Questionnaire: Poland

1. There needs to be a careful balance between collective and individual arrangements and responsibilities, which is not easy to achieve. Individuals can be involved in collective arrangements (through co-payments; or personal budgets) while local authorities can help people to cope independently with long-term care.

1.1 Is collective funding of long-term care in your country a part of the fiscal taxation or a part of the obligatory care-insurance or both?

Long-term care, including care services for elderly people, is provided within health care system and social assistance scheme, e.g. both systems envisage provision of permanent, day and night care within special establishments.

The conditions and scope of the provision of health care benefits financed from public funds, as well as the rules and method of financing those benefits are regulated by the Act of 27 August 2004 on health care benefits financed from public funds.

According to this Act, the nursing and care benefits, as well as palliative and hospice care, for the benefit recipient are financed from the public funds. The benefits are financed from public funds by the National Health Fund. The payer, i.e. the National Health Fund, finances the health services in the care and treatment centre or nursing and care centre, but does not pay the costs of board and accommodation. The persons staying in the care and treatment centre or nursing and care centre have to pay the costs of accommodation and board. The monthly payment is established at the level of 250% of the lowest pension, but the fee cannot be higher than the amount equivalent to 70% of the monthly income.

There is a special rule for the patients using the palliative and hospice care, according to which the patient does not bear any costs related to the scope of provided services. The palliative and hospice centres are financed by the National Health Fund under the concluded contract.

In 2006, **total expenses on health care in Poland amounted to 6.2% of GDP**, which was the second lowest value among OECD countries. The value of expenses on healthcare amounted to 910 dollars per capita (calculated on the basis of purchasing power parity), which was a distinctly lower value than the OECD countries average (2824 dollars). In the same year the share of public sector in financing health care in Poland amounted to 70%. **Expenditures for the long term care constituted in 2006 only 1,7% of all expenditures for health care.**

The most important income source for the healthcare system is a health insurance contribution. Its amount increased each year by 0.25%, starting from 7.5% of base amount in 2000 up to 9% of base amount in 2007. The increase in contribution as well as the observed economic growth that entailed increasing salaries caused that there are more funds coming gradually into the health care system. Other income sources, whose main aim is to act against unequal access to the benefits and social exclusion, are: state budget, budgets of local government units, enterprises' funds and funds paid by patients who

finance non-standard benefits presented in the Annex to the Public Funding of the Healthcare Act.
Due to high debt level of public health care institutions since 2005 there have been taken measures that meant to improve financial situation of public health care units, pursuant to the Act of 15 April 2005 on public aid and restructuring of public health care institutions. Total amount of all debt on the national scale amounted to PLN 9527.8 million (as of 31 December 2007) and was lower as compared to 2006 by 7.9% and by 7.3% as compared to 2005.

Nursing and care allowances as well as palliative and hospice care are financed by the National Health Fund (NFZ) with public funds. Payer, in case of a care and treatment facility or a nursing and care facility – the National Health Fund, finances health benefits, yet food and accommodation costs are charged by patients. A monthly charge equals to 250% of the lowest retirement pension, yet it cannot exceed 70% of monthly income, pursuant to the social assistance provisions, of a resident of a care and treatment facility or a nursing and care facility.

However, the basic care services for people at their residence place are subject of social assistance system.

Types of long term care in social assistance scheme:

1. care services (ordinary and specialised for mentally ill people) provided in the place of residence of the beneficiary or in support centres;

2. social assistance homes for:
   - elderly persons;
   - chronic, somatic patients;
   - chronic, psychotic patients;
   - intellectually disabled adults;
   - intellectually disabled children and youth;
   - physically disabled persons.

In social assistance scheme there is no obligatory care-insurance. The services are financed via budgetary means, both central and that of the local authorities.

Tasks within social assistance are divided into: “self tasks” (financed by the local authority legally responsible for providing services - the means derive from the local authorities’ share in personal and corporate taxes), by the state allocation for the self tasks and through the subsidies from state budget.

Although services are carried out directly by local authorities (communes, poviats and, exceptionally, on the regional level), they can also be delegated by local authorities to social partners (profit and non-profit).

1.2 Is long-term care the same for everybody (packet / content; cost) or does a possibility exist that someone receives (after assessment) a "better" or "more luxurious" packet of long term care by paying a higher or additional premium?

There are no "better" or "more luxurious" packets in health care. The public authorities are obligated to guarantee equal access to health care services, financed from public funds, to all citizens irrespective of their financial situation. There are a number of private nursing homes where the patients pay for better accommodation but the level of the medical care isn't better then in public nursing homes.

The health care benefit means in long-term care are:

- a health service, i.e. the activity aimed at the prevention of diseases, preservation, saving, recovery or improvement of health and other medical activity resulting from the treatment or separate provisions regulating the rules of their provision;
- material health benefits include medicinal products, medical products, including products being orthopaedic items and auxiliary means, related to the medical treatment, the medical transport services.

The nursing homes and the long-term care at home provide access to such means for the patients.

In social assistance scheme there are no "better" packages. The scope of long-term care services depends on persons' needs and their personal situation. The range of community services, provided at the person's place of residence includes: nursing care, house cleaning, shopping, supply of meals, having made an appointment to a doctor, being brought to a doctor etc. The standards for specialized services and social assistance homes are determined by way of regulations by the minister competent for social security.

1.3 Referring to the system of objective assessment / indication of long-term care: is it common practice to take personal characteristics into account, like age, personal income and / or wealth, to belong to and behave (or not) as a part of a social network of family / friends / neighbours?

In the Polish traditional model the care of older and dependent people is being first of all provided by families. In case of people whose family isn't able to provide the necessary service, the public services are in place. The long – term care is being dedicated to people who require care, welfare and rehabilitation benefits as well as the continuity of pharmacological and dietary treatment. The care has been provided by stationary devices or at home (by patients). The services in the area of long term care are being dedicated for adults and for children as well. The appropriate Act of law determines in a very detailed way the obligations of public authorities with the aim to ensure an equal approach to the health care services.

It isn't a common practice to take personal characteristics into account by making a decision about scope of provided long-term care, but the decision about hospitalization or accommodation in a nursing home takes into consideration such characteristics.

The Act on Social Assistance of 12 March 2004 states the main rules for social services. They are comprehensive and personalised integrating the response to differing needs in order to guarantee fundamental human rights and protect the most vulnerable.

A lonely person who – due to age, disease, or other reasons – requires the assistance of other persons, being deprived of such assistance, has the right to care services.

Care services may also be awarded to a person that requires other persons' assistance, where the family, as well as a spouse, ascendants, or descendants not living in the same household, may not ensure the provision of such assistance.

Care services shall also include assistance in satisfying one's everyday living needs, hygienic care, nursing recommended by a doctor, and – to the extent possible – ensuring contacts with the surrounding environment.

While awarding care services, a social assistance centre shall determine their scope, duration and the place of receiving the benefit.

Detailed conditions for the awarding of, and the payment for, care services and specialised care services, with the exception of specialised care services for persons with mental disorders, and detailed conditions for partial or complete exemption from charges, as well as the procedure for the collection thereof determine local authorities.

A person requiring care 24 hour a day due to age, illness or disability, which cannot be provided in form of care services at the place of residence and in daily support centres, is entitled to be placed at the social assistance home.

A social assistance home shall be operated in a way that provides the proper scope of services in accordance with the standards set for the particular home type, and based on individual needs of its residents. In order to determine individual needs of its residents as well as the scope of services, therapeutic care teams shall be appointed including mainly workers employed at the home, and directly engaged in support services for its residents (among them the first-contact worker). An individual resident support plan shall be adopted within 6 months from the day of admitting a resident.

The personal income for admitting the right to social assistance services is taken into consideration only in relation to the payment for services. Expenses for services are repayable in part or in full, if the income per person in the family of the person obliged to repay the expenses exceeds the amount of the criterion of income.

As regards social assistance homes the Act on Social Assistance of 12 March 2004 has introduced new financing rules of these facilities, imposing, among others, greater responsibility on families and local communities.
Persons living in regional (at poviat level) social assistance homes until 31 December 2003, as well as those having the decision issued before this date and waiting for the place in the care facility, have the right to stay in the social assistance homes on the basis of old financing rules, i.e. the person in need pays up to 70 per cent of her/his income and the remaining sum is paid through the state allocation. However, since 1 January 2004, when the new rules have been applied, a person in need, her/his family and the local community participate in the costs of living in social assistance homes. A person placed in the social

assistance home pays up to 70 per cent of her/his net income, then her/his family is obliged to finance the remaining sum to the full cost of living. If, due to the family difficult situation, it is not possible to cover the whole cost, the local community (i.e. local self-government authority due for the person's permanent residence place) pays the rest of the sum. As for the local (at community level) social assistance homes, a person placed there pays up to 70 per cent of her/his income and the rest is financed by the community.

2. Clear boundaries need to be drawn between long-term care and related schemes like subsidised housing or home-help, so that people are aware of what services they are entitled to and how this is decided.

At present the long term care in Poland has been carried out by two departments of central government: health and social protection. The care of older, chronically ill, disabled people should be based on mutual co-operation of institutions which provide services in the health care and social protection sectors. The special attention should be paid to the non–governmental organisations supporting families and friends who take care about chronically ill people.

The basic principle, which outlines the cooperation is the goal to establish the organisation of health – and social care which will enable to be provided at home as long as possible.

*2.1 Are residential or living arrangements part of long-term care, (**a**) in the current legal / financial system and / or **(b)** in the practice of care delivery?*

Health care services in long–term care are oriented to care and rehabilitation benefits which follow the aim of preparing the patient, his family and/or other caregivers for taking over a care and nursing in home circumstances. It does not concern financing of the improvement of housing conditions and the adaptation of houses to the patient's needs.

*2.2 Is medical treatment ("cure") part of long-term care, (**a**) in the current legal / financial system and / or **(b)** in the practice of care delivery?*

In current legal status the long–term care in Poland does not concern a medical treatment but the continuation of treatment only. The definition of long-term-care in Poland was set up for the need of purchasing of health care services like "a long-term care".

(a) Long-term care is about nursing and rehabilitating in a long lasting, continuous and professional manner, as well as proceeding with pharmacologic and diet treatment. This kind of care is provided at stationary care facilities and at the patient's home. According to the directive of the President of the National Health Fund of 19 September 2007 laying down rules for conclusion and execution of contracts concerning long-term care, the said kind of care is designed for bedridden and chronically ill persons, who do not require hospitalisation, who do not manage to take care of themselves properly and who require round the clock, professional and intensive care and nursing, as well as further treatment. Long-term care covers also education in the field of caring of family members and others addressed to the relatives providing care. Continuation of treatment refers to further medical procedure

adjusted to the patient's health condition, including administration of medicines, conduct of diagnostic examinations required where an illness of a chronic nature is present and application of instructions after treatment at a hospital ward is finished and after an individual assessment has been made by a doctor from a long-term care facility. Long-term care is not designed for persons qualifying to be admitted to social assistance homes or those who should be provided with care mainly due to difficult social conditions or an advanced cancer.

(b) In the practice of care delivery the nursing homes have sometimes to guarantee the medical treatment but they don't have the possibility to receive from National Health Found back the means for it.

As regards social assistance services the reform of health care system in 1998 changed the conditions of functioning of the social assistance homes in the field of health care. As a result of statutory provisions social assistance homes are not entitled to provide health care services. They only enable the residents to exercise the right to health care provided by the National Health Fund. At the same time social assistance homes became the institutions financed and organised by local authorities (poviat level) in the course of their own tasks, which theoretically enables local authorities to create their own strategies of development within binding law. Social assistance homes, which are the organisational units of social assistance, satisfy basic needs of their residents. They do not act as the health care provider, which relates also to nursing services.

People living in social assistance homes who are in need of health care have the right to the same health services as people living in their own homes. They are provided with all day care services, except for medical services that are assured on general basis. Sometimes nurse care in social assistance homes is delivered by public health services, however, in practice nurses are employed and paid by social assistance institutions. This makes the situation of social assistance homes worse as the residents do not take advantage of their rights derived from health insurance.

The division between social assistance and health care systems as regards specialised care services for persons with mental disorders, is not very strict. They are legally based both on the Act on Social Assistance of 12 March 2004 and on the Act on Protection of Mental Health of 19 August 1994.

The latter states that protection of mental health comprises ensuring the persons with mental disorders many-sided and generally accessible health care and other forms of care and assistance essential for living in family and social environment.
Moreover it states that health care of the persons with mental disorders is provided within basic and specialized health care, especially psychiatric health care, in form of emergency, ambulant, day, hospital and residential help, and in social assistance homes.

The standards established for psychiatric health services for social assistance homes and support centres require employment of medical staff in these institutions even though they are within social assistance system. This causes disturbances as to the financial consequences as the medical staff is paid on a different basis.

*2.3 Is there a separation between residential (intramural) care and ambulant (extramural) care concerning (**a**) the current legal / financial system and / or (**b**) the actual organisation of the care system?*

There are no significant differences between residential and ambulant care concerning legal and financial system. In Polish legal system there is only some differentiation in the area of regulations connected with the financing of stationary care services, treatment at an outpatient's clinic and the long-term-care. The payee (the National Health Fund) finances the services in the area of long-term care as well stationary and at home, but it does not pay for boarding and accommodation. The health services have been financed by the National Health Fund or by appropriate ministers according to the rules and to the scope described in the Act from 27th of August 2004 about health services financed from public means.

A number of nursing homes provide also ambulant care. Both forms of care – residential and ambulant – are financed by National Health Fund.

2.4 Do you observe (or expect) that clear boundaries between long-term care and related schemes will improve or complicate an integrated and client-oriented approach (traject management, case management, chain management)?

Our observations let us to formulate such opinion, that the boundaries between long-term care and related schemes are necessary. The aim of drawing such boundaries are: to avoid double financing of forms of the care and to avoid such fields where no one will provide the necessary care. It is important for constructing such organisation of long-term care which aims to meet the needs of the patient. Without such share of competences it will be impossible to use the different forms of management like traject, case and chain.

3. Qualified personnel are as important as funding being available, while balancing supply and demand needs to take account of demographic and, labour market factors.

*3.1 Is the availability of sufficient personnel a worrisome item for long-term care, (**a**) now and (**b**) in the coming decennia?*

During the last few years the problems with the personnel in social assistance institutions has been observed. Among the most important factors are the financial problems of these institutions. As unemployment in Poland decreases, the pressure on higher wages increases.

Although at present personnel shortages are not frequent, there may be a problem in near future if the situation will not improve. Good pay and conditions are essential for reaching the stability of the high qualified staff (nurses, psychologists, rehabilitative staff). A phenomenon of migration to other European countries applies to a high degree to the social assistance staff. At the same time the inflow of economic migration to Poland increases the employment in social care services, however mainly in private sector as well as on the informal basis.

In Poland the average salary in social assistance institutions in 2007 amounts about 2000 PLN (about 500 euros) incl. taxes (in social assistance homes even less). Medical staff (nurses) in social assistance homes earned about 1655 PLN, social workers in social assistance homes 1591 PLN, therapists 1463 PLN caretakers – 1369 PLN, occupational activities' instructor – 1372 PLN. The average salary in the nursing homes amounted 2007 about 2000 PLN. The average salary in Poland amounted to 2007 2691 PLN.

It is worth mentioning that 86 % of the personnel constitute women.

3.2 *Do you expect that long term care, as a branch, will be able to compete with other branches in terms of a tight labour market? Do you expect that branches within the public sector (like education) will challenge long-term care in this respect in the future or do you expect more competition from the side of trade and industry branches?*

It is expected that the long–term care as a separate business line will effectively compete with other branches in case of problems in the area of the labour market. The most important reasons for that are migration of caregivers and low salaries which causes that the nurses and carers are going to change the profession and to look for another job. Because of art of education (medical services) the competition with other branches is not very important. More important is the possibility that the carers can turn from the public sector to private market of long-term care.

One of the priorities of the education system is the investing in human capital, which is essential for further development of the country, as stated in the National Strategy Report on Social Protection and Social Inclusion 2008- 2010. One of the aims is orienting school education towards the needs for the labour market.
In the course of a few last years new professions emerged in social care field. The most important for long-term care services are:

- a domestic caregiver,
- a caretaker in social assistance home,
- a caretaker of the elderly.

A caretaker of the elderly will be tasked with supporting the elderly in their natural environment, helping in everyday activities, counselling in planning and organising their household.

The need for the new jobs results from the necessity of adjusting the social assistance system to the needs of ageing society in Poland. It is important to secure older people the stay in their homes as long as possible.

In Poland private sector in long-term care has been developed recently. One of the examples are all-day care private residential homes for elderly persons. They are not strictly a part of social assistance system, apart from the fact, that they are regulated in the Act on Social Assistance (standards, authorisation). The stay in these homes is paid fully by the individuals, regardless of any income criteria. They are run as economic activity. The binding law does not require them to employ professional staff, so as the result the level of services provided is usually lower than in public social assistance homes.

3.3 Are there programmes or initiatives to make schooling and training of future personnel in long-term care enough attractive and large-scale so that sufficient supply of personnel can be guaranteed in the future?

The possibility of improvement of quality in the area of the long-term care could be seen in training activities for non- professionals (family caregivers) who take care of a dependent person in home circumstances and in education of new staff in the profession of medical caregiver.

In September 2007 the education in the area of this profession has been started in Poland. In December 2007 103 people declared their willingness to take the professional, qualifying exam as the medical caregiver in the summer examination session 2007/2008. To the tasks of the medical caregiver will belong to carry out the hygienic and care services, what will effect with the higher efficiency of nursing services.

As states the Law on Social Assistance organisation of education, including the running of public schools of social services and organisation of professional training for the social assistance personnel lays within the competences of the regional authorities. The minister competent for social security is also responsible for creating training activities for the personnel as a part of his task of inspiring and promotion of new forms and methods of activity.

Increasing professional qualifications by participating in training courses and self-education is a statutory task for social workers.

The regional component within the Operational Programme - Human Capital financed from the European Social Fund envisages projects aimed at training the personnel employed in social assistance homes.

Also within the Swiss-Polish Cooperation Programme there are schemes which aim to improve the qualifications of personnel (second component – the enhancement of professional qualifications of the employees of community homes and/or childcare centres and third component – the improvement of the quality of nursing services for the persons living in community homes covering the enhancement of professional qualification of the nurses employed in community homes, providing community homes with the equipment for nurses to render services, being the minimum necessary equipment of the nurses).

Due to the character of the programme schemes will be implemented in four regions (voivodeships).