds causes hospital management to behave strategically, which entails increasing the number of admissions and moving patients into wards that are "more profitable". Even though in 2001 sickness

funds intensified the differentiation of rates by pegging them to the duration of treatment in particular wards, hospitals still win by admitting patients for a short time instead of providing outpatient services, even though this is possible in a number of cases.

Some services, especially treatment in cost-intensive wards (e.g. intensive care units) and long-term care wards, are financed on a person-day basis. This method of financing motivates hospitals to maximally increase bed occupancy and extend hospitalisation as much as possible. The rates offered by the sickness funds for this kind of services must be very attractive indeed, since Polish hospitals show perceptible preferences for this kind of wards.

In recent years, the stability of sickness fund finances has been seriously threatened by refunding the cost of medicines, on which the funds have no influence whatsoever as it is the Minister of Health who draws up the lists of refundables. Attempts to persuade physicians to prescribe less expensive medicines undertaken by e.g. the West-Pomeranian Sickness Fund caused conflicts and a sharp reaction on the part of the Office for the Supervision of Health Insurance, which prohibited such actions. Meanwhile, spending on refunding the costs of medicines in 1999-2001 increased by over 57%.[19] Such an increase, predictably, must have had an impact on financing other areas of health care. Joint responsibility for this particular development is borne by politicians, physicians, opinion leaders and pharmaceutical companies which aggressively promote and introduce new and ever more expensive medicines in lists of refundable medicines as well as in various ways encourage physicians to prescribe specifically those. Inspections conducted by sickness funds have revealed massive abuses of the system, especially in the area of refunding the costs of medicines prescribed to disabled war veterans.[20]

5.1.4 Benefits, Coverage of the System and Access to Care

Every individual has the right to health protection. All citizens, regardless of their material status, are guaranteed by the government equitable access to health care financed from public funds. The conditions and range of services provided are determined by relevant legislation. The above declarations establishing the right to health care are part of Article 68 of the Constitution of the Polish Republic (1997). The Constitution does not, however, guarantee access to all services, neither does it ensure financing all of them from public funds. The range of services and their accessibility depend on whether or not a given individual is insured.

---

19 It is hoped that thanks to drastic changes in the lists of refundable medicines introduced in the spring of 2002 the upsurge of costs related to refunding will be somewhat reduced.

20 10% of the sickness fund budget allocated to refunding medicines covers the needs of eligible war veterans and some members of their families. The group constitutes only 0.34% of all insured persons. See Bochenek (2001), p. 27.

Universal Coverage

Compulsory Universal Health insurance covers almost all Polish citizens resident in Poland as well as foreign persons resident in Poland who have a working visa, permanent or temporary residence permits if they have to be insured or insure themselves optionally. No health insurance contributions are payable on family members of insured persons (e.g. children and spouses) if there is no obligation for them to be insured separately. After many modifications, the list of persons who have to be insured includes several dozen social groups, starting with hired labour, farmers, private entrepreneurs, the unemployed, pensioners and recipients of various benefits, ending with officials of various state services and forces. Although persons exempted from universal health insurance can insure themselves on their own accord, frequently they choose not to do it, consequently, the absence of a statutory obligation to be insured is tantamount to the absence of cover in the event of a sickness.

Polish legislation does not provide for opting out of the public system by taking out private insurance. The Universal Health Insurance Act provides that all insured individuals can choose the sickness fund into which they wish to contribute. Sickness funds, on their part, are obliged to accept as members both persons resident within their area of operation and, on application, persons resident outside. In practice, though, the freedom of choice is substantially limited by the regional organisational structure of the sickness funds.

Range of Services for the Insured

The insured persons, pursuant to specific provisions, are eligible for free physician consultations, diagnostic tests, treatment (inpatient, outpatient, home visits and as part of emergency services), rehabilitation, nursing services, obstetrics and gynaecological care, prenatal and postnatal care, care during breastfeeding, initial assessment of the health status and development of the newborn, preventive care, provision of medicines and medical materials, provision of orthopaedic and auxiliary equipment as well as technical means of treatment, official pronouncements regarding the health status of individuals, palliative and hospice care and community health services. Principles governing the provision of those services are listed in relevant acts of parliament and executive orders that accompany them.

Outpatient services

The Universal Health Insurance Act stipulates that the insured persons may choose primary health care physicians, dentists and specialists from the roster of doctors who have contracted for their services with the relevant

sickness fund.[21] Switching allegiance between first-contact physicians within less than six months entails a registration fee equal to 2.5% of the average salary.

Specialized outpatient services are provided on referral from physicians contracted by the sickness fund, except in cases where no such referral is needed, including gynaecology, obstetrics, dentistry, dermatology, genitourinary medicine, oncology, psychiatry, ophthalmology, detoxification, AIDS and TB treatment, as well as the treatment of disabled war veterans. In a majority of cases referrals are made out by first-contact physicians, and the referral applies to an entire range of health services related to the treatment of the condition stipulated in it. Referrals are also needed for diagnostic tests, outpatient treatment, rehabilitation and hospital admissions, except for services provided in emergencies.

Inpatient Services

Patients may freely choose hospitals they wish to be admitted to, the only condition being that the target unit has contracted for relevant services with a sickness fund, which may or may not be identical with the one that the patient is affiliated with. An amendment to the Universal Health Insurance Act of July 20, 2001, removed the provision obliging patients to refund the difference in treatment costs if they choose to be admitted to hospital with a higher reference level than that specified in the referral. This change abolished unjustified discrimination against patients from smaller localities and counties who were forced to use the services of county hospitals of a lower reference level than those directly accessible to patients from present or former voivodship centres.

Dental Services

The insured have the right to free basic dental care and basic dental materials. The Minister of Health is responsible for drawing up a list of those basic procedures and materials.

Medications

Sickness funds refund in part or in full the cost of around 2.300 of medicines specified in the list of refundables. For some of these, patients pay only small lump sums, in other cases 30 or 50% of their prices, as provided by relevant executive orders issued by the Minister of Health. Separate provisions apply to several social groups, including e.g. disabled war veterans, who are entitled to free refundable medicines and persons suffering

[21] It is this provision that restricts the freedom of choice of sickness funds. In reality, the insured persons may only choose among the funds that have contracted for services with doctors practising in their area of residence.

from several chronic diseases. Such lists of refundables also apply to the provision of medical and orthopaedic equipment.

Extra Services in Health Care

Extra services which are not paid for by sickness funds as part of health insurance are, among other things, services rendered by the medicine of work, statements of eligibility for driving licenses as well as other decisions and certificates issued to the interested party if they are not related to further treatment, rehabilitation, incapacity to work, continued education, participation of children, students, teacher trainees in sports, organized recreation, or if they are not issued for the purposes of social welfare or obtaining a nursing benefit, health services in spas and sanatorium hospitals, unrelated to direct reasons for referring patients to spa treatment, preventive vaccinations other than those stipulated by other regulations, services beyond established standards and other services, medicines and technical means of treatment financed from the central state budget. Similarly, sickness funds do not cover the costs of patient treatment abroad, unless international agreements provide otherwise, neither do they finance the costs of stay and food in care and treatment facilities and nursing care facilities.

The list of non-standard services includes emergency services except for accidents, injuries, emergency life-threatening circumstances, sudden deterioration of health status and services related to pregnancy and labour, plastic and cosmetic surgeries in cases where the condition is unrelated to a congenital fault, injury, disease or treatment effects, sex change operations, dental services that in excess of the basic range as well as acupuncture, except those related to pain treatment.

The Range of Services Available to Persons without Health Insurance

The range of services available to persons who are not insured is significantly narrower than that available to the insured ones. In emergencies, conditions related to accidents, poisoning, injuries, labour and life-threatening situations, both physicians and health care units are obliged to provide appropriate aid to all patients, including the uninsured ones. Even though the Universal Health Insurance Act provides that uninsured patients must cover the costs of services provided to them and, in the case of patients unable to cover such costs, their treatment should be refunded from local government resources, the reality is such that health care units must take into account the prospect that they will not be reimbursed for their services. The right to medical aid in life-threatening situations is also regulated by the Code of Medical Ethics.

The right to free treatment regardless of insurance status is enjoyed by patients suffering from tuberculosis, communicable and sexually transmitted diseases, AIDS, mental conditions and undergoing treatment for addictions.

Treatment costs of insured patients are borne by sickness funds, whereas the state budget pays for the uninsured ones. The law also provides that all citizens enjoy equal access to services paid for by the state budget, including highly specialized procedures, such as organ transplants. However, in many cases this is only a formal right since the uninsured persons are not entitled to public financing of several procedures, including the preparation for highly specialized ones.

