ESPN Thematic Report on Challenges in long-term care

Poland

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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

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Summary

The Polish population is foreseen to age dynamically in the decades to come. This phenomenon has been addressed through the national policy framework along with various policy measures. The latter include establishing universal child-raising benefit as well as supporting active and healthy ageing policies. The responsibility for setting up a policy and legal framework on long-term care is split between the Ministry of Health and Ministry of Family, Labour and Social Policy.

The provision of long-term care services is organised in a two-tier system, by institutions in both the health and social assistance sectors. The overall public expenditure on long-term care is estimated at about 0.8% of GDP (European Commission 2015). Though care is mainly a family responsibility (strongly supported in a conservative, traditional society), there are various long-term care institutions in place. These include residential care facilities in the health and in social assistance sectors, day care services in the social assistance sector, and home care services in the health and social assistance sectors. Eligibility criteria, accessibility of services and the type of services diverge between sectors. In principle, in the health sector services are granted to people with a high level of functional impairment and with rehabilitation needs; whilst in the social assistance sector services are granted to people with less medical, but more social, needs in cases where the family is incapable of care provision. In fact, it is often reported that patients in similar conditions are living in different institutions, thus receiving different types of care are in both types of facilities (either care or nursing and rehabilitation). There is a need for investment in care services to assure equal access to support. The central government has begun to financially support the provision of services to the oldest people living in rural areas and in towns with up to 40,000 citizens. Improving the availability of services, introducing patient-oriented (personalised) services and improving coordination of services between sectors are becoming crucial for addressing the growing needs for care.

Inequalities in access to services across regions and long waiting times for residential care services are reported. The development of day care services for older people is supported through a dedicated governmental programme; however obstacles to developing services and assuring the long-term sustainability of newly established centres are reported. These obstacles are related to a poor recognition of older people's needs as well as the low financial and human capabilities of local communities to establish new care units.

Another challenge the long-term care is facing is the improvement of monitoring. Strict standards of care are defined in the health sector and in residential care, while in the social assistance sector – and especially for home care – standards are less sound and care is poorly monitored. The least well monitored is care provided in private facilities. Available monitoring measures and indicators concentrate on input and output rather than outcome. Comprehensive, cross-sector and comparative information on long-term care is limited, as all statistical monitoring is divided between sectors: health, social assistance, and social insurance in the case of cash benefits. There is a need for strengthening the evaluation of outcomes, costs and expenditure related to care.

With a low level of service provision, informal care is the most commonly used option. Unpaid care is typically provided by women prior to their retirement or retired. An LFS-based study has pointed to care responsibilities being among the reasons for taking early retirement. Other estimates suggest that about two thirds of carers are not active in the labour market. Measures supporting the work-life balance and labour market activity of care providers are scarce. The available cash benefits cannot be combined with employment. There is a disproportion between financial support for carers of disabled children and for those of adults (older people). Cash benefits for the former are twice as high as those for the latter. Benefits for carers of older people are granted only in the case of disability. The main benefit available to older people, although universal, is very low. With changes in women's roles, and with nuclear families becoming more common, the provision of unpaid family care often becomes difficult. Informal, paid care provided in the grey sector of the economy becomes an alternative. A private market of care develops,

with services often provided by migrants; but the size and quality of privately provided care remains unknown.

1 Description of the main features of the country's long-term care systems

Long-term care for elderly people in Poland is traditionally and legally a family domain, which is strongly supported by conservative values and social expectations. It is estimated that 70-90% of care is provided informally (Kotowska et al. 2007, Łuczak 2013). Given the foreseen ageing of the population, with the share of people 65+ projected to double (from 15.2% in 2015 to 32.9% in 2060) and the share of people 80+ projected to triple (from 3.9% in 2015 to 12.0% in 2060) (Eurostat 2017), the government has prepared several diagnostic and policy documents related to long-term care. As long-term care services are provided through the two tiers of the welfare system, health and social assistance, there are separate policy documents for each.

The provision of long-term care is rooted in sectoral regulations on medical services and social assistance and is organised at the local level. Although not reaching a wide population, a diversity of services is provided. These include the following.

