ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives

Poland

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Agnieszka Sowa and Irena Topińska
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with comments from Agnieszka Chłoń-Domińczak

Directorate-General for Employment, Social Affairs and Inclusion
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Summary/Highlights

In Poland, support for working-age people caring for disabled/chronically ill dependants is not well developed. Much more attention is paid to the carers of children than to those looking after adults or seniors, but combining work with care is rarely considered.

Long-term care provision is not separated as a distinct policy area, and it remains predominantly a family matter. Residential, day care and home services are provided in two sectors: health and social assistance. Residential care constitutes the core of the system and has to be paid for in part. In the health sector, facilities include nursing/care homes, hospices and palliative care units. Social assistance offers care or family care homes. Eligibility criteria differ by sector, and involve either functional capacity (health sector) or economic status (social assistance). Day care centres are developing, though their number is still small. Home care or nursing services are provided selectively to individuals who are in need of medical treatment and who are incapacitated in daily life. However, overall provision of services is low, reaching just 3.4% (home care) and 4.6% (residential care) of the dependent population.

Cash benefits are numerous but fragmented. They target either the dependants (nursing allowances and supplements) or the carers (nursing benefits, special care allowances) and their families (adjusted rules of family allowance, supplements for rehabilitation and care). Also certain disability-related expenses may be deducted from taxable income. All these benefits support mostly the families and carers of disabled children; but apart from a single programme that offers co-payment to employed parents who use formal care for children with disabilities, there are no cash benefits to stimulate the employment of care providers. Benefits are usually granted to individuals who have resigned from work or who are not able to take up employment due to care responsibilities. In general, rather than enabling a work-care balance and the labour market reintegration of carers, cash benefits simply supplement family incomes and help cover the costs of rehabilitation and care. Still, the (relative) poverty rate of families with disabled members, and especially disabled children, is visibly higher than the rate for the whole population (2014: 23%, 30% and 16%, respectively).

In-kind support for working carers is meagre. Paid days off for caring for sick children or other family members (up to 60 days a year) or extended unpaid child-raising leave for parents of disabled children are available and benefit mostly women. In 2013–14, two mechanisms supporting the employment of carers were added: flexible working arrangements and the opportunity for the labour market reintegration of unemployed people who have been informal carers. The impact of both measures remains limited. By 2015, fewer than 1,800 companies had introduced flexible working arrangements, and the take-up of subsidised employment by former carers is marginal.

Counselling and the training of carers are the new forms of activity. Up until now, they have been provided occasionally, mainly by non-governmental organisations (NGOs), but the development of organised assistance for carers is planned within regional/local activities supported by the European Social Fund. The pre-school and primary education of (disabled) children remains the responsibility of municipal governments. It is their task, but they are subsidised by the state budget. Care and education are provided in regular or special facilities. Still, as recent surveys show, parents rarely return to the labour market after enrolling their disabled children in kindergarten/school.

The reconciliation of work and care has never been a priority for social policy in Poland. This may be explained, at least partly, by the traditional family roles and a reluctance to use formal care. Policy efforts should aim at improving the coherence and transparency of the benefits, specifically cash benefits; strengthening support for the carers of adults/seniors; rethinking policy goals, with more attention paid to the work-care balance; and improving the adequacy of the benefits granted.

1 Description of main features of work-life balance measures for working-age people with dependent relatives

1.1 Overall description of long-term care regime

Long-term care in Poland is a relatively new policy field. There is no separate long-term care system, and the provision of care for dependent children and adults remains the domain of the family, with care largely provided informally by family members. There are different estimates of the scope of informal care in Poland. They vary from 80% (Kotowska and Wóycicka, 2008) to over 90% (Łuczak, 2013) of the dependent population. At the same time, according to the EHIS[1] study, one person in six (16% of respondents) declares regular (at least once a week) provision of care to a dependent (long-term ill, disabled or older) family member. Informal care providers are typically women over the age of 45. Women aged 45–64 tend to provide care for seniors, while women entering retirement age (60+) provide informal care for children (GUS, 2012).

The organisation of formal long-term care (LTC) services is based on numerous regulations and is anchored in the healthcare system, social assistance and social security. As a result, responsibilities for various elements of long-term care provision lie within the Ministry of Health, the Ministry of Family, Labour and Social Policy[2] and the Social Insurance Institution. In the healthcare system, the organisation of long-term care units is the responsibility of local self-governments and care providers (i.e. hospitals), with supervision by the Ministry of Health and financial supervision by the National Health Fund. In the social sector, provision of care is organised by local governments in cooperation with the social assistance centres, and is supervised by the Ministry of Family, Labour and Social Policy.

Public LTC comprises residential care, home-based care, semi-residential care and cash benefits. In the health sector, residential care is provided in so-called care and treatment facilities (*zakład opiekuńczo-leczniczy* – ZOL), nursing and care facilities (*zakład pielęgnacyjno-opiekuńczy* – ZPO), hospices, palliative care units and geriatric hospital departments. In the social sector, it is provided in social assistance homes (*dom pomocy społecznej* – DPS) and family care homes (*rodzinny dom pomocy*). There are six types of social assistance homes: for older people, for chronically somatically ill people, for chronically mentally ill people, for mentally disabled adults, for mentally disabled children and young people, and for physically disabled people. Family care homes target the dependent population in need of full-time care due to age or disability, and are designed to provide care for 3–8 dependent people.