Paralegal Limitations to Accessibility of Services

The most serious restrictions on accessibility of medical services are not those related to legal regulations, but difficulties connected with obtaining referrals and the build-up of queues. The waiting period for certain medical services depends on the type of service and place of residence. The emergence of regional discrepancies in accessibility of services follows from at least three reasons. First of all, each sickness fund follows an independent policy of contracting for specific types of services. Depending on how many services of a particular type are contracted and how this compares against the health needs of insured persons, accessibility of services is either easier or more difficult. Another reason lies in differences in the financial standing of individual sickness funds. Despite the introduction of equalization settlements among sickness funds aimed at improving the financial situation of sickness funds (the equalization settlement redistributed 2001 about PLN 1 bil. - ca. 3,7% of total revenues of the sickness founds) that insure more elderly people, (above 60) and persons who pay lower contributions, the funds differ in terms of available per capita funding adjusted for age.[22] In

[22] The equalization settlement among sickness funds based on the following algorithm:

$$(pw)^n = w * \left[\frac{\sum_{n \in N} P^n_{[+1]}}{\sum_{n \in N} S^n_{[-1]}} * S^n_{[-1]} - P^n_{[+1]} \right]$$

$(pw)^n$ - amount which the sickness fund *n* has to pay to (with minus) ore will get from (with plus) the equalization settlement,

$$w = \frac{(100 - a)}{100}$$

a – part ot the total contribution revenues which is taken into account by the equalization (now 60%),

$P^n_{[+1]}$ - expected (planned) contribution revenues of the n-sickness fund for the year of equalization,

$S^n_{[-1]}$ - the "corrected" number of insured people:

$$S^n_{[-1]} = \frac{u^{n,\leq 60}_{[-1]} + k * u^{n,>60}_{[-1]}}{d^n}$$

$u^{n,\leq 60}_{[-1]}$ - number of people below 60 insured in the n-sickness fund (on June, 30th. of previous year),

consequence, their capacity to contract for services differ, which, in turn, leads to inequities in accessibility of services. The third reason is related to unequal territorial distribution of health care units and medical staff, especially those capable of delivering more complex, specialized medical care. Given the relatively low patient mobility, access to many services in rural areas (especially in the former state-owned farms in northern and southern Poland) is much more difficult than in developed regions and big cities traditionally better equipped with health care units.

5.1.5 Public Acceptance for the System

Of the four grand reforms introduced by the right-wing coalition in power from 1997 to 2001 (pension system, administrative, educational system and health care reforms) the health system reform is universally considered to be the worst prepared, the worst implemented and the least successful. Many political commentators consider this to be the main reason for the defeat of the coalition in parliamentary elections of 2001.

In opinion polls conducted two years after the reform was introduced, as many as 62% of the public polled replied that the new health care system performs much worse than the pre-reform system. About 70% of Poles feel that the health care system, especially the public sector, does not work properly. Yet at the same time 57% of citizens fear that subsequent changes, which have already been announced (see 5.3.2.), will cause and even greater chaos and damage.[23]

There are many reasons for such a low degree of public acceptance for the present system of health care and such a negative perception of reforms. No doubt, the most important ones are rooted in great expectations aroused before the introduction of universal health insurance, but which, to date, have remained largely unfulfilled. The majority of the public expressed their dissatisfaction with the way the health care operated before the reforms were implemented. People expected the reform to facilitate access to health care and to curb corruption. Instead, the reform started amidst organisational

---

$u_{[-1]}^{n,>60}$ - number of people above 60 insured in the n-sickness fund (on June, 30th. of previous year),

k – so called "age-corrector", k=2,5679,

d^n - so called "income corrector":

$$d^n = \frac{\dfrac{P_{[+1]}^n}{u_{[-1]}^{n,\le 60} + u_{[-1]}^{n,>60}}}{\dfrac{\sum_{n\in N} P_{[+1]}^n}{\sum_{n\in N}\left(u_{[-1]}^{n,\le 60} + u_{[-1]}^{n,>60}\right)}}$$

[23] Cited data come from various public opinion polls conducted by the Public Opinion Research Center (CBOS).

chaos and absence of many crucial executive orders. Legal loopholes appearing time and again, unclear formulations and errors in the Act itself have forced politicians to amend it frequently, which, predictably, makes informed participation in the system more difficult. Most Poles felt insufficiently informed and during the first stage of reform, which was decisive as to its success or failure, did not know their rights and duties. Limitations on services, chaotic contracting policies linked with a huge dose of uncertainty on the part of service providers caused not only frustration among their staff, but also great difficulties in accessing specialized services. Promised increases in health care funding are confronted current with economic stagnation and crisis on the labour market. Public discontent intensifies owing to ever-increasing patient participation in the costs of health care within the system, especially as regards the purchase of medicines. Patients also feel helpless against service providers, especially in cases of medical errors. Protection of patients' rights in Poland is still underdeveloped and unsystematic.

5.2 Evaluation of Future Challenges

5.2.1 Main Challenges

The main challenges faced by Poland's health care system are, among others, the restoration of public trust and a sense of security in providing for the most basic health needs. Without such trust and a degree of stabilisation, the health care system will be constantly exposed to "broadsides" on the part of various demagogues trying to make their political capital on public discontent and impatience.

Poles have got used to having the state responsible for their health. For this reason, 72% of Poles demand that comprehensive responsibility in this area, including its financial aspect, should be returned to the state. Yet a very difficult financial situation of the central budget precludes a significant inflow of public funds into the system, although this has continually been announced in various political documents, including those promulgated by the central government. What is thus needed is a gigantic informative effort geared towards increasing the public awareness of the impossibility to finance health care entirely with public funds. The most pressing need is to detail out the basic level of services guaranteed to all patients and financed with public funds. Until the present, however, all the governments of the Third Republic have, more or less skilfully, avoided the issue of Guaranteed Health Services Act, content to leave the rationing of those to the sickness funds.

Since all promises to increase global spending on health care must be considered empty, whatever *can* be done *must* be done in order to optimally utilise the means that the system does have at its disposal. The reform process forced almost all service providers to start accounting for costs and

react to financial stimuli conveyed by fundholders. The latter, however, have not yet learnt how to use their power. They still have a lot to do in the area of shaping financial mechanisms that would allow for optimal use of available funding.

Still another challenge is posed by the development of a workable and efficient data collection, flow and processing system in the area of health care. Poland's health care reform, one of whose elements was to be the adjustment of treatment capacity of the system to actual health needs of the populace, was introduced without a proper assessment of those needs. All activity undertaken in order to institute a national system of information about the health needs of the public and the means of catering for them (the so-called Register of Medical Services) have abysmally failed. Some sickness funds have managed to create their own information banks, regrettably, even in this respect, their statutory independence causes that the existing systems are incompatible and do not provide a full range of comparable information concerning the health status of the populace, main threats and theoretical demand vs. actual use of services. Political tensions between central government, local governments and sickness funds additionally threaten the existence of those incomplete information systems.

One of the most taxing social problems in Poland is gigantic unemployment fuelled by baby-boomers entering the labour market. As a result, the revenues of sickness funds drop in line with increased spending on services. Additionally, Poland is gradually affected by changes in the demographic structure of its populace. Polish society is growing older. Even though it does not have to entail a drastic explosion of health care costs, it poses a serious enough threat to the system based on the pay-as-you-go principle.

Challenges to health care are great, and they do not all derive from the emergence of new diseases. Perceptible impoverishment of large social groups with concomitant neglect of preventive and promotional activities in health care entails increased risks of re-appearance of diseases caused specifically by poverty, such as tuberculosis and many communicable diseases. Despite numerous political declarations, the unhealthy lifestyle of most Poles remains unchanged. To date, no solutions have been offered to the problems of alcoholism, smoking and greater susceptibility to cardiovascular diseases and some types of neoplastic diseases (e.g. lung cancer) in Poland as compared with some Western European countries.

A lot remains to be done in the area of obstetrics and infant care. Although the infant mortality rate has been halved over the past ten years (from 19.3 per one thousand of live births in 1990 to 8.85 in 1999), it still remains much higher than that in most member countries of the European Union.

Polish health care has no workable system of medical emergency service, which is drastically apparent in the event of sudden increases in occurrences of particular conditions, e.g. heart infarcts, road and work-related accidents. Although there exists a model of integrated medical service based on that operating in the European Union, supported by relevant legislation, its actual implementation has been delayed until 2003 for financial reasons.

5.2.2 Financial Sustainability

An assessment of stability and sufficient funding levels may be conducted from two points of view: that of needs and that of the actual capacity of the system. As is generally known, health needs are, in principle, unlimited. The aim of each health care system financed with public funds cannot be to fulfil all the needs of the public, but only to ensure a basic standard of care to all who need it, at a level that the public can afford.

Poland spends about 6.65% of its GDP on financing health care, including public expenses estimated at about 4.15% of GDP. Given other social and economic needs, as well as the overall economic condition of the country, it appears that Poland has reached an upper limit in terms of its financial capacity. Under these conditions, the most important objective in this area is not to seek new sources of financing, but to ensure current levels of financing and a more effective distribution of available funds. Every recession and economic stagnation, every crisis on the labour market under the present system causes almost catastrophic consequences for health care financed from contributions linked directly with gross income of the populace. There is no guarantee that in order to salvage the central budget the contributions in the future will not be reduced, as was the case in early 2002, when the health tax base for several social groups, whose contributions are paid for by the state budget, were lowered.

In order to ensure financial viability to the system, one option might be to transform informal payments from patients, such as bribes, into a formal source of financing, such as additional insurance after defining basic insurance coverage. Even so, such a move is likely to face a strong resistance on the part of those professional groups that gain most from corruption.