- Residential services provided in medical care units and social assistance sector units. Nursing and care facilities (*zakłady pielęgnacyjno-opiekuńcze – ZPO*) and nursing and treatment facilities (*zakłady opiekuńczo-lecznicze – ZOL*) are medical sector facilities providing care to persons of all ages with a high level of need for full-time medical and nursing care. Residential services provided in the social assistance sector units cover social assistance homes (*domy pomocy społecznej – DPS*), family care homes[1] (*rodzinne domy pomocy*) and private care units registered with regional government. Social assistance homes, which are the most common, provide care to different groups of recipients: older people, chronically ill people, mentally disabled adults, disabled children etc.
- Community care and day care services provided by the social assistance sector.
- Nursing home care services provided in cooperation with primary medical care units and home care services/specialised home care services provided by the social assistance sector.

In 2018 the government established a programme entitled 'Care 75+' (Opieka 75+) supporting local authorities financially in the provision of specialised care services to the oldest people living in rural areas and in towns with up to 40,000 citizens. The government foresees increasing the number of services provided and reaching people in need who have not used services in the past. The government subsidises the costs of services under two conditions: that local authorities cover at least 50% of the total cost, and that they do not outsource services to a private or non-profit provider.

Eligibility criteria for home, nursing and residential services differ, depending on the sector that provides it. In medical care, services are granted where someone needs full-time care, nursing and rehabilitation, based on a referral from a physician. Only persons whose functional health is assessed below 40 points on the Barthel scale are eligible. In the social assistance sector, services are provided to individuals who cannot assure their own care due to low income, a difficult family situation or loneliness. The situation and needs of an older person are individually assessed by a social worker. A project aimed at the standardisation of eligibility criteria in social assistance in relation to the functional abilities of people in need of care is ongoing, supervised by the Ministry of Family, Labour and Social Policy.

[1] Small care facilities for up to 8 persons.

As with services provision, the financing of care is separated into the two branches of the social protection system and – additionally – between different levels of government. Services provided by medical care units are financed from obligatory social health insurance. Services provided by the social assistance sector are financed from general taxes as well as local government resources, depending on the type of service.

There is cost-sharing for residential care services in both sectors, and for home care services provided by the social assistance sector. Patients in long-term care units in the healthcare sector cover accommodation and nutrition costs. The particular (per patient) level of cost-sharing is set by the unit manager, depending on individual incomes. The patient contribution is set at 250% of the lowest retirement pension and should not exceed 70% of a patient's individual monthly income. There is no financial obligation on the patient's family. In social assistance homes, cost-sharing should also not exceed 70% of individual incomes; however, an exception is made for individuals who were enrolled before 2004, when the total cost of staying in a residential home was fully covered from budgetary resources. In cases where care recipients are on low incomes and neither they nor their family[2] can co-fund the costs of care, local government contributes towards the costs of staying in social assistance homes. According to the data of the Ministry of Family, Labour and Social Policy, 68% of recipients in social assistance homes receive support from local government to cover the costs of their stay(MRPiPS 2017a). Those who are not eligible for care in public units often receive care in the private sector. Private full-time care facilities are developing, with about 360 facilities registered with the Ministry of Family, Labour and Social Policy; however, a large number of unregistered private full-time care providers operate in a free market, which are not monitored and supervised (NIK 2016). The cost of full-time care provided in family care homes and registered private facilities is fully paid for by the user. The cost of care is often very high and many people cannot afford these services.

There are several cash benefits related to care, although only some of them are available to the older population or to those providing care to older dependent people. In general terms, there is more care-related support for the parents of disabled children than for the carers of older people; and there is no financial support for the latter unless the dependent person is disabled (Sowa, Topińska 2016).

The most common cash benefit is the nursing supplement (*dodatek pielęgnacyjny*), granted universally to all individuals aged 75 or more who are entitled to receive a retirement pension. The benefit is financed from the social security insurance scheme. The monthly benefit is almost universal and equals PLN 215.25/EUR 51 in 2018. Those who are not entitled to receive the nursing supplement, due to a lack of social insurance, are granted nursing benefit (*zasiłek pielęgnacyjny*), which is an element of the family benefits system, financed from local government resources. The latter benefit equals PLN 153/EUR 35) per month in 2018. The difference in benefit levels is a result of annual indexing of the nursing supplement, together with the retirement pension. Both benefits are low, hardly allowing for any services and in fact are a contribution to older people's incomes. They are not subjected to any purpose-related monitoring or reporting of the type of expenditure.

Carers of adults, including people aged 65+, who have a certified (legal) disability based on a medical assessment and recognised by the social security institution are entitled to receive financial support if they resign from employment or are unable to undertake employment due to caring responsibilities. The special care allowance (*specjalny zasiłek opiekuńczy)* can be granted under the above conditions and when family income per capita is below PLN 764/EUR 182. The benefit amounts to PLN 520/EUR 124 monthly. Additionally, care providers who lost the right to receive nursing benefit due to the new eligibility criteria

[2] According to the law on social assistance, a family is obliged to cover the costs of care if the income of a person in need is insufficient. Families whose incomes are below 300% of the social assistance threshold for a given type of household are exempted from this obligation.

introduced in 2013[3], are eligible for an allowance for carers (*zasiłek dla opiekunów*) paid at the rate of PLN 520/EUR 118 monthly in 2018.

There is a significant inequality between support for the parents of disabled children and that for the carers of disabled adults: cash benefits for the former are double those for the latter. The nursing supplement (*świadczenie opiekuńcze*) for disabled children is annually indexed and equals the level of net minimum wage.

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

The main challenges that the country is facing with respect to long-term care include the development of formal care services for older people who do face a certain level of limitations, but who are not severely impaired and legally disabled. Additionally, since traditionally services are to a large extent provided by families, support for informal carers is needed in the form of work-life balance measures, respite care, training and psychological care. Another issue is coordination of care between the two sectors, preferably at the local level, but stimulated by national regulations. The development of services and increased coordination will not be possible without an improvement in the assessment of older people's needs and better cross-sector statistical evidence on the need for, and utilisation and costs of, care.

2.1 Access and adequacy challenge

The overall number of residents in long-term care homes of different types and in both sectors (health and social assistance) amounted to about 135,000 people in the years 2015-2016 (GUS 2017, MRPiPS 2017a). There were 47,600 patients in long-term care and nursing homes (ZOL, ZPO) in 2015 (GUS 2017); 77,700 residents in social assistance sector residential homes (DPS) in 2016; and 9,200 in registered full-time care facilities in 2016 (private companies) (MRPiPS 2017a). Provision of services in family care homes is marginal, reaching less than a couple of hundred people per year. Older people (60/65+) are the main users of residential care, constituting 76% of patients in care and nursing facilities in the health sector (defined as age 65+) and 57% of recipients in social assistance homes (defined as age 61+) (GUS 2017a, MRPiPS 2017a).

Waiting times for residential services are reported in both sectors. In the health sector (ZOL and ZPO), waiting times strongly differ between regions and facilities. In some, services can be provided almost immediately, in others waiting times are reported to be as long as a year (NIK 2010). Similarly, in the social assistance sector, residential care (DPS) is unequally available across the country, also varying as to the type of DPS in a given location (for older people, chronically ill people, adults with disabilities, children with disabilities, etc.). Overall, the number of clients on waiting lists for a stay in DPS at any one time amounts to about 6,000 people (MRPiPS 2017a).

Inequalities in access to residential services across sectors are reported between regions and between types of service provision. There are differences in the number of facilities and available beds across regions. In the health sector the highest availability of residential services is reported in southern-western of Poland as well as in central Poland (Dolnośląskie, Śląskie, Opolskie and Mazowieckie have 10 to 12 beds per 10,000 population) and the lowest in western and northern-central Poland (Wielkopolskie, Warmińsko-Mazurskie and Zachodniopomorskie have 4 to 6 beds per 10,000 population) (GUS 2017). Also, preferences are reported for using services in nursing and care homes

[3] According to regulations of 7th December 2012, only carers of disabled children or adults whose disability arose 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 unconstitutional and in 2013 an allowance for carers was introduced.

financed from the social health insurance system rather than more expensive social assistances homes (due to typically higher cost-sharing) (NIK 2016). Recipients of care in both types of facilities (health and social assistance) are in a similarly poor health condition, but receive different types of care (Golinowska, Sowa 2010). More medical and rehabilitation-oriented services are provided in health sector facilities and more care-oriented services in social assistance sector facilities.

Day care is strongly supported in Poland, although availability of services is still limited. In 2016 there were 308 day care homes in Poland (an increase from 231 in 2014), offering different types of integration and activation services for the older population (health education, education, play, social support, excursions, etc.) to 21,700 people (21,200 in 2014) (MRPiPS 2017b). The number of day care homes has increased over the past couple of years thanks to the Senior+ (previously Senior-Wigor) programme. The programme is expected to create 323 new day care centres and 650 clubs by 2020, providing services to 51,000 seniors. Although the programme is the flagship of governmental activity in the field of ageing, it is criticised for insufficient use of available funds and the low number of facilities created. Only about 5% of local authorities participated in the programme in its first two years, whilst many lack the funds needed for establishing and running a day care centre (NIK 2017). Experts also point to sustainability problems, such as the high costs of running a day care centre, the high level of cost-sharing for users of services, and the poor recognition of the needs of older people at the community level.

Nursing, rehabilitative and medical home care services are provided within the sectors separately. In the health sector, home nursing care services are provided by community or long-term care nurses or by residential care facilities (ZOL and ZPO). In the social assistance sector, social care services and specialist care services are provided either by a social worker, a specialist (i.e. physiotherapist) or by an outsourced care provider; and about 1,800 people are provided with home nursing services from residential health sector facilities (GUS 2017). Home care services provided in the social assistance sector reach about 90,000 recipients each year (MRPiPS 2017b). The availability and quality of home care services remain questionable. Services are unequally distributed across the country, depending on the financial abilities of local government (social assistance centres) to pay for services, the availability of professional staff with adequate qualifications, or the existence of a local network of care providers.

An alternative to home care services, access to which is limited, is either unpaid care by a family member or care provided by an informal carer, often a migrant, typically from Ukraine or Belarus. Migrant care services are not monitored, are paid for fully by the user, and are typically not registered – contributing to the creation of a grey zone in the economy.

Overall, the number of recipients of formal care services is very low when compared with the total number of dependent people (estimated at 4.7 million in the national census of 2011), the total number of people aged 65+ (6.1 million in 2015) or the number of older disabled people (estimated at about 2.5 million) (GUS 2016a). The Supreme Audit Office estimates that only about 4% of older people use any sort of care from the social assistance centres (NIK 2017).

2.2 Quality challenge

Quality requirements and standards strongly differ between types of long-term care and the sector in which services are provided. In principle, more demanding quality standards apply in the health sector and in residential care facilities. In community and home care services, especially in the social assistance sector, quality requirements are much more flexible and strongly depend on local regulations and decisions, as well as competing with restricted financial and human capital.

In the early 2000s medical professions were established in long-term care in the health and social assistance sectors, including long-term care nurses, medical care workers, community care workers and assistants of older persons. However, there is little interest

in the medical community in these professions, as the work is typically low paid given the level of obligations and responsibility. There are inequalities between the health and social assistance systems in conditions of employment, which are typically better in the health sector where quality standards are well established and remuneration is higher. Separate quality standards for residential long-term care apply in health and social sector settings with regards to employment, procedures (especially in nursing care) and accommodation standards (access to toilets, number of beds, etc.). Overall, the quality of care in public facilities has been positively evaluated by the Supreme Audit Office *(Naczelna Izba Kontroli - NIK*) (NIK 2016). Care provided in private residential units is less monitored. Private care units registered with regional authorities have to fulfil accommodation standards and report on basic output measures (number of clients). However, some private units are based on commercial law, are registered as providing something other than care activities (e.g. as a hotel) and are not registered with the regional authorities where they operate. The quality of services in these facilities, which in fact provide full-time care to residents, is not standardised and monitored (NIK 2016), often being very poor and even life-threatening.

There are no common and clear standards for community care services. In the recently established Senior+ (Senior-Wigor until 2017) programme, criteria related to employment and minimum standards in day care facilities were defined: however, the Supreme Audit Office points out that they were often difficult to meet, especially in poorer local communities (*gminy*). This resulted in a loosening of programme standards and requirements in 2017. The activities of day care centres and clubs are not monitored on a regular basis; however, anecdotal evidence as well as Supreme Audit Office controls suggests that they are positively evaluated by their users (NIK 2017).

The quality standards of home care services vary markedly according to the sector in which the service is provided. In the health sector, services are strictly defined by the contractor, with standards and requirements set by the payer (National Health Fund – *Narodowy Fundusz Zdrowia*). Services are provided according to a prescription from a primary physician and are related to the patient's medical condition. They are provided by certified personnel: community nurses or long-term care nurses. Conversely, in the social assistance sector there are almost no universal standards in home care services. Personal, rehabilitative or assistive services (home-keeping, cleaning, cooking) are individually granted to care recipients, with no clearly defined standards and certification rules for the personnel. It is often reported that services are provided by the 'cheapest' provider, which impairs the quality of care (NIK 2016).