Semi-residential care is provided in day care centres and support centres. Day care centres are run by local governments in cooperation with social assistance centres, and provide care for up to five days a week for no more than 12 hours a day. Since 2015, the government has supported the establishment of day care centres within the Senior-Wigor programme, which aims, among other things, at the creation of Senior-Wigor day care centres. Home-based care is provided in the form of nursing services managed by the primary care units in the health sector and care/specialist care services in the social assistance sector for dependent people, including dependent people with mental disorders.

Entitlement to services provided in the health sector and in the social sector differs. In the health sector, entitlement is based on health needs, assessed by a functional abilities evaluation using a Barthel scale. For a person to be eligible for residential or home-based nursing services, he or she must fall below the threshold of 40 points in the Barthel test. In the social assistance sector, services can be obtained after agreement with the social

[1] European Health Interview Survey.

[2] Since December 2015 (formerly Ministry of Labour and Social Policy).

assistance centre. Entitlement is based on information about the income and family situation of the potential care recipient. Preference is given to single people and – in the case of residential care – assumes that they are not able to live independently.

There are also private providers of care, mostly residential. The activity of private care providers is not supervised by any public institution involved in care management. They operate under the same regulations as any other type of private company. Privately paid home care is provided mostly in the grey economy – in many cases by immigrants.

While not constituting part of long-term care as such, educational and rehabilitation services for children with disabilities might be of importance for the well-being of carers' families, and might stimulate the labour market reintegration of parents/carers. Thus, next to the long-term care institutions, services and benefits, this report also provides an overview of these services.

1.2 Description of carers' leaves

Leave entitlements for taking care of a disabled/chronically ill child or adult family member are scarce.[3] In this respect, carers of children are in a much better position.

1.2.1 Leave for taking care of a disabled child

The most evident policy option for carers of a disabled child is their right to additional child-raising leave (*dodatkowy urlop wychowawczy*). In general, paid maternity/paternity/parental leave lasts altogether for a maximum of 52 weeks and may be followed by up to 36 months of unpaid child-raising leave, to be used before the child's fifth birthday. In the case of a child's disability (certificate needed), an additional 36 months may be claimed, to be used before the child turns 18 years. As in the general case, those parents whose work records extend for at least six months are eligible. The leave can be taken in up to five blocks, and can be interchanged with employment or education, assuming that the care is provided by the parent in person. Both parents can take up to four months' leave at the same time.

During the child-raising leave, the state budget pays pension contributions for the carer (the amount is strictly limited). Also, a supplement to the family allowance may be received, at a monthly rate of PLN 400 (approx. EUR 95), assuming that the family passes a general income test, with a threshold set at PLN 764 (EUR 173) per capita per month.

1.2.2 Days-off for taking care of a sick family member

Employees covered by compulsory or voluntary sickness insurance under the Social Insurance Institution have an entitlement of up to 60 days off per year to take care of a sick child or other family member, assuming that a medical certificate is presented and there is no other carer in the family (the latter condition does not apply if the child is less than 2 years of age). During these days, care allowance (*zasiłek opiekuńczy*), set at 80% of the personal average annual wage, is payable for the whole period if the child is under 14, and for a maximum of 14 days otherwise.

1.2.3 Flexible working arrangements

The main forms of support for care providers to enhance their work-life balance are flexible working arrangements and labour market reintegration measures. In Poland, one measure was introduced in 2013, through an amendment to the Labour Code. It consists of two elements: extension of the reference period of the work settlement from 4 to 12 months, and the introduction of flexible working hours (opportunity to individually agree time of starting and finishing the workday).

[3] Based on the Labour Code, Act of 1974 [Ustawa z dnia 26 czerwca 1974 r. Kodeks Pracy], with amendments http://isap.sejm.gov.pl/DetailsServlet?id=WDU19740240141

1.3 Description of carers' cash benefits

There are several cash benefits related to LTC provision that are available either to the carers themselves or their families, or else directly to the care recipients (or potential care recipients, in the case of older people). Importantly, the rules governing the benefits available for caring for children and for adults/seniors usually differ, being more advantageous in the former case. It should also be noted that cash benefits for carers of the disabled/chronically ill are rarely designed specifically to balance work and family life. They support family well-being, rather than work opportunities for the carers. Benefits are tax free, and the state budget pays the social and health contributions in respect of the benefit recipients.

1.3.1 Cash support for carers of the disabled dependents

Benefits for carers of disabled children

Nursing benefit (*świadczenie pielęgnacyjne*) is granted to a parent/legal guardian who has not undertaken any gainful job or has left the labour market to take care of a disabled child in need of all-day care.[4] The age of the dependant is immaterial, but there is a requirement that his/her disability must have lasted from childhood (thus before the age of 18, or 25 if in full-time education; condition introduced in 2013) and must be legally certified.[5] In 2015, the rate of nursing benefit was set at PLN 1,200 per month (ca. EUR 286), and it was increased to PLN 1,300 (EUR 295) from January 2016. From 2017, the benefit level should be regularly indexed following any increase in the minimum wage. Note that the same amount of benefit is paid irrespective of the number of disabled children or the nature of their disability. This was questioned by the Constitutional Tribunal in its decision of 21 October 2014. It pointed to the need to adjust payments according to the number of dependent disabled (children) in the family. This issue has not yet been resolved.

Benefits for carers of disabled adults

A more restricted benefit called special care allowance (*specjalny zasiłek opiekuńczy*) is granted to the carers of disabled adults. This benefit can be received by the parents or spouse of a person with a certified disability/functional incapacity and in need of all-day care, provided the carer concerned either does not take up employment or has quit employment due to his/her care obligations. Importantly, special care allowance is income tested. It is available if the claimant's net per capita family income is below PLN 764 (ca. EUR 174). The rate of special care allowance is only PLN 520 (ca. EUR 118).

Additionally, for care providers who lost their right to nursing benefit due to the new eligibility criteria introduced in 2013,[6] an allowance for carers (*zasiłek dla opiekunów*) paid at the rate of PLN 520 (ca. EUR 118) using the old/previous rules has been established.

Benefits for carers of the elderly

There are no cash benefits available to carers of older people, unless the older person holds a disability certificate.

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[4] The Act on family benefits of 2003 [Ustawa z dnia 28 listopada 2003 o świadczeniach rodzinnych], as amended http://isap.sejm.gov.pl/DetailsServlet?id=WDU20150000114

[5] In the past, nursing benefit was income tested, but the income test was removed in 2010. Given the rapidly increasing number of beneficiaries, as well as alleged misuse of this benefit, its rules were tightened from January 2013, following amendments of December 2012.

[6] According to regulations of 7 December 2012, only carers of disabled children or adults whose disability took place before the age of 18 (25 if in full-time education) were eligible for nursing benefit, while carers of disabled adults (including older people) whose disability occurred later in life lost the right to the benefit. This was found to be unconstitutional, and in 2013 an allowance for carers was introduced.

Cash support for the elderly/disabled[7]

Benefits for old/disabled pensioners

Nursing supplement (*dodatek pielęgnacyjny*) is a universal benefit granted to all those entitled to old-age, disability or survivor's pension, who are aged 75 or over, or who are completely incapable of work and need all-day assistance (certified). The amount of the supplement equals PLN 208.17 monthly (ca. EUR 50),[8] and is indexed annually with pensions. It should be noted that eligibility for this benefit is related only to age/certified disability and insurance entitlement, not to any actual need for care or to a disability/functional limitations assessment.

Benefits for the disabled/elderly

Nursing allowance (*zasiłek pielęgnacyjny*) is a care-related benefit granted in relation to the need for the provision of care to: a disabled child; a disabled person over the age of 16 who is assessed with a higher degree of disability; a disabled person over the age of 16 who is assessed with a moderate degree of disability that occurred before the age of 21; or an older person (75+) who is not eligible for the nursing supplement. The amount of nursing allowance is PLN 153 (ca. EUR 35), and indexation is linked to family benefits (every three years, the last revision took place in November 2015).

While the nursing supplement is granted by social insurance, other benefits are granted from the central budget. They remain the responsibility of the Ministry of Family, Labour and Social Policy and are managed locally by the social assistance centres (*ośrodek pomocy społecznej*) and district centres of family assistance (*powiatowe centrum pomocy rodzinie*).

1.3.2 Special rules of family benefits

In principle, child-related cash benefits are provided to families at risk of poverty. This is assessed against an income threshold. In the case of a child's disability, the threshold is higher than the regular one. Also, a supplement to the benefit may be granted.[9]

Currently, from October 2015, family allowance is paid if per capita family income is lower than PLN 674 (EUR 153) per month, but this threshold is higher – PLN 764 (ca. EUR 174) – for families raising a disabled child. The benefit rate does not consider disability, but there is a supplement to the allowance for the education and rehabilitation of a child with a disability. It is paid at PLN 50 (ca. EUR 11 for children aged 5 years and under) or PLN 100 per month (ca. EUR 24 for children aged 6–24). A similar rule of using a higher threshold for the income test in the case of child disability applies to the newly established benefit within the Family 500+ programme. From April 2016, PLN 500 (ca. EUR 119) per month is to be paid for the second and any subsequent child in a family, and also for every first child if per capita income is below PLN 800 (EUR 182), or below PLN 1,000 (EUR 227) if the family is raising a disabled child.

Tax deductions

Tax relief is available to individuals with certified disability assessment, or to the families who bear their costs of maintenance. The cost of medicines, rehabilitation appliances, care services, educational materials, etc. (listed items, strict limits) may be deducted from taxable income. Only personal income taxpayers can use it, which excludes farmers and people living on various social benefits (social assistance, nursing benefits, etc.). The long list of disability-related deductibles includes expenses relating to rehabilitation,

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[7] Disability-related social pension is not discussed in this section

[8] PLN 281.58 (ca. EUR 47) since March 2016.

[9] The Act on family benefits of 2003 [Ustawa z dnia 28 listopada 2003 o świadczeniach rodzinnych], as amended http://isap.sejm.gov.pl/DetailsServlet?id=WDU20150000114 and the Act on state support for raising children of 2016 [Ustawa z dnia 11 lutego 2016 r. o pomocy państwa w wychowaniu dzieci] http://orka.sejm.gov.pl/opinie8.nsf/nazwa/216_u/$file/216_u.pdf

transport, appliances, part of the costs of medicine, holidays with rehabilitation programmes, etc.

1.3.3 Active Local Government programme

Co-financing of the fees for formal childcare borne by working parents who are raising children with disabilities has been effective since 2012. This is the only cash support used directly to help balance the work and family lives of carers. The co-payment is provided within the pilot programme Active Local Government (*Aktywny Samorząd*), established and financed by the State Fund for Rehabilitation of the Disabled (*Państwowy Fundusz Rehabilitacji Osób Niepełnosprawnych* – PFRON).[10] It assumes a grant of PLN 200 per month (ca. EUR 42–45), with a maximum of PLN 2,400 a year (ca. EUR 504-540), for each disabled child attending a nursery, kindergarten or children's club, assuming the parents are working and the child carries a certificate of disability. The programme may also co-finance other expenses, such as rehabilitation holidays for the disabled (also for carers accompanying children), orthopaedic and other appliances/equipment, education fees (at higher level) and the like, within clear limits. Notice, however, that the Active Local Government programme was established by a resolution of the Supervisory Board of the PFRON, not by a solid legal act. It is implemented by those district governments (*poviats*) that are prepared to join the programme.

1.3.4 Co-financing of rehabilitation and activation

Co-financing of rehabilitation, appliances, recreational tours and sports events for adults and children may draw on various sources – such as PFRON, the National Health Fund (*Narodowy Fundusz Zdrowia*) and local governments (usually district/ *poviat*). In any case, there are strict limits regarding the payments, goods and services considered, as well as the disability status of the beneficiary. For instance, co-financing for children's holidays with a rehabilitation programme co-financed by PFRON cannot be granted more than once a year and cannot exceed 20–40% of the actual average wage in the economy (depending on the age and degree/severity of the participant's disability), but it may also cover the carer (20%). This requires an income test to be passed, with the threshold for per capita net family income set at 50% of the average wage (65%, if the person is single).[11] The same way of income testing is used to check eligibility for medical/rehabilitation equipment.

1.4 Description of carers' benefits in kind

Support for care providers can take various forms of in-kind benefits: respite support, training, counselling and psychological support, benefits aimed at labour market reintegration, or – in the case of employment – flexibility at work, support for activities of the dependent persons, including the education of disabled children. Still, in Poland in-kind support for informal care providers is at a very early stage, with some changes introduced only recently.

1.5 Counselling, trainings

Programmes aimed at recognising the needs of informal care providers and introducing training or counselling are in the very early stages of development. Occasionally, they are offered by non-government organisations (NGOs), often subsidised by public funds (information exchange, counselling, psychological support for parents). Discussion of care providers' empowerment, recognition of their needs and an adequate response to

10 PFRON (2015) and http://www.pfron.org.pl/pl/programy-i-zadania-pfr/aktywny-samorzad/1644,dok.html

11 The Act on vocational and social rehabilitation and employment of the disabled of 1997 (Ustawa z dnia 27 sierpnia 1997 r. o rehabilitacji zawodowej i społecznej oraz zatrudnianiu osób niepełnosprawnych), as amended http://isap.sejm.gov.pl/DetailsServlet?id=WDU20111270721 and Regulation of the Minister of Labour and Social Policy of 2007 amended in 2014.

fulfil these needs have all recently become the topic of local and regional research, as well as of regional and local social policy. Research in the Łódzkie region (voivodship) has revealed that the needs of informal care providers include psychological support to prevent depression and burnout, first-aid training, training in care for chronically ill and immobile patients, training in simple medical procedures (such as performing injections) and massage, and simple rehabilitation (Janowicz, 2014). In 2014–20, the development of support, counselling or respite care centres by local governments or NGOs will be supported by the European Social Fund.

1.6 Labour market reintegration of care providers

Another mechanism, introduced in 2014 as an amendment to the Act on employment promotion and labour market institutions,[12] addresses the labour market reintegration of care providers. It enables the creation of employment opportunities (teleworking or other subsidised employment) for a former carer who has been providing personal care to a child under the age of 6 or another dependent person and who, for this reason, had given up her/his job in the three-year period before registration with the employment office. Employers can receive a subsidy equal to half of the minimum wage for 12 months, or a third of the minimum wage for 18 months, if they employ a registered unemployed person who had previously been providing care to a dependent person. The second reintegration mechanism is the creation of a teleworking position, subsidised by the Labour Fund up to a maximum of six times the minimum wage in a year; this covers to employment of a former carer for at least 12 months full time or 18 months part time.
Educational arrangements for the disabled children

Specific arrangements in the education system are important for supporting families with disabled children.

According to the Education Act,[13] the provision of early education and care for (disabled) children is the task of municipalities (*gmina*). Municipal governments are responsible for the establishment, management and financing of public kindergartens, including special kindergartens for children with disabilities or with special needs (certified). They are also responsible for the establishment and management of primary schools with integration classes, as well as of special educational centres. For this, they receive a subsidy from the state budget for each pupil (*subwencja oświatowa*); this is higher in the case of a child with a disability. Municipalities should also provide free transportation for children aged 5 and over with disabilities/special needs who attend kindergartens/primary schools, and teaching assistants in schools (the latter is not always obligatory). Similar rules apply with regard to secondary education organised by the district (*poviat*) governments. It may also be noted that, while pre-school education is not compulsory for children under 5 (under 6, from 2016/17), families with disabled members/children have priority admission to regular kindergartens.

2 Analysis of the effectiveness of work-life balance measures for working-age people with dependent relatives

2.1 Assessment of individual measures

The provision of public LTC services is very low in Poland. Only 4.6% of the dependent population receives formal home care and 3.4% receives formal care in residential institutions. These shares are among the lowest in the EU (European Commission, 2015).

[12] Act of 4 April 2004 on labour promotion and labour market institutions with amendments [*Ustawa z dnia 4 kwietnia 2004 r. o promocji zatrudnienia i instytucjach rynku pracy*], articles 60b and 60c.

[13] Education Act of 1991 [*Ustawa z dnia 7 września 1991 r. o systemie oświaty*], with amendments http://isap.sejm.gov.pl/DetailsServlet?id=WDU19910950425 and the website www.wszystkojasne.waw.pl

Access to formal residential care in the health and social sectors is poor. The density of beds in residential facilities in the health sector is among the lowest in the Organisation for Economic Co-operation and Development ((OECD) countries, with fewer than 20 beds per 1,000 population aged 65+ in 2014 (OECD, 2016). Overall, in 2014 there were over 32,000 beds and slightly over 30,000 patients (70% of whom were patients aged 65+) in residential care facilities in the health sector (GUS 2015a: ZOL, ZPO, hospices and palliative care facilities). The number of older patients increased by 21.6% compared to 2011, which reflects the growing need for care in this cohort. At the same time, there were 77,900 beds and 76,700 patients in residential care (DPS) in the social sector (MPiPS, 2015a). Semi-residential activities in day care centres arranged by local governments remain underdeveloped, as in 2014 only 196 units operated throughout the country, offering services to 13,700 people (MPiPS, 2015b).

The number of day care centres is growing, thanks to the Senior-Wigor government programme: 99 Senior-Wigor facilities providing day care had been created by the end of 2015. This type of care is important for the activation of the older population, while it also supports the employment of informal care providers. The provision of nursing care services in the health sector is monitored by the National Health Fund, but statistical information on service coverage is limited. According to the latest available data, in 2012 some 64,600 patients received services, and over 80% of recipients were aged over 65 years. Home care services from the social assistance sector were provided to 88,900 individuals in 2014, and 12,300 received specialist care services for people with mental health problems (MPiPS, 2015b). Low provision of home care reflects the low capacity of the social assistance centres, rather than the needs of the dependent population (Błędowski and Maciejasz, 2013). Barriers to home care provision include poor information on the services available, poor knowledge of law related to home care provision among social workers, financial constraints (both on account of the social assistance resources and because of the co-payment obligation) and the small number of professionals who can provide this type of care.

Overall, poor provision of formal care services and the fact that the services are targeted either at people in poor health (assessed by a Barthel test) or at single people with low incomes create pressure on the provision of informal care. The development of day care centres for seniors (which began in 2015) is important, as it may help care providers to reconcile their family obligations with other activities, including labour market activities. However, the sustainability of day care centres in the long run is uncertain, as their activity depends on the ability of local governments to cover their operational costs.

Long-term care policy is oriented toward assuring a minimum standard of living for families with dependent people and (limited) coverage of the costs related to rehabilitation and care, rather than toward a work-care balance and the labour market reintegration of care providers. The high level of informal care has a negative impact on the employment rate, especially of women in their 50s, and often leads to an early labour market exit, due to the need to provide care to dependent elderly parents or grandchildren. Though the employment rate for women aged 55–64 increased in the period 2010–14 from 24.2% to 32.9%[14] (and for men from 45.2% to 53.1%), it remains low compared to other European countries. According to Labour Force Survey data (GUS, 2012), while 9.1% of people aged 15–64 who are inactive on the labour market provide informal care, the figure is only 6% of people who are active on the labour market. Informal care is also provided by 9% of the unemployed.

2.2 Carers' leaves

Carers' leave is used predominantly by women. Although national statistics do not provide information on the number of parents who are on the extended child-raising leave, granted for taking care of a disabled child, data on the users of child-raising leave

[14] *Labour Force Survey statistics – Badanie Aktywności Ekonomicznej Ludności IV kwartał 2014.*

(in general) show that in 2005 ca. 50% of mothers who were bringing up one or more children aged under 8 took at least one month's leave, while the share of fathers was only 2.5%; in 2010, these figures decreased to 38% and 1.2%, respectively.[15] Because of the rules governing it, child-raising leave is clearly not very popular, although it might be more widespread among the parents of children in need of long-term care.