5.2.3 Health Care Policy and EU accession

The Maastricht treaty gave the European Union supranational powers in the areas of disease prevention and health promotion, but an overall European health policy is far from unified, and legislation concerning the ways of organising medical services and health service differs by country and is likely to remain so for a long time. Hence the process of adjusting Polish regulations to Union directives applies to "peripheral issues" of health care, e.g. the free flow of goods and services, social policy and employment,

insurance market regulations, food, medicines, medical supplies, chemical agents, cosmetics and mutual recognition of medical qualifications and patient rights rather than system organisation and financing. Legal adjustments should present no problems, but whether Poland is capable of fulfilling European technical and sanitary norms, is still doubtful.

On the other hand, Article 2 of the Treaty entrusts the Union with ensuring a high level of social welfare, Article 3 stipulates a high level of health insurance, while Article 11 of the European Social Charter guarantees people's right to receiving health care. Consequently, even if all member states have the right to implement their own solutions in the area of organising and financing health care, according to the subsidiarity principle, they are obliged to ensure quality in this area. The creators of Poland's health policy should also consider overall political, economic and organisational accession criteria, such as guaranteeing fundamental democratic rights (freedom of choice), respect and protection of patient rights, equitable access to services, long-term financial stability, the capacity of the system to adjust to changing demographic, social and economic conditions and constant efforts to rationalise and optimise the system.

Another problem may be posed by the fulfilment of Union requirements, specifically, the European Convention on Social Insurance Cover in its parts related to disease control and maternity, which provides that a citizen insured in one Union country is entitled to all health care services in all other member states, with costs of services provided to visitors settled by respective insurance institutions from member states. For Polish institutions that finance health care it may prove impossible to cover such expenses on behalf of patients insured in Poland and treated abroad due to significant differences in treatment costs.

5.3 Evaluation of Recent and Planned Reforms

5.3.1 Recent Reforms and Their Objectives

Politicians responsible for the development and implementation of the 1999 reform were convinced that ensuring the broadest possible and equitable access to medical services with effective allocation of limited resources and financial stability of the health care system would be feasible only in a decentralized system with independent fundholders, such as sickness funds, the introduction of quasi-market relationships between the fundholders and service providers (regulated market) and enfranchising the patient. After three years of the system's operation, it can be said for certain that it has proved impossible to ensure to all citizens either equitable or unrestricted access to medical services financed with public funds. The lack of equity in access to health services derives from decentralization of the system, specifically, from discontinuing a nationwide health policy for the benefit of seventeen independent and uncoordinated policies of individual sickness

funds. On the other hand, limited availability of services is also due to financial constraints.

Neither was it possible to stabilize health care financing to a satisfactory extent. Until recently it was thought that at least the financial side of the system was independent of the central budget and political partisanship. Nevertheless, changes in legislation that affect budgetary provisions for 2002 prove that health care financing is still very strongly connected with the condition of state treasury and political priorities of successive governments. The option to deduct health care contributions from personal income tax causes that, at least in the short run, all actions geared at increasing the contribution are doomed to failure. The sudden shift in economic climate connected with a crisis on the labour market resulted in decreased volume of health care contributions, which is made worse by unchanged or even increased demand for services.

The biggest success of the reform may be perceived in the area of improved efficiency of allocation of limited means at the level of service providers. Quasi-market relationships between the sickness funds and service providers along with relatively harsh budget limitations forced many providers to restructure and rationalize employment levels. Competition among service providers also resulted in positive changes in the patient-physician relationships and, in some instances, led to improved standards of services offered. But even in this area there is ample room for improvement. For instance, it turned out to be impossible to prevent health care units from contracting new debts. Since the almost complete debt forgiveness at the outset of the reform process, public health care units contracted new debts of over zl5 bil by the end of 2001. Neither did the reform succeed in effecting a complete institutional separation of fundholders from service providers. The causeway linking some providers with sickness funds are Boards of Directors of individual funds appointed by local governments, which are the founding bodies for voivodship hospitals. This connection leads to a discrimination of non-voivodship units. Serious problems are encountered in the fundholder function, especially in the lack of workable management instruments (information, payment rates, financing mechanisms, quality assessment methods and contract performance monitoring), which would allow the funds to fulfil those functions properly. After all, it does not matter what a fundholder is called, what matters is its capacity to implement improved management and organisational practices in the system for the benefit of patients and the public at large.

5.3.2 Political Directions of Future Reforms

It appears a foregone conclusion that Polish health care system is facing new fundamental changes. The left-wing coalition, in power since autumn 2001, appealed to the voters by promising to undertake a new reform of the health care system. The shape of the latter is determined by a document titled

National Health Care (Narodowa Ochrona Zdrowia). The program keeps changing its contents, which makes it very difficult to review the suggested solutions, but several basic elements appear to be certain.

As most similar political plans, the declaration contains ambitious objectives, such as ensuring access to medical care at all times of day and night to all citizens, the disappearance of waiting lists for primary health care physicians and specialists, improved safety in inpatient treatment, rationalisation of management of public funds, ensuring to all patients equitable access to medicines regardless of their material status, reduction of administrative costs in health care and promotion of an ethical model of medical personnel's conduct. The means to achieve those ends, however, remain remarkably uderspecified.

The most fundamental change proposed for the system is the dissolution of sickness funds and the creation in their place of a central National Health Fund (Narodowy Fundusz Zdrowia) accountable to the Minister of Health. Sixteen voivodship branches of the Fund are to contract for services locally on the basis of voivodship health plans, their own assessments of service provision levels and tenders of service providers. What this change means in reality is the abandonment of decentralization of the system in favour of a significant concentration of power. It also means an end to the idea of insurance (from a theoretical economical point of view, the present system does not have much in common with insurance, either), even if the Fund remains formally separate from the central budget and has its own legal status.

The program announces a complete unification of requirements and prices for contracted services without specifying the level at which those "uniform prices" will be set. Elsewhere, the program mentions only maximum prices. Consequently, it remains obscure whether the prices will be uniform or only maximum pricing levels will be set, with the Fund freely imposing lower prices.

The program blames sickness funds for following service contracting policies that take into account only their financial capacity without considering the recognized needs of the populace. Instead of financial balance, the program promises a health policy directed towards in improvement in Poland's sanitary status, restricting the incidence of civilisation-related and social diseases, disability and premature death through prevention, treatment and promotion of an active and healthy lifestyle. Finding the means to finance those objectives may pose a problem. The most recent available version of the plan of March 28, 2002, assumes that health care contribution will be increasing up to a target of 9% in 2006. As we now know, for the time being, this "assumed increase in contribution" has been made impossible.

The program strongly emphasizes the significance and weight of centralisation, especially in the area of inpatient care. A network of public hospitals answerable to the Minister of Health is to be created. The first draft of the document mentions local hospitals that would not belong to the network, possibly to be privatised. In more recent versions those "other public hospitals" are only mentioned in passing, whereas non-public hospitals are explicitly excluded from the national network. The creation of a nationwide network of public hospitals is supposed to ensure equitable access to health services. At present, it is hard to say how this can be achieved, similarly, the exact meaning of the right to effect a "flexible" allocation of public funds remaining at the disposal of the Minister of Health on hospital investment remains obscure.

The program stipulates that the Minister of Health will have the right and freedom to decide on case-by-case basis as to whether or not public property, hitherto owned by independent health care units, can be transferred to corporations or foundations. The Minister of Health would be empowered to decide personally on the privatisation of health care units or their parts even in the case of units responsible to local governments. It is widely believed that those changes are intended to block altogether the process of privatisation in this sector.

Most unanswered questions are contained in those sections of the program that are related to improved effectiveness in the use of allocated resources. They contain correct diagnoses of flaws inherent in such financing mechanisms as fee for service or consultation, but at the same time they suggest "other rational" or "more diversified" forms of funding. The question of "what other forms" still remains unanswered. The assessment of debt forgiveness as unjust with respect to units that have so far balanced their revenues and expenditures is also correct. But the Ministry of Health has often hinted that it will solve the problem of debts incurred by health care units across the board. Will the debtors be able to repay their debts, either on their own or aided by their founding bodies, as the plan suggests? Any form of aid on the part of the latter, however legally feasible, is bound to face financial constraints. Most local governments have to cope with budget deficits anyway. Besides, it remains unclear what the "securitisation" of existing debts program will consist in and how the unification of contracting principles and service pricing may contribute to preventing new debts and allow for repayment of the old ones.

5.3.3 Conclusions

In 1999 Poland introduced a new financing and organisational system of health care based on universal health insurance covering almost 100% of Polish population. Independent of central government, autonomous sickness funds started contracting for services and financing them on behalf of their members following principles similar to those of a regulated market.

However, the fulfilment of the formal right to universal and equitable access to health services faces serious financial limitations of public fundholders and the lack of coordination of the activity of individual sickness funds.

Limited financial means of public fundholders cause that Poland, among OECD countries, demonstrates one of the highest rates of out-of-pocket service financing that reach 34% of total spending in this sector. Such a high proportion of private financial input into health care results in total spending on health reaching 6.65% of GDP. Private financing, however, always entails inequity in accessibility of services, which, in Poland, is made even more striking by differences in financing levels of individual sickness funds (which are factors that remain outside their control) and by differences in contracting for specific services (induced by them).

Poland's health care system requires further reform. This fact is undisputed and supported by experts. There is, however, no consensus regarding the direction of changes. Will the return to central administration, especially in the area of financing, bear fruit as promised to the public? Quite possibly, the answer will only be known with hindsight. But it may be worth stopping to think if those theoretical gains are really worth experimenting on a system so weak and unstable that it may not survive the test. Finally, it must be remembered that someone who cannot learn from the mistakes already made by themselves or others, is bound to make them again.

5.4 Annex to Chapter 5

I. Health status

Table 5.1: Infant mortality

Year	Infant mortality rates
1990	19,3
1991	18,2
1992	17,3
1993	16,1
1994	15,1
1995	13,6
1996	12,2
1997	10,2
1998	9,5
1999	8,9
2000	8,1

Source: GUS (Central Statistical Office), Statistical Yearbook 2001, p. XXXVIII-XXXIX

Table 5.2: Life expectancy

Men at age	**1990**	**1995**	**1999**	**2000**
0	66,5	67,6	68,8	69,7
15	53,1	53,9	54,8	55,6
30	39,1	39,8	40,6	41,4
45	26,0	26,7	27,3	27,9
60	15,3	15,8	16,3	16,7
women at age	**1990**	**1995**	**1999**	**2000**
0	75,5	76,4	77,5	78,0
15	61,8	62,6	63,8	63,8
30	47,2	47,9	48,6	49,0
45	33,0	33,6	34,3	34,7
60	20,0	20,5	21,1	21,5

Source: GUS, Statistical Yearbook 2001, p. 113

Table 5.3: Causes of death (per 100 000 population)

Causes	**1996**	**1999**				
		total	males	females	urban areas	rural areas
total	998,2	986,8	1085,8	893,0	940,3	1061,1
cardiovascular diseases	503,2	469,5	463,5	475,2	430,6	531,6
malignant neoplasms	203,7	211,1	249,7	174,6	217,5	200,8
External causes	70,5	70,8	108,1	35,4	65,6	78,9
infectious and parasites diseases	5,9	5,9	8,0	3,9	6,1	5,6
diseases of the respiratory system	37,0	46,4	55,5	37,7	41,3	54,5
Diseases of the digestive system	32,4	37,7	45,8	30,0	40,9	32,4

Source: GUS, Statistical Yearbook 2001, p. 111

II. Resources and utilization

Table 5.4: Health personnel per 10 000 population, by type, 1990-2000

type	1990	1995	1999	2000
Physicians	21,4	23,2	22,6	22,0
Dentists	4,8	4,6	3,4	3,0
Pharmacists	4,0	5,0	5,7	5,7
Felzers	0,7	0,3	0,1	0,1
Nurses	54,4	54,8	51,0	49,1
Midwives	6,3	6,3	5,9	5,7

Source: GUS, Statistical Yearbook 2001, p. 262

Table 5.5: Health personnel by type in absolute numbers, 1990-2000

Type	1990	1995	1999	2000
Physicians	81 641	89 421	87524	85 031
Dentists	18 205	17 805	13260	11 758
Pharmacists	15 110	19 447	21587	22 161
Felzers	2 710	1 315	501	374
Nurses	207 767	211 603	197153	189 632
Midwives	24 016	24 440	22683	21 997

Source: GUS, Statistical Yearbook 2001, p. 262

Table 5.6: Doctors in public system

Affiliation	1990	1995	1999	2000
civilian health service	81 641	89 421	87 524	85 031
Ministry of Defence	4 161	4 417	4 145	3 700
Ministry of Internal Affairs	1 729	1 744	1 766	1 600
total	87 531	95 582	93 435	90 331
per 10 000. population	22,92	24,76	24,17	23,37

Source: GUS, Statistical Yearbook 2001, p. 262-263 plus own calculation

Table 5.7: Dentists in public system

affiliation	1990	1995	1999	2000
civilian health service	18 205	17 805	13 260	11 758
Ministry of Defence	603	609	601	558
Ministry of Internal Affairs	257	267	219	142
total	19 065	18 681	14 080	12 458
per 10 000. population	4,99	4,84	3,64	3,22

Source: GUS, Statistical Yearbook 2001, p. 262-263 plus own calculation

Table 5.8: Pharmacists in public system

Affiliation	1990	1995	1999	2000
civilian health service	15 110	19 447	21 857	22 161
Ministry of Defence	380	277	201	191
Ministry of Internal Affairs	215	143	71	57
total	15 705	19 867	22 129	22 409
per 10 000. population	4,11	5,15	5,72	5,80

Source: GUS, Statistical Yearbook 2001, p. 262-263 plus own calculation

Table 5.9: Nurses in public system

Affiliation	1990	1995	1999	2000
Civilian health service	207 767	211 603	197 153	189 632
Ministry of Defence	5 624	5 493	4 957	5 070
Ministry of Internal Affairs	3 339	3 350	3 101	3 030
total	216 730	220 446	205 211	197 732
per 10 000. population	56,76	57,10	53,09	51,16

Source: GUS, Statistical Yearbook 2001, p. 262-263 plus own calculation

Table 5.10: Midwives in public system

Affiliation	**1990**	**1995**	**1999**	**2000**
Civilian health service	24 016	24 440	22 683	21 997
Ministry of Defence	239	229	212	221
Ministry of Internal Affairs	176	163	167	146
total	24 431	24 832	23 062	22 364
per 10 000. population	6,40	6,43	5,97	5,79

Source: GUS, Statistical Yearbook 2001, p. 262-263 plus own calculation

Table 5.11: Doctors specialists as of 31 XII

Specification	**1995**	**1999**	**2000**	**1995**	**1999**	**2000**
	total			of witch with grade II specialization		
Total	70572	72162	70969	36660	42980	43995
in % of total doctors	78,9	82,4	83,5	41,0	49,1	51,7
anesthesiology and intesive therapy	3507	3800	3873	1656	2191	2353
Surgery	9239	9599	9340	5555	6120	6104
pulmonary diseases	1647	1694	1612	1308	1395	1362
internal diseases	14885	13385	12755	5781	6109	5973
dermatology and venereology	1717	1649	1546	732	853	827
Cardiology	495	766	850	476	766	850
family medicine	231	2507	2937	231	2507	2937
Neurology	2616	2775	2703	1367	1643	1678
Ophtalmonology	2865	2803	2675	1357	1429	1485
Oncology	94	109	98	77	99	80
Otolaryngology	2507	2373	2327	1267	1284	1320
Pediatrics	10566	8717	8238	3799	3649	3634
obstetrics and gynaecology	6179	5962	5861	3806	3920	3944
Psychiatry	2170	2497	2531	1218	1416	1462
Radiodiagnostic	2172	2684	2730	1134	1442	1517
Dentists –specialists			6319			2100
in % of total dentists			53,7			17,9

Source: GUS, Statistical Yearbook 2001, p. 262; Basic date for health care 2000, p. 2

Table 5.12: Institutions of ambulatory care

Type/location	**1990**	**1995**	**1999**	**2000**		
				total	facilities	
					public	non-public
Health care institutions as of 31 XII:	9912	9785	8227	8188	4717	3471
urban areas	6584	6473	5312	5468	2665	2803
rural areas	3328	3312	2915	2720	2052	668
Out-patients departments:	6584	6473	5425	5685	2699	2986
for general public	3289	3329	2849	2289	2289	x
work place service	2481	1991	1176	1104	364	740
students	77	74	59	43	40	3
rehabilitatio n service	432	385	301	278	6	272
medical and dental co-operatives	305	181	135	122	x	122
other		513	905	1849	x	1849
rural health centres (total)	3328	3312	2802	2503	2018	485
Medical practices:	x	x	2509	5080	x	5080
urban areas	x	x	2076	4211	x	4211
rural areas	x	x	433	869	x	869

Source: GUS, Statistical Yearbook 2001, p. 265

Table 5.13: Medical practices 1999-2000

Items	1999	2000
Urban areas total	2076	4211
of witch individual	1644	3132
individual specialists	293	980
group medical practices	87	90
Rural areas total	433	869
of witch individual	326	695
individual specialists	43	136
group medical practices	40	36

Source: GUS, Basic date for health care 2000, p. 4

Table 5.14: Consultations provided in ambulatory care I

Type/location	**1990**	**1995**	**1999**	**2000**		
				total	facilities	
					public	non-public
Consultations provided in thous:	271 756	246 042	233 518	234 805	151 984	82 821
of witch consultations provided by doctors	220 742	207 128	206 683	209 085	139 911	69 174
in % of total consultations	81,23	84,18	88,51	89,05	92,06	83,52
of witch specialized	59 385	67 270	65 368	68 365	53 564	14 711
in % of consultations provided by doctors	26,90	32,48	31,63	32,70	38,28	21,27
consultations provided by health care institutions in urban areas in thous.:	231 403	208 047	187 780	182 395	126 629	55 766
in % of total consultations	85,15	84,56	80,41	77,68	83,32	67,33
provided by general public out-patient departments:	181 700	171 134	147 724	115 535	115 535	x
in primary health care	91 974	83 301	78 589	56 368	56 368	x
in specialized medical care	58 934	62 794	53 844	50 343	50 343	x
stomatological out-patient clinics	30 792	25 039	15 291	8 824	8 824	x

Type/location	**1990**	**1995**	**1999**	**2000**		
				total	facilities	
occupational medicine service out-patient departments	40 418	24 627	16 157	13 909	6 256	7 653
students out-patient departments	2 174	2 088	1 817	1 476	1 437	39
medical and stomatological co-operatives	5 242	2 709	2 079	1 887	x	1 887
rehabilitation out-patient departments in handicap co-operatives	1 869	1 230	875	661	8	653
other out-patient departments	.	2 931	15 847	45 501	x	45 501
Rural health centres in thous.	40 353	37 995	36 156	35 583	25 355	10 228
in % of total consultations	14,85	15,44	15,48	15,15	16,68	12,35
Medical practices in thous.	x	x	9 582	16 827	x	16 827
in % of total consultations			4,10	7,17		20,32
urban areas	x	x	6 601	12 537	x	12 537
rural areas	x	x	2 981	4 290	x	4 290
Per capita consultations provided	7,1	6,4	6,0	6,1	x	x
of witch consultations provided by doctors	5,8	5,4	5,3	5,4	x	x

Source: GUS, Statistical Yearbook 2001, p. 265-266

Table 5.15: Consultations provided in ambulatory care II (in hundred thous.) in 2000

Specification	Total			Consultations by doctors			Consultations by dentists		
	Total	PHC	special ized	total	PHC	special ized	total	PHC	special ized
Total	2348,1	1542,3	760,3	2090,8	1372,9	683,7	257,2	169,4	76,6
In urban areas	1949,3	1155,9	747,9	1738,8	1030,2	674,3	210,5	125,7	73,6
Health care institutions	1824,0	1061,9	716,6	1658,4	969,0	655,2	165,6	92,9	61,4
for general public	1155,3	624,7	530,6	1067,1	563,7	503,4	88,2	61,4	27,2
Ministry of health	43,0	1,7	41,3	38,6	1,5	37,2	4,3	0,2	4,2
local self-government	1112,4	623,1	489,3	1028,5	562,2	466,3	83,9	60,8	23,0
work place medical service	139,1	85,9	43,3	129,1	85,9	43,3	10,0	.	.
Ministry of health	1,5	1,0	0,5	1,5	1,0	0,5	0,1	.	.
Local self-government	58,8	33,8	21,1	54,9	33,8	21,1	3,9	.	.
PKP	2,2	1,0	1,2	2,2	1,0	1,2	-	.	.
public employer	17,5	11,1	4,2	15,4	11,1	4,2	2,1	.	.
private employer	49,6	30,2	15,6	45,8	30,2	15,6	3,8	.	.
individual medical practice	9,4	8,7	0,7	9,4	8,7	0,7	0,0	.	.
student's	14,8	10,3	4,5	12,7	8,4	4,2	2,1	1,9	0,2
medical co-operatives	18,9	0,2	18,7	11,1	0,2	10,9	7,8	0,0	7,8
rehabilitation in handicap co-operatives	6,6	4,2	1,1	5,3	4,2	1,1	1,3	.	.
private health care institutions	436,7	328,9	107,8	382,3	300,1	82,2	54,4	28,8	25,6
other non-public health care institutions	18,3	7,8	10,6	16,5	6,6	1,0	1,8	1,2	0,6
hospital emergency admission	34,3	.	.	34,3	.	.	.	.	.
Medical practices	125,4	94,1	31,3	80,4	61,3	19,2	44,9	32,8	12,2
In rural areas	398,7	386,4	12,4	352,0	342,7	9,3	46,7	43,7	3,0
Health care institutions	355,8	346,1	9,8	323,5	314,9	8,7	32,3	31,2	1,1
local self government	253,5	247,0	6,5	227,2	221,0	6,2	26,4	26,0	0,4
private	102,0	98,9	3,1	96,2	93,8	2,4	5,9	5,2	0,7
other non-public	0,2	0,1	0,1	0,2	0,1	0,1	0,0	0,0	0,0
Medical practices	42,9	40,3	2,6	28,5	27,8	0,6	14,4	12,5	2,0

Source: GUS, Basic date for health care 2000, p. 6-7

Table 5. 16: Hospitals

Kind of hospitals	**1990**	**1995**	**1999**	**2000**
general civilian hospitals	677	705	715	716
civilian psychiatric and sanatoria for persons with nervous disorders	49	50	51	51
detoxification centres	8	10	10	11
addiction recovery centres	22	34	43	44
sanatoria for persons with tuberculosis and pulmonary diseases	24	13	4	2
rehabilitation facilities	9	9	7	2
chronic medical care homes	x	x	95	126
nurcing homes	x	x	20	49
hospice	x	x	15	26
rehabilitation sanatoria	34	33	28	26
military hospitals	35	32	27	27
police hospitals	34	29	29	29

Source: GUS, Statistical Yearbook 2001, p.268-269

Table 5.17: General civilian hospitals

Items	**1990**	**1995**	**1999**	**2000**
general civilian hospitals	677	705	715	716
public	x	696	699	686
Ministry of health				62
clinics				42
health institutes				16
Voivodship self-government				222
short term care				113
long term care				33
Mixed				76
powiat self-government				391
short term care				259
long term care				5
Mixed				117
gminas self-government				21
Short term care				16
Long term care				-
Mixed				5
non-public	x	9	18	30

Source: GUS, Statistical Yearbook 2001, p. 270, Basic date for health care 2000, p. 19

Table 5.18: Beds in general hospitals (per 10 000 population)

Beds in	1990	1995	1999	2000
general civilian hospitals	57,2	55,4	51,4	49,4

Sources: GUS, Statistical Yearbook 2001, p. 270

Table 5.19: Beds in general civilian hospitals as of 31 XII

Items	**1990**	**1995**	**1999**	**2000**
general civilian hospitals	218 560	213 969	198 688	190 952
Public	x	213 826	198 242	189 378
Ministry of health				26 061
Clinics				20 159
health institutes				4 604
voivodship self-government				71 812
short term care				35 861
long term care				4 518
Mixed				31 407
powiat self-government				87 206
short term care				53 418
long term care				752
Mixed				33 036
gminas self-government				4 299
short term care				2 847
long term care				122
Mixed				1 330
non-public	x	143	446	1 574

Source: GUS, Statistical Yearbook 2001, p. 270, Basic date for health care 2000, p. 19

Table 5.20: Beds in general hospitals as of 31 XII

Items	1990	1995	1999	2000
general civilian hospitals	218 560	213 969	196 888	190 952
internal wards incl. cardiological	43 774	42 849	39 453	37 713
surgical	51 055	49 850	49 919	47 987
paediatric	21 544	19 034	13 737	12 344
obstertic-gynaecological	31 714	30 119	25 269	22 769
onocolgical	3 603	4 370	3 319	3 738
anhethesiology and intensive therapy	1 673	1 889	2 361	2 524
intensive cardiological care	195	313	369	286
communicable	10 861	9 864	6 455	5 430
tubercular and pulmonary	13 071	12 994	11 574	10 553
dermal-venerael	4 352	4 181	3 448	3 131
neurological	6 619	7 148	7 085	7 145
Psychiatric incl. detoxification	3 729	3 871	4 214	4 590

Source: GUS, Statistical Yearbook 2001, p. 270

Table 5.21: Beds in in-patient care as of 31 XII

Items	1990	1995	1999	2000
general civilian hospitals	218 560	213 969	196 888	190 952
civilian psychiatric and sanatoria for persons with nervous disorders	33 623	29 215	24 612	23 728
detoxification centres	750	700	639	674
addiction recovery centres	504	970	1 199	1 451
sanatoria for persons with tuberculosis and pulmonary diseases	5 839	2 479	635	210
rehabilitaion facilities	987	995	775	160
chronic medical care homes	x	x	8 521	9 633
nurcing homes	x	x	861	1 800
hospice	x	x	234	451
rehabilitation sanatoria	4 634	4 115	4 124	3 601
military hospitals	9 360	8 762	8 202	7 391
police hospitals	6 601	6 450	5 542	5 516

Source: GUS, Statistical Yearbook 2001, p. 268-269

Table 22: In-patients I

Items	**1990**	**1995**	**1999**	**2000**
general civilian hospitals	4596 715	5142 568	5685 288	6007 091
Public				5940 124
Ministry of health				826 083
clinics				637 689
health institutes				134 223
voivodship self-government				2067 073
short term care				1135 821
long term care				62 621
mixed				867 596
powiat self-government				2890 812
short term care				1833 846
long term care				9 454
mixed				1047 512
gminas self-government				156 256
short term care				110 328
long term care				1 202
mixed				44 726
non-public	x	6	22	66 867

Source: GUS, Statistical Yearbook 2001, p. 270, Basic date for health care 2000, p. 20

Table 5.23: In-patients II

Specification	1990	1995	1999	2000
general civilian hospitals	4 596 715	5 142 568	5 685 288	6 007 091
civilian psychiatric and sanatoria for persons with nervous disorders				208 687
detoxification centres	4 808	5 854	6 671	8 377
addiction recovery centres	1 088	2 274	3 962	4 613
sanatoria for persons with tuberculosis and pulmonary diseases	24 968	14 586	4 173	1 352
rehabilitaion facilities	4 669	8 129	5 722	1 814
chronic medical care homes	x	x	8 296	9 322
nurcing homes	x	x	763	1 642
hospice	x	x	3 142	5 784
rehabilitation sanatoria	29 203	33 283	37 560	41 868
military hospitals	150 600	139 100	165 200	190 000
police hospitals	93 000	92 800	122 000	134 900

Source: GUS, Statistical Yearbook 2001, p. 269

Table 24: In-patients III in thous.