Unpaid care provided by family members remains the area with neither standardisation nor formal, organised support, except for cash benefits for older people or benefits for the carers of disabled people.

Overall, monitoring of service quality is a weak element in service provision. In the health sector, standards are clearly established, being a contracting requirement. In the social assistance sector, with the exception of residential care, standards are barely established. Monitoring is occasional, performed either by the Supreme Audit Office or as a result of an intervention in cases of abuse. There is a need to establish standards of care in the social assistance sector, along with methods for regular assessment of the quality of care provided in both sectors.

2.3 Employment challenge

Unpaid care provided by family members is the dominant type of care in cases of old age and dependency. According to the EHIS survey study, every sixth person is engaged in care provision on a daily basis (16% of the population) (GUS 2016b). Care providers to older and dependent people are typically women in their 50s and 60s or older, who are taking care of their spouses or parents (Kotowska et al. 2007, Łuczak 2017, Jurek 2016). Łuczak (2017) points out that about two thirds of working-age (below 65) carers of adult disabled persons are females. Although the employment rate in the female population aged 55 to 64 has steadily increased (by about 2 pp.) over the past decade, it amounted to only

37.6% in 2016, being about 10 percentage points lower than the average in the EU-28 (48.9% in 2016). An LFS-based analysis has suggested that care obligations might be among the reasons contributing to the low employment and labour market activity of females (Saczuk et al. 2016). An increase in the number of women who are inactive in the labour market due to care obligations is observed especially in cities and is found to be related to the rising number of people aged 80 or above (Saczuk et al. 2016). Further, a decrease in the employment rate might be expected due to a withdrawal from reforms increasing retirement age[4]. Part-time employment due to caring duties towards children or incapacitated adults is not common, accounting for only 10% of the total[5].

Additional disincentives for carers to undertake employment are created by the fact that care-related benefits are targeted at individuals who resign from employment and the benefits – when received – cannot be combined with any form of employment. Studies show that about two thirds of carers of disabled adults are inactive in the labour market (retirees) or unemployed (Łuczak 2017, Jurek 2016).

Support for informal carers in the form of training, rehabilitation or psychological support is scarce. Typically, this type of intervention is provided thanks to community initiatives, mostly organised by non-governmental organisations and supported through European Social Fund (ESF) resources. In 2015, the government introduced benefits supporting the labour market re-integration of individuals previously engaged in care responsibilities, via subsidised employment measures; however the use of the benefits in the first year was marginal.

2.4 Financial sustainability challenge

The level of current expenditure on long-term care services is estimated at 0.8-0.9% of the GDP, depending on the types of service defined as long-term care, and has been stable over recent years (Golinowska et al. 2013, European Commission 2015). There have been no recent changes in long-term care service provision and utilisation. However, it is foreseen that the number of beneficiaries will strongly increase due to population ageing, which will inevitably lead to an increase in expenditure, especially on cash benefits granted universally to people aged 75 and older (Golinowska et al. 2013). Also, the need for services will strongly increase due to changes in family composition (towards nuclear families) as well as the higher engagement of women in the labour market.

A few years ago there was a debate, stimulated by Members of Parliament and experts, on the introduction of obligatory long-term care insurance, of care vouchers, and the development of measures supporting informal carers. The project was abandoned in 2016, however, after Parliamentary elections which resulted in a change of government., The current government emphasises the need for the development of services for older people. However, programmes and activities in long-term care are not systematic and are mostly undertaken at regional and local levels. They are supported either with governmental (Senior+ programme) or ESF resources.

The nationwide programme aimed at increasing the use of community services is Senior+. Despite being promoted by the Ministry of Family, Labour and Social Policy, the programme has reached only a small proportion of local government areas, and concerns have been raised over its long-term sustainability given the limited financial, infrastructural and human resources of local communities.

Other forms of investment in new models of care are supported by regional authorities under the framework of regional programmes using ESF resources. These include: competitions for local projects on innovation in the provision of services;

[44] The retirement age was planned to be equalised and gradually increased to 67 for both men and women, but in 2017, the government decided to cancel this reform and keep a retirement age of age 60 for women and 65 for men.

[5] Eurostat (2016 data), Main reason for part-time employment – distribution by sex and age [lfsa_epgar].

deinstitutionalisation of care; use of telecare or telemedicine tools; the creation of rehabilitation equipment rentals; and training as well as other forms of support for informal carers. These activities are at the very early stage of development, mostly with a time frame for implementation in 2020, and are not monitored; thus information on their scope and impact remains limited.

Initiatives are also being undertaken that are aimed at increased coordination of healthcare and social care service provision for specific groups of recipients: older patients, patients with chronic conditions, and psychiatric patients. A local pilot project is underway on the coordination of hospital and primary care services, as well as services for older patients, aimed at preventing re-hospitalisation. Also, regional governments support initiatives oriented at coordinating healthcare and social care services for dependent patients at the community level. These initiatives are, however, at a very early stage of development.

The government has undertaken several initiatives over recent years aimed at a diagnosis of the long-term care system, formulation of an action strategy towards older people, and an increase in access to selected services.

In 2012 the Ministry of Health formulated a diagnostic paper entitled 'Facts and Perspectives on Long-Term Care Development in Poland' (*Stan faktyczny i perspektywy rozwoju opieki długoterminowej w Polsce*), defining long-term care and concentrating on the need to developing services for older people, mostly local ones in the health sector. Later, in 2013, the Ministry of Labour and Social Policy[6] formulated a policy entitled 'Preconditions for Long-term Senior Policy in Poland for the period 2014-2020' (*Założenia długofalowej polityki senioralnej na lata 2014-2020)*. The policy defines several priority areas in policy towards older people: the development of medical services responding to older people's needs; health promotion and prevention; supporting the professional, social and cultural participation of older people; and the development of social care services. The national policies listed above are formulated in the active ageing framework (Szatur-Jaworska 2016), underlining the participation of communities and third sector-organisations in implementing activities targeted at older people.

In 2016, the Ministry of Family, Labour and Social Policy began preparation of a long-term strategy entitled 'Social policy towards older people 2030. Security, solidarity, participation' (*Polityka społeczna wobec osób starszych 2030. Bezpieczeństwo, solidarność, uczestnictwo*). The scope of policy objectives remains under debate at the point of writing. The situation of older people is also discussed within the policy framework targeting disabled persons. In 2016 the same Ministry announced the creation of a cross-sectoral committee to work on improving the situation of disabled people and their families (*Zespół do spraw Opracowania Rozwiązań w zakresie Poprawy Sytuacji Osób Niepełnosprawnych i Członków ich Rodzin*). Among themes under debate are inequalities in benefits for carers of disabled children and of disabled adults, including older people.

The most visible actions in the field of services towards older people are the two governmental programmes: the 'Governmental Programme Supporting the Social Activity of Older People for 2012-2013 to 2014-2020' (*Rządowy Program na rzecz Aktywności Społecznej Osób Starszych na lata 2012-2013 i 2014-2020 – ASOS programme*); and the 'Senior-Vigor' (*Senior-Wigor*) programme, established in 2015, redefined in 2017 as the Senior+ programme, and planned to last until 2020. The aim of the first programme is to stimulate local initiatives aimed at older people and to support local activation programmes. The aim of the second programme is to establish day care centres and – since 2017 – senior clubs for people aged 60 or above. Preferences are given to localities with a high share of older people and lower incomes. Overall, 119 territorial governments participated in the programme in 2015 and 146 in 2016.

In 2018 the Ministry of Family, Labour and Social Policy formulated a programme aimed at increasing access to care services for the oldest people. The programme, entitled Care

[6] Renamed in 2016 as Ministry of Family, Labour and Social Policy.

75+, offers subsidies[7] for the provision of social care services to the population aged 75 and above in rural areas and in towns with fewer than 40,000 inhabitants. The rationale is to support poorer communities with incomes typically below the national average.

Nonetheless, long-term care remains underdeveloped. It is only recently that dependency in older age is becoming perceived as a social risk, while regulations still concentrate on the provision of services and benefits in cases of disability rather than older age and dependency. Policy recommendations regarding accessibility, quality and financial sustainability in long-term care include the following.

- There is a need for improved recognition of dependency in older age as a social risk that should be addressed with a comprehensive policy and set of actions.
- In a country with underdeveloped care services, further investment in the provision of care is needed. The Care 75+ programme is a good start, but further investment in home services will be needed to increase their availability. Access to publicly financed residential care should also be improved.
- In a two-tier system, mechanisms of cross-sectoral coordination at the local and patient level (e.g. by establishing individual care plans) should be introduced.
- Recently undertaken work on the introduction of quality standards in home care services should continue. Standards of care should be regulated by law and monitored.
- Measures are needed to develop support for informal carers by enabling them to reconcile work and care, and by providing training, psychological support and respite services. There is a particular need to invest in patient-oriented cooperation, aimed at providing the best mix of services from the two tiers of the system.

3 Analysis of the indicators available in the country for measuring long-term care

The growing policy interest in ageing has resulted in the establishment of an obligation to statistically monitor the problem. In October 2015, the Parliament adopted a law on older people (*Ustawa o osobach starszych*) obliging public authorities to collect information on the situation of older people (60+). Since then the Central Statistical Office (CSO) has regularly published reports on the demographic situation and health status of older people, their economic situation, social engagement and vulnerability. CSO reports are based on the census data, survey studies on health status and social cohesion, and selected administrative data.

At the same time there are no comprehensive data on long-term care. Since the provision of services is divided between two sectors, so is statistical monitoring. Health data cover information on services provided by the health sector, and social data cover services provided by the social assistance sector. Additionally, information on cash benefits is collected by the social security institutions. Estimates of the utilisation of, and expenditure on, public long-term care arise from occasional expert studies, typically supported by international organisations (World Bank, European Commission). Publicly available data and indicators on the utilisation and cost of long-term care services **are not age-specific**, covering the whole population of recipients. In some cases, mostly in relation to the health care sector and from the social insurance system, age-specific data can be obtained upon request. In the social assistance sector age-specific data are available only in selected categories (i.e. for residential care).

[7] Up to 50% of the cost of services can be subsidised.

Sector-based statistics on inputs (number of facilities, number of beds in residential care, personnel employed) and outputs (number of care recipients in different care settings) are mostly published on an annual basis by the sectoral administration and the CSO.

Table 1. Data and indicators available on long-term care

Indicator	Source	Timeframe	Availability
Needs assessment			
The number of older people, by sex	Central Statistical Office (census, further estimations)	Annual	Published
The number of people with ADL/IADL, by age and sex	Survey data (EHIS)	Every 5 years	Published
Input – access			
The number of residential care facilities (country, regions)	Ministry of Health Ministry of Family, Labour and Social Policy Central Statistical Office	Annual	Administrative registries; published
The number of beds in residential care facilities (per 10,000 population, country, regions)	Ministry of Health, Ministry of Family, Labour and Social Policy Central Statistical Office	Annual, indicator per 10,000 population can be calculated based on demographic data	Administrative registries; published
The number of day care centres, places in day care centres	Ministry of Family, Labour and Social Policy	Annual	Administrative registries; published
The number of Senior-Wigor/Senior+ day care centres and clubs	Ministry of Family, Labour and Social Policy	Unknown	Not published; only upon request
The number of personnel in residential care facilities (headcount, FTE)	Ministry of Health Ministry of Family, Labour and Social Policy, Central Statistical Office	Annual, FTE available only for some categories	Published
The number of personnel providing home nursing and home care services (headcount, FTE)	Ministry of Health Ministry of Family, Labour and Social Policy	Annual, available only for some categories	Published
Output – utilisation, financial sustainability			
The number of recipients of residential care services	Ministry of Health, Ministry of Family, Labour and Social Policy Central Statistical Office	Annual	Published

The number of recipients of day care services	Ministry of Family, Labour and Social Policy	Annual	Published
The number of recipients of home nursing care/home care services	Ministry of Health Ministry of Family, Labour and Social Policy	Annual	Data from the social sector are published; data from health sector available only upon request
Total expenditure on residential care	National Health Fund, Ministry of Finances Central Statistical Office	Annual	Data from the social sector are published; data from health sector available only upon request
Total expenditure on day care	Ministry of Family, Labour and Social Policy	Annual	Available only upon request
Total expenditure on home nursing care/home care	Ministry of Health, Ministry of Family, Labour and Social Policy	Annual	Available only upon request
Total expenditure on cash benefits	Social insurance institutions Ministry of Family, Labour and Social Policy	Annual	Available only upon request

Source: Own compilation.

There are no outcome indicators available in the national statistics and registries. Some information is provided based on occasional monitoring by the Supreme Audit Office. Other fields with limited statistical information and no monitoring include quality of care, projections of future demand for care and projections of future costs of care. There are also no data available that would allow the direct measurement of labour market exits due to caring responsibilities and the situation of care providers in the labour market, except for selected, dedicated studies undertaken as part of scientific projects.

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