Taking days off to care for an ill child/adult is more common, but it also shows a clear gender bias. In the second quarter of 2015, over 280,000 women, but only 90,000 men received care allowance paid for this type of leave.[16] In previous quarters, the numbers were lower, but the male–female proportion remained very similar (women: 250,000, men: 80,000 in 2Q 2014). But according to European Quality of Life Survey (EQLS) data for 2012, less than half of employees could take leave at short notice, if needed (43.8% of women and 44.2% of men).

2.3 Carers' cash benefits

The actual coverage of cash benefits related to care is high. This is mainly due to the nursing supplement, which is a universal benefit provided to (almost) all individuals over 75. Altogether, cash benefits reach 62% of the dependent population (European Commission, 2015). The main function of cash benefits is to provide compensation for the costs related to care. However, given the low level of most cash benefits provided to dependent people or their carers/families, their impact on the family situation remains limited.

2.3.1 Cash benefits for carers of disabled children

The role of nursing benefit, which is the main income replacement benefit for carers of disabled children, is ambiguous.

First, it is not permitted to combine nursing benefit with a paid job. This makes the question of the benefit rate a very hot topic. While the whole arrangement is seen by many experts as debatable, it is not strongly questioned by parent-beneficiaries. In 2013–14, there was visible pressure from parents to increase the benefit rate,[17] and this resulted in a considerable rise. The current rate is close to the net minimum wage (2015: PLN 1,200 or ca. EUR 286 for the benefit, versus PLN 1,286 or EUR 308 for the minimum wage; 2016: PLN 1,300/EUR 295, versus PLN 1,355/EUR 308).[18] Such a comparison is often put forward, given the widespread feeling that caring for a disabled family member should be treated as a regular job and should be paid accordingly (RPO, 2015).

Secondly, the eligibility criteria for nursing benefit are questioned, as they create inequalities between carers: it all depends on when the disability occurred. The benefit is available to carers of disabled children/adults if the disability occurred in childhood, whereas the carers of disabled adults whose disability occurred in adult life are not eligible. In October 2014, the Constitutional Tribunal declared that this age restriction was unconstitutional and that carers should be treated equally.[19] Responding to the Tribunal's decision, the government submitted a draft law intended to make the rules more just and transparent, but this draft has not progressed further.[20]

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[15] Source: GUS (2006; 2012); newest editions are not available.

[16] www.psz.zus.pl

[17] Occupation of the premises of the Parliament by the group of activists at the beginning of 2014.

[18] In fact, the minimum wage is set gross, the net version is calculated for convenience. Available at http://www.fakt.pl/finanse/pensja-minimalna-w-2016-r-ile-wyniesie-brutto-a-ile-etto,artykuly,573476.html

[19] http://trybunal.gov.pl/rozprawy/komunikaty-prasowe/komunikaty-po/art/7169-prawo-do-swiadczenia-pielegnacyjnego/

[20] http://www.mpips.gov.pl/bip/projekty-aktow-prawnych/projekty-ustaw/polityka-rodzinna/projekt-ustawy-o-zmianie-ustawy-o-swiadczeniach-rodzinnych-oraz-niektorych-innych-ustaw1-/

Thirdly, the rate of nursing benefit is much higher than the rate of special care allowance or the allowance for carers (benefits paid to the carers of family members who are not children). Moreover, nursing benefit is more easily accessible (there is no income test). This duality of rules has also led to criticism.

In 2014, there were 106,000 recipients of nursing benefit – a much lower figure than in 2013 (164,000); overall expenditure decreased from PLN 1,072 million to PLN 929 million (ca. EUR 252 million and EUR 221 million, respectively; MPiPS, 2015c). This decline was a result of the eligibility restrictions (disability from childhood) introduced in 2013. A decline in the number of supplements to the family allowance provided for rehabilitation and education of disabled children is also visible. Nevertheless, this income-tested support is quite common: over 137,000 claims were paid in 2014 (145,000 in 2013). In total, this supplement absorbs much less than the nursing benefit: PLN 126 million (ca. EUR 30 million) in 2014, 133 million (EUR 32 million) in 2013.

2.3.2 Cash benefits for carers of adults

There is a visible imbalance in the support provided to carers of disabled children and to carers of dependent adults (especially older people) in need of LTC. Moreover, the level of benefits for carers of disabled adults (care allowance and special care allowance) is only half the level of benefits for carers of children (nursing benefit). It is equal to about half of the minimum wage, although – as with the nursing benefit – it cannot be combined with employment, and so this may increase the risk of poverty. The number of recipients of special care allowance is low (12,800), while on average the care allowance reached 66,200 people each month in 2014 (MPiPS, 2015c).

2.3.3 Care-related benefits for the elderly/disabled

For older people who do not have a disability certificate, the only care-related benefit is the nursing supplement or (for those who are not covered by social insurance) nursing allowance. These benefits reach a broad section of the population, thanks to the universal character of the nursing supplement; but the amounts are too low and are inadequate to cover the costs of rehabilitation and care. The nursing supplement reached on average 2.2 million people each month in 2014 and 2.3 million people each month in 2015. Total annual expenditure amounted to PLN 5,508 million in 2014 and PLN 5,666 million in 2015 (ca. EUR 1,222 million and EUR 1,350 million, respectively).[21] The nursing allowance was paid to 926,900 people in 2014, mostly to disabled adults (74%). Only 3% of benefit recipients were older people aged 75+ (MPiPS, 2015c). Expenditure on nursing allowance amounted to PLN 1,702 million (ca. EUR 405 million) in 2014.

2.3.4 Measures introduced by PFRON and local governments

The cash support for parent-carers of children with disabilities that is provided by the State Fund for Rehabilitation of the Disabled (PFRON) is much lower. This concerns the most important benefit that is designed to help people to combine work and family life that is paid under the programme Active Local Government and that co-finances the fees for formal childcare. In the first three quarters of 2014, the number of beneficiaries of this type of support totalled 810, and the number of parents who received support for accompanying a child on a holiday tour with the rehabilitation programme was 9,420 in the whole of 2013 (PFRON, 2014; 2015). One should note, however, that the main task of PFRON is to develop the labour activation of disabled adults, including their education and training, co-payment of equipment, etc. Also, parents seem more reluctant to seek specific childcare-related support at PFRON, and administrative procedures are not very friendly.

[21] Information provided by the social insurance institution (ZUS) on individual request.

2.3.5 Impact on poverty

Cash support for families with disabled members certainly improves their standard of living. Still, the poverty rate for these families – especially if disabled children are present – is much higher than the country average. In 2013–14, poverty was stable in the country as a whole, and indeed was fairly stable (albeit higher) among households with disabled family members. However, it increased among households with disabled children, possibly as a result of the decline in benefit payments. National statistics show that in 2014, the relative poverty rate for households with at least one disabled child under 16 reached almost 30% (26% in 2013), while it was close to 23% for households with disabled members (any age), and 16.2% overall (unchanged from 2013).[22] Moreover, extreme poverty was also much higher if a child with a disability was present, and – unlike the situation overall – it increased in 2013–14 (2013: 11.5%, as against 7.4% for all households; 2014: 14.6%, as against 7.4%).

2.4 Carers' benefits in kind

2.4.1 Working arrangements and labour market reintegration

According to the EQLS 2012 data, only one employee in three (32.6% of women and 32.3% of men) had an opportunity to vary the time of starting and finishing work. This opportunity increases with age (35.6% of workers aged 50–64 can set their work time) and varies across incomes, with greater opportunities for flexibility in the lowest and the highest income quartiles (35% and 35.4%, respectively). This might be related to the specific position of employees with long work records (older workers), or to lower effectiveness (low income) or holding managerial posts (high income).

The impact of the 2013 regulation introducing more flexible work arrangements remains limited. By October 2015, only 1,766 employers had introduced flexible working time, although this number is growing (1,319 in January 2015). Flexible work arrangements tend to be reported by larger companies, with 50–249 employees (649).[23] There is no evidence, however, as to the types of activities undertaken by the employers and employees, or if (and how) care providers benefit from these solutions (Furmańska-Maruszczak, 2015).

The impact of the labour market reintegration benefits introduced in 2014 and aimed at the reintegration of unemployed former carers is debatable. According to statistics from the Ministry of Family, Labour and Social Policy, only 39 individuals benefited from the subsidised employment and nine from the subsidised employment in teleworking.[24]

2.4.2 Education system

Education services for children with disabilities may help parents to combine work and family life. But recent studies suggest that their impact on the labour activity of carers is not impressive.

National statistics show some expansion of formal care for disabled children aged 3–5, and stability at the primary education level. In the school year 2014/15, over 14,500 children with disabilities attended kindergarten (any type), or 1.6% of all children enrolled (GUS, 2015b). In previous years, these figures were lower (2011/12: 9,500 or 1.1%). But according to the Census 2011, the share of children with disabilities in the age group 3–5 was higher, in the range 2.1–2.8%. This indicates that, as regards pre-

[22] All poverty estimates in this paragraph are national estimates from GUS (2015d). They are based on household budget surveys. Households' standard of living is measured with equivalent expenditures. Poverty threshold is set at 50% of the mean equivalent expenditure for relative poverty, and at the subsistence minimum for extreme poverty. In any case, legally approved/certified disability is considered.

[23] Information of the Ministry of Family, Labour and Social Policy http://www.mpips.gov.pl/aktualnosci-wszystkie/art,5543,7443,1766-firm-z-elastycznym-czasem-pracy.html

[24] Statistics of the Department of Labour Market, Ministry of Family, Labour and Social Policy.

school education, disabled children were in a worse position than able-bodied ones. At the same time, the number of special primary schools for children with disabilities (149–150 depending on the year) and the number of pupils (2,900) were fairly stable. This also goes for the number of integration classes in regular primary schools (3,800 classes with between 14,100 and 14,600 children). Some development was noticed at lower secondary level and in special classes of primary schools.

However, a recent survey by the Educational Research Institute (*Instytut Badań Edukacyjnych* – IBE) shows that only 4% of parents returned to the labour market after enrolling a disabled child in kindergarten; 11% when the child began to attend primary school; and 4% on his/her enrolment in lower secondary school (Grzelak et al., 2015). In general, 43% of respondents declared that they had to leave the labour market to take care of a child with a disability.

The problems with access to care and education for children with disabilities are reported in various studies (Grabowska, 2015; NIK, 2013; ORE, 2015; RPO, 2015; and the website www.wszystkojasne.waw.pl). These problems include: lack of adequate information on benefits and services available to parents; shortage of care facilities, especially in rural areas; difficult access to some services, e.g. free transportation;[25] lack of acceptance of disabled children in regular schools/kindergartens – sometimes by teachers, but often by the parents of healthy children; and bias towards care/education in special kindergartens/schools (the IBE survey shows that parents often opt for this type of school/kindergarten for their disabled children).

2.5 Assessment of overall package of measures and interactions between measures

Reasons for the high level of informal care in Poland include: traditional family relations; frequent co-residence of older people with their children (high co-residence index); a high level of labour market inactivity among people aged 50+, or earlier labour market exit of females aged 50–64 due to family responsibilities (including care for older parents or parents-in-law); an underdeveloped supply of formal, publicly financed care; and a lack of affordable private care establishments (ASSIP, 2014).

It should be noted that access to LTC services remains poor due to the small number of residential and day care facilities, especially in rural regions. Often, transportation is not suited to the needs of older/disabled people. Additional barriers relate to the residential facilities: there are the issues of cost-sharing[26] and the screening-out of applicants on the basis either of medical assessment (facilities in the health sector) or of income plus incapability of family care provision (social assistance facilities). Access to services, especially to day care support for seniors and educational facilities for children, might be important in stimulating employment, although the data show that carers are rather reluctant to take up employment and/or use flexible work arrangements or part-time employment, which typically support family obligations.

Overall, Poland (together with other states of Eastern Europe) is one of the worst-performing countries in the European Union in terms of reconciliation of care and work (Eurofound, 2015), with the main reconciliation measures oriented towards flexible daily working hours. Although numerous, the cash benefits available to carers and dependent people are fragmented, not very transparent and rather low. Thus they hardly support independent living or care provision, covering only a small fraction of expenditure related to care. Benefits are mostly intended to support the carers of disabled children, while support for the carers of disabled adults, and especially older people, is scarce. Tax deductions are useful, especially as they apply not only to the dependent people, but also

[25] Contrary to the discussions on the Internet, the IBE survey does not indicate free transportation as an issue.

[26] In residential care facilities in the health and social assistance sectors, a co-payment is imposed with a ceiling of 70% of the individual income of the care recipient.

to the families they live in; together with cash benefits, they might play a certain role in poverty alleviation. However, the current design of a number of care-related benefits excludes the employment of care providers, and this may result in a poverty trap for families with members in need of LTC, especially children. The carers of adult disabled and older people face a higher risk of poverty and of labour market exclusion. The 2014 policy measure aimed at the labour market reintegration of former carers is of hardly any use.

Measures to support informal carers in the form of training are scarce. The proposal for long-term care reform submitted by MPs of the previous Parliament included the idea of new cash benefits for carers, as well as measures to support them with training. However, it failed to gain support and has been abandoned. At present, in place of a coherent system to help informal carers with nursing training or psychological support, local initiatives of services provided mostly by NGOs are supported through European Social Fund resources.

2.6 Policy recommendations

Discussion of the design and effectiveness of LTC-related measures in Poland allows four key policy recommendations to be made.

2.6.1 There is an urgent need to make the system more coherent and transparent.

At present, a quite large number of benefits are granted – services, cash payments, and, less commonly, in-kind support. These were introduced gradually, starting with the reforms of family benefits in 1996 and 2003, and continuing with reorganisation of the healthcare system in 1999, radical modifications to social assistance in 2004, and finally changes in response to the needs articulated by stakeholders/informal care providers (i.e. protests in 2012 and 2013). As a result, the design of the system is unclear (e.g. a variety of similar-looking cash benefits/allowances is available), responsibility for benefit provision is spread across various government agencies, and the main goals are ambiguous.

2.6.2 Adequate support for the carers of older people should be introduced.

The needs of carers of older people who do not have a disability certificate but who face dependency due to loss of functional capacity related to age are hardly recognised. Given the disproportionate amount of cash benefits for carers of disabled children and adults, and the lack of support for the carers of older people, the benefits should be revised, with more attention paid to the latter group of carers.

2.6.3 There is a need to set proper goals for LTC-related benefits.

At present, the goals appear obsolete. Purely informal care by relatives is still promoted, with inadequate attention paid to supporting the work-life balance. In fact, neither the reconciliation of work and care nor the labour market activation of care providers has ever been a priority of LTC-related public policy. The rules governing cash benefits, for instance, have clear incentives for the carers of disabled family members to stay at home. Although some flexibility in working hours and certain incentives for carers to return to the labour market have been introduced, their impact is very limited. Responding to the policy goal of the work-life balance and the needs of the dependent population, residential services, day care and home services should be further developed.

2.6.4 Adequacy of benefits, both services and cash support, should be improved.

Neither the needs of care recipients nor the needs of care providers are well recognised. This results in difficulty in setting a proper rate for cash benefits, and sometimes in debatable lists of co-financed services and appliances. To help solve these problems, it

would be useful to set a minimum income and propose an adequate service package for families with disabled/chronically ill members. In this respect, a deliberately developed basket approach might possibly be used.

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