Specification	1990	1995	1999	2000
general civilian hospitals	4597	5143	5685	6007
internal wards incl. Cardiological	1033	1158	1339	1410
Surgical	1087	1240	1556	1680
Paediatric	376	419	402	416
obstertic-gynaecological	1143	1026	958	979
Oncological	74	118	112	143
Anhethesiology and intensive therapy	51	67	94	103
intensive cardiological care	6	11	22	20
Communicable	145	153	135	134
tubercular and pulmonary	114	143	187	197
dermal-veneral	48	49	56	58
Neurological	120	149	192	206
psychiatric incl. detoxification	30	37	45	53

Source: GUS, Statistical Yearbook 2001, p. 270

Table 25: Rehabilitation sanatoria in 2000

Specification	facilities	beds	in-patients	Average patient stay in days
	as of 31 XII			
Total	26	3601	41868	16,6
voivodship self-governments	8	829	8422	23,5
powiat self-governments	1	100	869	33,2
share-holder company of the State Tresaury	1	103	2343	9,7
Private	16	2569	30234	14,7

Source: GUS, Basic date for health care 2000, p. 39

Table 5.26: Health resort treatment facilities as of 31 XII 2000

Specification	**total**	**health resort treatment in hospitals**	**health resort treatment in sanatorias**	**other**
Facilities	289	75	154	60
Beds (average number in year)	30000	10057	19943	x
in-patients	411102	127830	283272	x
patients treated as out-patient	73099	166	7126	65807

Source: GUS, Statistical Yearbook 2001, p. 269, Basic date for health care 2000, p. 39-40

Table 5.27: Number of pharmacies

Specification	1990	1995	1999	2000
Total	3957	6536	7875	8318
Private	1737	5994	7292	7739
Population in thous. pharmacy	9,6	5,9	4,9	4,6
of witch in rural areas	13,8	10,7	9,7	9,6
Druggists employed in pharmacies	7690	13016	15365	16242

Source: GUS, Statistical Yearbook 2001, p.271

Table 5.28: First-aid

Specification	1990	1995	1999	2000
first-aid departments and wards	412	373	337	305
voivodship emergency stations	15	30	28	23
other emergency stations	46	31	15	30
emergency filial posts		88	122	135
Ambulances	4983	4202	2722	2351
ambulance calls to illnesses in thous.	3625	3215	2495	2609
ambulance calls to illnesses per 1000 population	95	83	65	68
ambulance calls to accidents in thous.	376	349	357	374
ambulance calls to accidences per 1000 population	10	9	9	10
persons receiving medical assistance in thous.	10644	9650	7522	6326
persons receiving medical assistance per 1000 population	279	250	195	163,7

Source: GUS, Statistical Yearbook 2001, p. 271

Table 29: Vaccinations as of 31 XII in children and youth with the immunisation card

Specification	**1990**	**1995**	**1999**	**2000**
BCG (new borns)	96,9	98,1	95,8	95,5
Diphtheria/tetanus at 2 (primary)	95,9	96,0	97,7	98,2
Diphtheria/tetanus at 7 (basic full)	90,1	90,5	94,7	94,9
Whooping cough at 2 (primary)	95,5	95,6	97,6	98,1
Whooping cough at 3 (basic full)	89,1	90,0	94,5	94,7
Measles at 3 (basic)	94,6	96,1	97,0	97,4
Polio at 2 (primary)	95,7	95,8	97,6	98,2
Polio at 3 (basic full)	90,1	90,4	94,6	94,8
Hepatitis at 2 (primary)	x	23,2	98,9	99,3
Hepatitis at 3 (basic full)	x	4,8	98,6	98,9
Rubella - girls aged 14	x	94,3	97,4	97,8

In 2000, 99.2 of all 2 year-olds, 96,2 of 7 yea-olds, 97,8 of all 8 year-olds, 98,1 of all 12 year-olds, 95,9 of all 15 year-olds, 77,8 of 20 year-olds and 95,9 of girls, aged 14 (rubella), possessed immunisation card in health care facilities.

Source: GUS, Statistical Yearbook 2001, p. 272

Table 5.30: Health care major data by voivodship in 2000

Items	Doctors per 10 thous. population	Dentists per 10 thous. population	Pharmacists per 10 thous. population	Nurses per 10 thous. population	Midvives per 10 thous. population	Beds in general hospitals per 10 thous. population	In-patients in general hospitals per 10 thous. population	Medical consulations provider within the scope of out-patient health care per capita	Dental consulations provider within the scope of out-patient health care per capita
Poland average	22,0	3,0	5,7	49,1	5,7	49,4	1554,4	5,4	0,7
Dolnośląskie	22,8	3,7	5,5	57,8	5,5	53,0	2020,6	5,4	0,8
Kujawsko-Pomorskie	17,5	2,7	4,7	45,3	6,5	44,5	1525,2	5,7	0,6
Lubelskie	25,4	4,4	8,9	62,7	7,0	54,8	1663,7	5,5	0,7
Lubuskie	17,4	1,6	3,8	45,3	6,2	45,4	1629,6	4,9	0,4
Łódzkie	24,8	3,7	7,3	47,8	5,7	53,6	1637,0	5,5	0,6
Małopolskie	21,3	3,7	6,3	48,9	6,1	46,2	1348,6	5,7	0,8
Mazowieckie	26,9	3,4	6,1	48,9	5,0	47,8	1466,5	4,9	0,5
Opolskie	16,3	1,4	3,5	44,9	3,9	41,1	1422,4	4,7	0,5
Podkarpackie	17,7	3,5	4,2	49,0	7,4	40,8	1343,2	5,3	0,7
Podlaskie	27,7	1,9	5,3	54,4	7,4	52,0	1621,5	5,9	0,7
Pomorskie	21,1	2,6	8,1	44,3	5,1	43,7	1488,3	5,3	0,8
Śląskie	24,4	3,2	5,2	52,5	5,4	59,9	1480,5	6,4	0,9
Świętokrzyskie	20,3	2,9	5,1	52,6	6,1	46,0	1483,0	5,5	0,6
Warmińsko-Mazurskie	14,3	1,3	3,9	40,6	5,0	41,7	1500,4	4,6	0,7
Wielkopolskie	18,1	1,7	5,6	40,0	4,9	48,0	1648,2	4,8	0,4
Zachodnio-pomorskie	20,5	3,6	4,2	43,8	5,5	50,0	1621,8	5,4	0,8

Source: Statistical Yearbook 2001, p. LXX-LXXIII

Table 5.31: Public expenditures for health care

	1999	**2000**
state budget in thous zl	138 401 200	151 054 929
%	100,0	100,0
of witch health care in thous zl	6 312 645	4 300 019
%	4,56	2,85
lockal self-government budgets in thous. zl	65 115 441	74 824 065
%	100,0	100,0
of witch health care in thous. zl	2 043 305	2 690 729
%	3,14	3,60
insurance funs	23 538 386	23 784 523
public expenditures total in thous. Zl	28 589 383	29 047 036
as % of GDP	4,65	4,24

Source: GUS, Basic date for health care 2000, p. 53

Table 5.32: State budget expenditures for health care by type

Items	**1999**	**2000**	**1999**	**2000**
	in thous. zl		in %	
State budget total	138 401 200	151 054 929		
health care	6 312 645	4 300 019	100,0	100,0
general hospitals	810 923	758 676	12,8	17,6
Clinics	256 768	291 131	4,1	6,8
out-patient health care	17 091	60 248	0,3	1,4
mental care	14 716	21 760	0,2	0,5
emergency service	5 604	14 134	0,1	0,3
public blood service	162 264	132 444	2,6	3,1
health programs	374 906	500 072	5,9	11,6
high specialised procedure	677 688	641 410	10,7	14,9
insurance contribution and benefits vor not insured people	2 641 766	756 988	41,8	17,6
sanitary inspection	486 179	524 256	7,7	12,2
drug addict prevention	19 258	24 006	0,3	0,6
voivodship method-health care centres	39 525	42 631	0,6	1,0
work-place medical care	32 175	40 802	0,5	0,9
health care associations	67 427	71 920	1,1	1,7

Source: GUS, Basic date for health care 2000, p. 54

Table 5.33: State budget expenditure for health care

	1991	**1995**	**1999**	**2000**	
	in mln zl	in mln zl	in mln zl	in mln zl	of total public state budget expenditures
Health care	3885,4	13132,6	6312,6	4300,0	2,85

Source: GUS, Statistical Yearbook 1998, p. 471; Statistical Yearbook 2001, p. 497

Table 5.34: Local self-government entities expenditures for health care, mln zł.

Year	total	Gminas	cities with powiat status	powiats	voivodships
1991	312,4	312,4			
1995	1510,6	1510,6			
1999	2046,4	444,5	545,1	542,0	514,8
2000	2698,0	433,7	630,9	1087,8	545,6

Source: GUS, Statistical Yearbook 1998, p. 476; Statistical Yearbook 2001, p. 503

BIBLIOGRAPHY

1. Monography

Chlon Agnieszka, Marek Gora, Michal Rutkowski 1999. *Shaping Pension Reform in Poland: Security through Diversity*. Social Protection Discussion Paper No. 9923. The World Bank. August.

Cichomski B. (1998) – Nierówność szans edukacyjnych w Polsce 1992-1997 w świetle danych PGSS (Educational inequalities in Poland 1992-1997 on the perspective PPGS research). Materiał niepublikowany. Warszawa: UW (University of Warsaw).

Deniszczuk, L. (2002) - Zróznicowanie dochodów i konsumpcji w Polsce (Income and consumption differentiation in Poland), w : T. Kowalik (red.) - *Nierówni i równiejsi*, Warszawa: Fundacja Innowacja,

Dercz, M., Izdebski, H. 2001. *Organizacja ochrony zdrowia w Rzeczpospolitej Polskiej w świetle obowiązującego ustawodawstwa*. (Organisation of health care system in Poland) Polskie Wydawnictwo Prawnicze, Warszawa, Pozanań.

Erhel, Ch./ Gautie, J./ Gazier, B./ Morel,S. (1996) – Job Opportunities for the Hard-to-place, in: G.Schmid, J. O'Reilly, K. Schoemann – *International Handbook of labour Market Policy and Evaluation*, EE, Cheltenham, Brookfield

Frieske Kazimierz W., (red.) (1999), *Marginalność i procesy marginalizacji* (Marginality and exclusion process) , „Opracowania PBZ" z. 13, Warszawa: IPiSS, IPS UW

Golinowska S., Hagemejer K. (1999), *Społeczne wydatki w Polsce z odniesieniami do innych krajów* (Social expenditures in Poland compared with other countries), z. 11, PBZ IPiSS Warszawa

Golinowska, S (2000), *Polityka społeczna. Koncepcje-instytucje-koszty*. (Social policy. Ideas-institutions-costs), Warszawa: Poltext,

Golinowska, S. (1996) *Polska bieda. Kryteria. Oceny. Przeciwdzialanie* [Polish poverty. Criterions. Estimations. Counteractions.]. Studia i Materiały IPiSS. Warsaw: IPiSS

Golinowska, S. /Topińska, I. (2002) - *Pomoc spoleczna - zmiany i warunki skutecznego działania* [Social assistance - changes and conditions of the effective actions], Warszawa : CASE

Golinowska, S. ed. (1996 and 1997) . *Polska bieda. Kryteria. Oceny. Przeciwdzialanie* [Polish poverty. Criterions. Estimations. Counteractions.]. Studia i Materiały IPiSS. Warsaw: IPiSS

Gomulka Stanislaw, Marek Styczen 1999. "Estimating the impact of the 1999 pension reform in Poland, 2000-2050". Warsaw: CASE-CEU Working Papers Series, 27. Center for Social and Economic Research. Central European University.

Klugman, J. / Micklewright, J. / Redmond, G. (2002) – *Poverty in the Transition: Social Expenditures and the Working-Age-Poor.* Innocenti Working Papers No91, Florence: Innocenti Research Centre of Unicef,

Kolarska-Bobińska, L. (ed.). 2000. *Cztery reformy. Od koncepcji do realizacji.* (Four reforms). Instytut Spraw Publicznych, Warszawa.

Kordos, J. (1992) - Poverty Measurement in Poland, in : PTS /GUS - *Poverty Measurement for Economic in Transition in Eastern European Countries*, Warsaw: PTS/ GUS

Kryńska, E (1999)- *Socjalne skutki zmian w zatrudnieniu i dochodach z pracy w okresie przebudowy,* PBZ z. 1, Warszawa: IPiSS

Lipton, M. (1995) - Growing Points in Poverty Research: Labour Issues, in: Rodgers, G. (ed.) *New Approches to Poverty. Analysis and Policy - I.* The Poverty Agenda and the ILO . Issues for Research and Action, Geneva: ILO

McAuley, A.(1979) – Economic Welfare in the Soviet Union: poverty, living standard and inequality. University of Wisconsin Press, Madison,Wi.

Milanovic, B. (1997) - *Income, Inequality and Poverty during the Transition from Planned to Market Economy*, Washington DC: The World Bank

Mingione, E. (1996) - Urban Poverty in Advanced Industrial World: Concepts , Analysis and Debates, in: Mingione, E.(ed.) *Urban Poverty and the Underclass*, Basil Blackwell, Oxford

Müller, Katharina 1999. *"The political economy of pension reform"*. Cheltenham and Northhampton: Edward Elgar.

Nowicka, E. /Łodziński, S. (2001) – *U progu otwartego świata. Poczucie polskości i nastawienia Polaków wobec cudzoziemców w latach 1988 – 1998* (Entering open world. Perception of being Pole and attitude towards foreigners 1988 –1999), Kraków: Nomos

Rymsza, M. (2001) – Samotne macierzyństwo i polityka społeczna (Lone mothers and social policy), Warsaw: ISP

Sowada, Ch. 2000. *Grundversorgung mit Gesundheitsleistungen in einer Krankenversicherung. Normative Prinzipien und die Umsetzung in der allgemeinen Krankenversicherung in Polen*. PCO Verlag Bayreuth.

Szulc, A (1996) – Skale ekwiawalentności w pomiarach ubóstwa i dobrobytu (Equivalenvy scale in poverty and welth measurment, in : Golinowska, S. ed. *Polska bieda. Kryteria. Oceny. Przeciwdzialanie* [Polish poverty. Criterions. Estimations. Counteractions.]. Studia i Materiały IPiSS. Warsaw: IPiSS, p. 204-219

Tarkowska, E. (2000) – Popegerowska bieda, w: E. Tarkowska (red.), *Zrozumieć biednego. O dawnej i nowej biedzie w Polsce* (Understanding of the poor man. About the old and the new poverty), Warszawa: Typografika.

Tarkowska, E. / Korzeniewska, K. (2001) – *Młodzi z dawnych PGR-ów* (Youth from the old state farms - PGR), Instytut Spraw Publicznych, ISP: Warszawa

Topinska, I. (1997), Ubóstwo w Polsce: 1993-1996, w: S. Golinowska (red.) *Polska bieda. Kryteria. Oceny. Przeciwdzialanie* [Polish poverty. Criterions. Estimations. Counteractions.]. Studia i Materiały IPiSS, IPiSS, Warsaw

Włodarczyk, W. C. 1998. *Reforma opieki zdrowotnej w Polsce. Studium polityki zdrowotnej*. (Health Care Reform in Poland. Study of Health Politics) Uniwersyteckie Wydawnictwo Medyczne ”Vesalius”, Kraków.

World Bank 1994. *Averting the Old Age Crisis. Policies to Protect the Old and Promote Growth.* Washington, D.C.: Oxford University Press.

2. Articles

Bochenek, T. 2001. “Refundacja leków – osiągnięcia, zagrożenia, kierunki rozwoju” (Subsidizing pills – success, danger, possible developments) in *Polityka Społeczna* no 10/2001, pp. 25-29.

Boni, M. (2002) - The Labor Market in Poland: Current Trends and Challenges, in: Funck, B / Pizzati, L - *Labor, Employment and Social Policies in the EU Enlargement Process* , Washington DDC: The World Bank, s. 57 - 77

Deniszczuk, L. (2002) - Zróznicowanie dochodów i konsumpcji w Polsce (Income and consumption differentiation in Poland), w : T. Kowalik (red.) - *Nierówni i równiejsi*, Warszawa: Fundacja Innowacja, p. 90 -146

Domański, H. (2002) - Co wiadomo na temat równości płci? (What is known about sex inequalities) *Res Publica* nr 6

Golinowska Stanislawa 1998. „O reformie emerytalno - rentowej w kategoriach ekonomii Politycznej". („About the pension reform in terms of political economy") in *Ekonomia polityczna reformy emerytalnej (Political economy of pension reform).* edited by Golinowska S., J. Hausner. Warsaw: Centre for Social and Economic Resarch. Raporty CASE No. 15. December 1998. pp.9-25.

Golinowska, S., Czepulis-Rutkowska, Z., Sowa, A. 2001 "Wydatki ludności na ochronę zdrowia" (Private expenditures on health care) in *Polityka Społeczna* no 10/2001, pp. 6-11.

