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Quality and cost-effectiveness in long-term care and dependency prevention: the Polish policy landscape

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CASE Reports

Quality and cost-effectiveness in long-term care and dependency prevention: the Polish policy landscape

Stanisława Golinowska
Agnieszka Sowa-Kofta

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Table of Contents

Authors.....	5
Abstract	6
1. Introduction.....	7
2. Brief overview of the LTC system in Poland.....	8
3. Recent policy developments in the field of LTC	11
4. Policies aiming to reduce dependency	18
5. Informal care support	22
6. Information policy and new technologies in LTC	25
7. Coordination in LTC	31
8. Conclusions	33
References	35

List of Tables and figures

Figure 1: Organisation of LTC services in Poland	9
Table 1: An overview of the areas, priorities, and objectives of the Preconditions for Long-Term Senior Policy for the period of 2014–2020	14
Table 2: Tasks identified within the healthy and active ageing objective of the NPZ	19

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Abstract

With the population ageing the development of sustainable long-term care institutions is of great importance in many European countries. In Poland, currently dominant, traditional and family based care will become insufficient with increasing cohorts of older people. Presented paper discusses recent developments in long-term care policy in the country. Long-term care institutions are separated in the two sectors, with little field for cooperation and coordination of activities. Over the past years policy addressing ageing related problems was developed, focusing on the active ageing instruments. Dependency prevention and active ageing are among goals of national policies formulated separately in the health and social sector. Information policy and monitoring long-term care services' provision remains insufficient. Coordination of activities mainly takes place at the local level. Local governments and non-governmental organizations, often cooperating with representatives of older people, are active in providing services to older people in community and often incorporating innovative solutions in care.

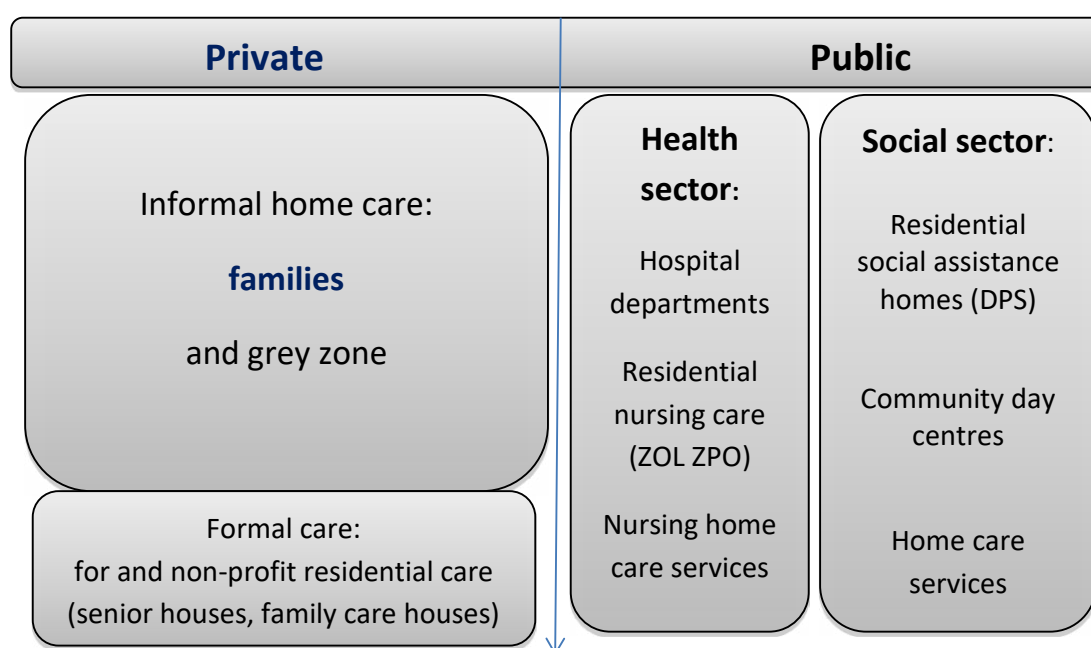
1. Introduction

The demand for long-term care (LTC) depend on the size and the health status of older population who would need assistance from others because of problems with daily living. The share of the older population in Poland is foreseen to rapidly increase in the years to come, making the provision of long-term care (LTC) a crucial policy matter. Poland has one of the most rapidly ageing populations in the European Union (EU): by 2060, the share of the population aged 65–79 is expected to double and the share of the population aged 80+ is expected to triple (European Commission, 2015; GUS 2014). Old age dependency ratios will thus sharply increase, from about 14.0 in 2015 to 27.8 in 2060 putting a pressure for organization of some form of organized assistance for older people with care needs. The demand will raise not only due to improvement in the number of people, but also due to substantial improvement of the life expectancy of Poles which signifies an important success of the last quarter of a decade. There is still however a large gap in the health status of men and women. The life expectancy of women is 81 years, compared to only 73 years for men (GUS, 2016). In addition, longer lives are usually unequally distributed, and very often do not entail longer and healthier lives for all (GUS, 2017, Wizner et al., 2012). The new challenge is thus not only to live for longer, but also to stay healthy over these extra years of life and prevent dependency. Studies of the health of those at an older age reveal different tendencies, with some pointing to a slight decrease in the health status of the elderly (expansion of morbidity associated with growing levels of dependency due to disability and higher levels of chronic conditions and multi-morbidity) and others pointing to improvements in health status among the elderly (compression of morbidity). The phenomenon of ageing, changing health and care needs has not yet been fully perceived by the policy agenda, with incoherent policy towards older people subsistence, retirement, healthcare and long-term care.

2. Brief overview of the LTC system in Poland

Care for older dependent people is predominantly a family domain in Poland. In most cases, caregivers are family members who – in case of care over older dependent people – receive little or no financial remuneration for the care provided (Sowa & Topińska 2016). Polish and international studies indicate that care for the elderly in Poland occurs mainly within the closest family and is provided by female family members – spouses, daughters or daughters in law. Recent study by Łuczak (2017) points that carers are mostly retired women or women in pre-retirement age, typically in poor health status themselves, especially if intensively involved in care provision. About 80% of those aged 65+ do not use institutional care or home care provided by a third party (AZER Study – Kotowska & Wóycicka, 2008). In wealthier households, family carers are supported by immigrants employed informally, which is not reflected in statistics. The organisation of care for dependent elderly people in Poland, as depicted in Figure 1, is complex. The following sections of this report provide a detailed account of how the provision of care is organised for both publicly and privately financed LTC.

Figure 1: Organisation of LTC services in Poland



Source: authors' compilation

Public LTC services

Public care for dependent older people is provided, as in other countries, through two sectors: (i) the health care sector, which includes cases of dependency or palliative care requiring a range of medical and rehabilitation services, and (ii) the social sector, which includes care for dependent older people who are also in a socially difficult situation (i.e. those who live alone, come from dysfunctional families, or are poor). In fact however, while the eligibility criteria and types of services provided are different, most of the recipients are in similar conditions in terms of health and functional abilities (Golinowska & Sowa 2010). Care provided in both sectors covers home (nursing) care and residential services. Additionally, there are several types of cash transfers available to different types of beneficiaries: older people, dependent people with disabilities, and caregivers of children with disabilities provided from the social insurance or locally managed family benefits.

Home care services

Home-based care includes nursing services provided through the health sector and managed by primary health care units and care services provided through the social sector and managed by social assistance centres. Entitlement to services provided in the health sector is based on an assessment of health needs. Services provided in the social sector can be obtained upon agreement from the social assistance centre and are granted following the evaluation of income and other family conditions. Home care services cover assistance with every day activities, personal hygiene, tasks related to housework (meal preparation and cleaning, among others), nursing (if prescribed by a physician), and support in social networking. Specialist home care is adjusted to the specific medical and rehabilitation needs of the recipients based on their illness or disability, and services are provided by qualified personnel, such as physiotherapists. Specific services are also targeted at the population with mental health problems. The scope of services and place of provision (i.e. home or care facility) is set individually depending on the needs of the recipients and the local institutional environment. The level of provision of home care services strongly depends on the ability of local governments to organise adequate care in terms of staff and their qualifications and facilities. In 2016, there were 99,368 recipients of care services, of which 5% were recipients of specialist care services (MRPiPS, 2016).

Residential services

Public residential care services are also provided in the health and social sectors, with different eligibility criteria, financing rules, and types of services.

There are three types of residential LTC homes in the health care sector: care and treatment facilities (*zakład opiekuńczo – leczniczy* – ZOL), nursing and care facilities (*zakład pielęgnacyjno – opiekuńczy* – ZPO), hospices and palliative care homes. Overall, there were about 500 ZOL and ZPO units and over 150 hospices and palliative care homes in 2015 (GUS 2017). Some of the care facilities in the health sector were developed in result of the hospital restructuring processes undertaken in late 1990s when a development program of residential care homes for dependent people was created and operating standards were defined. The territorial self-governments participated in the process of establishing the residential LTC system and the National Health Fund (NFZ) contracted out services in the established homes. Creation of LTC facilities contributed to the reduction of the average length of stay (ALOS) in hospitals in Poland.

3. Recent policy developments in the field of LTC

In the social sector, residential care is organized mainly through the social assistance (welfare) system: stationary social assistance homes (*domy pomocy społecznej* – DPS), family care homes (*rodzinne domy pomocy*), and recently-developed full-time care facilities (*domy opieki całodobowej*). An overwhelming majority of residents – over 86 thousand in 2016 – stay in DPS, while other types of residential care is marginal (MRPiPS¹, 2017). In 2015, about 10 thousand residents stayed in full-time care facilities (MRPiPS, 2016) run by private providers and funded from public sources. The smallest facilities are family care homes, which provide care to three to eight dependent older people per facility. Overall, these homes provided care for only 175 residents in 2014 (MPiPS, 2015).

A DPS can accommodate full-time residents, providing protection as well as supportive services at the level of the current standards identified by the law on social assistance and other documents of the Ministry of Family Labour and Social Policy. DPS residents include persons who require permanent institutional care, provision of which the family is incapable of. There are several types of DPS, which provide care for the different groups of people in need: older people; chronically ill people; mentally ill people; intellectually disabled adults; intellectually retarded children and youth; and physically disabled people.

Day care centres

An important and recently developing type of care are day care centres offering leisure time activities for seniors. These facilities are managed by local governments in cooperation with social assistance centres. Activities of different types: education, culture, excursions, but also health promotion are provided for persons living at home, but whose family members are not able to provide care for the older person because of professional activities. During working hours (i.e. five days a week for no more than 12 hours a day),

¹ Note that late 2015 the ministry changes its name from the Ministry of Labour and Social Policy (Ministerstwo Pracy i Polityki Społecznej – MPiPS) to Ministry of Family Labour and Social Policy (Ministerstwo Rodziny Pracy i Polityki Społecznej – MRPiPS).

the dependent person can spend time in the day care home, where he or she receives the necessary living and care services. The number of beneficiaries of day care centres amounted to about 300, covering 21 thousand people in 2016 (MRPiPS, 2017).

Public discussion on problems related to population ageing undertaken over the last two decades has been dominated by the debate on the sustainability of the pension system. In 1999, the pension system changed from the defined benefit to the defined contribution system. This was followed by an increase in the retirement age and a withdrawal from this change only last year. Public opinion still does not perceive ageing as a significant social problem (CBOS, 2012). Hence, for a long time, politicians were not motivated to undertake the debate on the necessity of investments in LTC. Recently, the notion of senior policy (*polityka senioralna*) was developed; it covers selected LTC problems and responds to an active ageing policy direction (Golinowska, 2016; Szatur-Jaworska, 2016). An attempt to diagnose and formulate recommendations to develop the LTC system was undertaken by the working group on the preparation of the regulation on insurance from the risk of dependency by the parliamentary group of the Civic Platform (*Platforma Obywatelska*) couple of years ago. Its work began in 2010 with a diagnosis of the LTC system (Augustyn, 2010). Following, a draft regulation was prepared; however, it did not gain the support of the Civic Platform government, nor did it gain the support of the new government led by the Law and Justice (*Prawo i Sprawiedliwość*) political party.

Significant contributions to the discussion on the situation of older people were the activities undertaken in the European Year of Active Ageing and the programme Solidarity between Generations (2012). Strongly supported and promoted by the Ministry of Labour and Social Policy, it not only drew attention to the problem of population ageing, but also stimulated research on activities in the field of care in different sectors and at the community level. