CASE Network E-briefs

No. 05/2012 February 2012

Provision of Long Term Care for the Elderly in Poland in Comparison to Other European Countries

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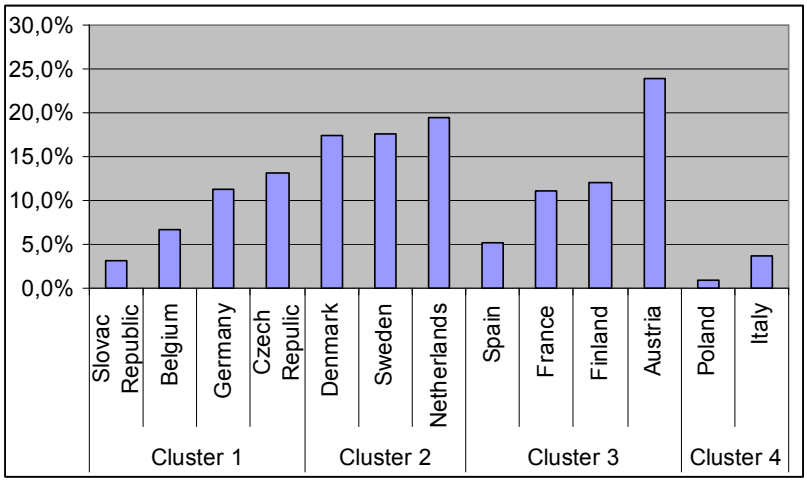
In recent years, population ageing has attracted the attention of research and policy advisors in all European countries. Several policy actions have been directed toward ensuring optimal long-term care (LTC) for elderly people while maintaining fiscal rationality. Despite general concerns, the Polish LTC system is still at the bottom of the pile in terms of the organization and provision of care. During the last decade, no specific regulations covering LTC services, institutions providing these services, or the rules to access and finance these services have been determined.

LTC systems are very different across all European countries. Their design is characterized by diverse arrangements for the provision of care/organization and financing. There is no readily available pool of information for LTC and any existing data usually only covers LTC to a very limited degree. A study by Kraus et al. (2010) provides a comprehensive typology of LTC systems for a broad range of EU member states. Four clusters are distinguished. Cluster 1 consists mainly of continental countries (Belgium, Germany, Czech Republic, and Slovakia). Their LTC systems are oriented towards informal care (IC) provision with IC support. They are characterized by low spending on formal LTC, low private funding and modest provision of cash benefits. Cluster 2 includes mostly Scandinavian countries (Denmark, Sweden) and the Netherlands. Their LTC systems can be defined as generous, accessible, and formalized. In these countries the public sector plays a much greater role. They are characterized by a high provision of formal LTC, low informal LTC use, and a relatively small role of cash benefits. Total public spending is high, IC support is also high and private funding is low. The third cluster, which is somewhat intermediate between the previous two groups, consists of Western European Countries (Austria, France, Spain), England and Finland. Their LTC systems are oriented toward IC with a high level of support. Public spending on formal LTC is medium, and cash benefits and private financing are high. The last group of countries, which includes Poland and Italy, is characterized by low public spending on formal LTC, low support of IC, medium cash benefits, and a high level of private financing. In these countries, IC provision appears to be a necessity.

In order to draw a general picture of LTC provision among all these countries, the percentage of the population aged 65 and over receiving formal LTC is presented in Graph 1. In accordance with the above classification, the highest fraction of the population obtaining formal LTC is mainly among countries with well formalized LTC systems, like the Netherlands, Sweden or Denmark. Provision in Austria is also high. Poland and Italy are the countries with the lowest provision of formal LTC.

Graph 1. Population aged 65 years and over receiving formal LTC, 2009 (or nearest year)



Source: OECD Heath Data 2011, http://www.oecd.org/dataoecd/6/28/49105858.pdf, pg. 171

While taking into account the differences in the

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organization of LTC systems among countries, the question arises about the chances an average elderly person has of receiving LTC in each of them. In the study by Sowa and Styczyńska (2010), an attempt was made to identify possible individual features that influence the probability of receiving formal LTC in selected European countries. The analysis indicates substantial differences in the probability of obtaining LTC depending on the personal characteristics of individuals. The provision of formal LTC in all countries depends mostly on the age and health status of an individual. However, the "younger elderly" with basic limitations have lower chances of obtaining formal LTC in countries with a weaker organization of LTC (like Italy or Poland). They have higher chances of obtaining formal LTC in countries with formalized LTC systems such as the Netherlands and Germany. Gender is statistically insignificant in countries with well developed LTC provision. It plays a significant role in obtaining formal LTC only in countries with lower access to LTC. As women tend to outlive their partners, they are more likely to obtain LTC.

Elderly people are less likely to obtain formal LTC when they live with someone else in the same household (partner or a child) in countries where the public sector does not have a legal duty to provide care when the partner of a person in need is available (like in the Netherlands). Living with a partner decreases the chances of receiving formal care, whereas living with a child is statistically insignificant in continental countries like Germany, where the family is identified as the primary care unit. In countries where the family has a legal duty to support its relatives, like Italy or Poland (Pommer et al. 2007), these variables are mainly statistically insignificant. This might be caused by the relatively restricted and disorganized provision of formal LTC (Tediosi et al, 2010). The financial determinants of formal LTC provision are statistically insignificant for all countries due to the fact that the provision of benefits depends mainly on the level of dependence of an individual and much less (or even not at all) on family income.

To sum up, personal characteristics that are statistically significant and influence the probability of obtaining formal LTC are mainly related to the legal regulations enforced in countries with relatively better developed LTC systems. They are mainly statistically insignificant in countries with less advanced LTC systems. In these countries, the provision of formal care is mainly restricted to the elderly that are most in need (i.e. older with more health problems).

Poland is positioned at the bottom in terms of organization and provision of LTC in comparison to other European countries. Several reasons lie behind this phenomenon. The most important obstacle of effective and efficient provision of LTC is the lack of integration of care services that are being provided independently by two sectors: health care and social assistance. In the health care sector, LTC services are mainly available on a stationary basis in care and treatment facilities (ZOL), nursing and care facilities (ZPO), and palliative care homes. The accessibility of home-based LTC has increased only in the last couple of years. The fulfilment of health conditions necessary to become a beneficiary of LTC is measured by a person's level of independence which includes ten basic daily life activities (like feeding, bathing, mobility, aso). LTC services in the social sector are mainly provided on a stationary basis as well as in residential social assistance homes (DPS) and day-care social assistance homes (DDPS). They are mainly provided by nurses and personnel contracted from the health care sector. The eligibility criteria for benefiting from LTC services in the social sector are based on living conditions like poverty, limited functionality of an individual, and the lack of care from relatives. Home-based care is provided by environmental nurses and social care givers (Golinowska, 2010).

Second, access to formal LTC in Poland is relatively restricted and over the last couple of years, policy makers have made this accessibility even more difficult. As of 2005, a co-payment for residing in a DPS in the social sector has been introduced (which is not only expected from care receivers, but also from their families). This has slightly reduced queues to DPS and has significantly limited access to LTC services. Additional eligibility restrictions have been also introduced in the heath care sector. Since 2008, a relatively high level of dependence is required in order to get access to LTC services. Also, the accommodation costs of residents has shifted from the National Insurance Fund (NFZ) to individuals, so a co-payment was introduced in the health care sector as well. These changes have significantly restrict accessed to LTC.

Third, home-based LTC is evolving with huge difficulties. Environmental and family nurses have to take care of too many patients, including not only elderly with limitations in IADL, but also younger people with significant health problems and disabled individuals. Moreover, in 2009 the NFZ introduced a rule that each environmental nurse should have her own office. This has decreased the possibility of providing this profession significantly. Consequently, informal LTC is

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still the most significant source of care for the elderly.

At the same time, efforts have been undertaken in order to increase the access and quality of LTC. Additional courses, which aim to educate caregivers in new specializations, have been introduced. The Minister of Health has also created a draft of the Regulation on the LTC system, which was subject to public consultations in 2011.

Despite this, the Polish LTC system is still perceived as closed and hardly accessible. There are no prospects for the comprehensive regulation of LTC and its institutional separation as a recent political debate has mainly been dominated by the promotion of reforms, which decrease social expenditures. Improvement of LTC provision in Poland requires several basic and urgent policy decisions and increased expenses at the governmental, local, as well as institutional levels. A unified LTC system should be established as soon as possible. In order to ensure fair and extended access to LTC, eligibility criteria should be verified and unified between sectors. Also, home-based LTC should be widened significantly. These initial changes would ensure better living standards for the elderly in need.

The author prepared this E-brief in the framework of the FP7 project ANCIEN - Assessing Needs of Care in European Nations. Click here for more publications on this topic: http://www.case-research.eu/en/node/52624.

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