Górecki, B /Wiśniewski, M. (1998), Zróżnicowanie dochodów gospodarstw domowych w Polsce w latach 1987 – 19995, w : Podział dochodu i nierówności dochodowe. Fakty, tendencje, porownania. Rasa strategii – Społeczno Gospodarczej przy Radzie Ministrow, Warszawa, s. 133-170

Kolankiewicz, M. (1999) – Zagrożone dzieciństwo. Adopcje, rodziny zastępcze, instytucje opieki w okresie zmian społecznych (Menaced childhood. Adoption, foster families, institutional care in time of changes) in: Balcerzak-Paradowska, B. – *Sytuacja dzieci w Polsce w okresie przemian*, Warszawa: IPiSS and Fundacja SOS, 192- 211

Krajewski Piotr 2001. „Implikacje budzetowe reform sektora publicznego a kryteria fiskalne z Maastricht" ("Budget implications of the public sector reforms and fiscal criteria from Maastricht"). *Gospodarka Narodowa* No. 9. pp. 72-86.

Laskowska – Otwinowska, J. (2002) – Elementy kultury romskiej jako źródło marginalizacji i bogacenia się Romów polskich (Elements of culture of Romes as a sources of exclusion and growing rich of Polish Roma), in: Tarkowska, E. (ed.) *Lata tłuste lata chude*, Warszawa: IFiS PAN, 211-238

Laskowska – Otwinowska, J. (2002) – Stereotyp biednego Roma (Steerotype of poor Roma), in: Tarkowska, E. (ed.) *Lata tłuste lata chude*, Warszawa: IFiS PAN, p. 239-258

Markowska Hanna, Hanna Zalewska 1999. „Przepisy wspólnotowe w zakresie świadczeń emerytalno-rentowych. Konsekwencje finansowe dla Polski" („Community rules concerning pensions. Financial consequences for Poland"). *Polityka Społeczna* No. 4. pp. 21-24.

Szumlicz Tadeusz 2001. „Reforma systemu ubezpieczen emerytalno-rentowych" („Reform of pension insurance"). in: *Diagnoza spoleczna 2000 (Social diagnosis 2000).* edited by Czapinski J., T. Panek. Warsaw:

Rada Monitoringu Spolecznego, WSP TWP. Rada Glowna PTS-BbiAS. pp. 156-166.

Tarkowska, E. (1998) - Ubóstwo w byłych PGR-ach. W poszukiwaniu dawnych źródeł nowej biedy. *Kultura i Społeczeństwo* nr 2

Witkowski, J. (2001) – Transformacja rynku pracy w Polsce (Transition of labour market in Poland), in: Kontrola Państwowa, Nr 3, s. 40-57

Zukowski Maciej 1994. "Pensions policy in Poland after 1945: Between 'Bismarck' and 'Beveridge' traditions" in *Beveridge and social security. An international retrospective*, edited by Hills J., J. Ditch, H. Glennerster. Oxford: Oxford University Press. pp. 154-170.

3. Reports / Documents

CASE (2002) *Polish Economic Outlook* No 1

Centrum Badań Opinii Społecznej (CBOS) (Public Opinion Research Center) –. *Research reports:*

Czapiński, J., Panek, T. 2000. *Diagnoza Społeczna* 2000. Kancelaria Prezesa Rady Ministrów, Warszawa.

European Observatory on Health Care Systems. 1999. *Health Care Systems in Transition – Poland*.

Eurostat data on employment

- Evaluation of the functioning of the health care reform - June 2000,
- Four reforms in the social opinion - January 2001,

GUS - Statistical Yearbooks

GUS (1997) – *Wskaźniki ubóstwa w swietle badań budzetów gospodarstw domowych* (Poverty indicators in view of household budget surveys), Warszawa

GUS (1999)- *Warunki życia ludności w 1999 r.* (Living conditions of the populations in 1998), Warszawa

GUS (2000) – Podstawowe informacje o rozwoju demograficznym Polski (Basic Information on Demographic Development of Poland, Warszawa: GUS

GUS (2000) – *Warunki życia ludności w 1999 r.* (Living conditions of the populations in 1999), Warszawa: GUS

GUS 1992, 1995, 2001. *Statistical Yearbook of the Republic of Poland 1992, 1995, 2001*. Warsaw: Central Statistical Office.

Innocenti Research Centre of Unicef (1995). *Poverty, Children and Policy: Responses for a Brighter Future*. Regional Monitoring Report No 3. Florence

Innocenti Research Centre of Unicef (2001)- A Decade of Transition, The Monee Project CEE/CIS/ Baltics, *Regional Monitoring Report No 8*, Florence

KUP (National Labour Office) data on unemployment

Laskowska -Otwinowska, J. (2002) Community Sudy Report – Czarna Gora, in: Poverty, Ethnicity, Gender (international project) www.yale.edu.ccr/laskowska.pdf

Lewitas, A / Golinowska, S. / Herczyński, J. (2001)- *Improving rural education in Poland*, report prepared for the Warsaw Delegation of the European Commission, Warsaw: CASE Foundation

Main Statistical Office (GUS). (*Monthly) Statistical Bulletin (Biuletyn Statystyczny GUS)*. Warszawa.

Main Statistical Office (GUS). 1998. *Health Care Yerabooks 1997*. Warszawa.

Main Statistical Office (GUS). 2001. *Basic Data of Health Care in 2000*. Warszawa.

Main Statistical Office (GUS). *Statistical information (Informacja statystyczna)*. Warszawa.

Main Statistical Office (GUS). *Statistical Yerabooks 1995, 1996, 1997, 1998, 1999, 2000, 2001*. Warszawa.

- Medical treatment after the implementation of the reform – Opinions on the quality of medical services - February 2000,

Ministerstwo Finansów (1998) – *Biała księga podatków* (White book about taxes), Warsaw

Ministry of Health and National Centre of Health System Management. (*Health) Statistical Bulletin published yearly*. Warszawa.

Ministry of Health. 1998. *Transformacja systemu ochrony zdrowia w Polsce*. (Transformation of health care system in Poland). Warszawa.

Ministry of Health: Narodowa Ochrona Zdrowia. 2002. *Strategiczne kierunki działań Ministra Zdrowia w latach 2002-2003.* (National Health Care). Warszawa, 28 marca 2002 r.;

MPiPS (Ministerstwo Pracy i Polityki Społecznej) (2002) – *Transfery socjalne* (Social transfers0, Warszawa

MPiPS (Ministry of Labour and social Policy) (2000) Basic Statistical Data on Social Policy, Warszawa: MPiPS

National Centre of Health System Management. 1998. *50 years of health care in Poland*. Warszawa.

National Centre of Health System Management. Published yearly. *Health Care in Figures*. Warszawa.

NBP (Narodowy Bank Polski) - Exchange rate of National Bank of Poland

Office for the Supervision of Health Insurance - Urząd Nadzoru Ubezpieczeń Zdrowotnych (UNUZ). 2001. *Powszechne Ubezpieczenie Zdrowotne w latach 1999-2001. Analiza funkcjonalna w świetle doświadczeń UNUZ*. Warszawa.

Office of the Government Plenipotentiary for Social Security Reform. 1997. *Security Through Diversity: Reform of the Pension System in Poland*. Warsaw.

- Opinions on the health care after two years of the reform - February 2001,
- Opinions on the health care at the end of the second year of the reform - January 2001,
- Opinions on the health service after implementation of the reform - July 1999
- Opinions on the social reforms one year after - January 2000,

Sierosławski, J. 1998 *Problmy alkoholowe w ocenie mieszkańców* (Alkohol-related problems from the citizens perspective). Raport z ogólnopolskich badań ankietowych zrealizowanych w 1998 r., www.parpa.pl

Sowa, A.(2002) – Alcohol abuse and poverty, In: Beblo/ Golinowska/ Lauer/ Piętka and Sowa – *Poverty dynamics*. Warsaw: CASE (just comming)

The World Bank (2000) – *Making Transition Work for Everyone. Poverty and Inequality in Europe and Central Asia*, Washington DC

UNDP /CASE (1998) Access to education. Human Development Report Poland 98, Warsaw: UNDP

UNDP 2000 - *Rural Development. National Development Report Poland 2000*, Warsaw

WHO Regional Office for Europe. 2001. *Highlights on Health in Poland*. Copenhagen.

Włodarczyk, W. C. 1999. *Health Care in Poland* in The University of York, Pantheion Comensus II, Project 22-9710-0016: Monitoring the development of social protection reform in the CEEC.

World Bank (1990), *Poverty World Development*, Report 1990, Oxford University Press

World Bank (1994), *Poverty in Poland*, Washington D.C.

World Bank (1995), *Understanding Poverty in Poland*, Washington D.C.

Zienkowski, L. (1998) –Dochody gospodarstw domowych w okresie transformacji 1989 1996 (Income of households in the transformation period 1989-1996) – Warszawa: ZBSE-GUS i PAN,

ZUS 1992. *Rocznik statystyczny ubezpieczeń społecznych 1985-1990 (Statistical Yearbook of Social Insurance 1985-1990).* Warsaw: Zakład Ubezpieczeń Społecznych.

ZUS 1997. *Rocznik statystyczny ubezpieczeń społecznych 1990-1995 (Statistical Yearbook of Social Insurance 1990-1995).* Warsaw: Zakład Ubezpieczeń Społecznych.

4. Websites

http://www.zus.pl/statyst

Zaklad Ubezpieczen Spolecznych (Social Insurance Institution) Statistics, available at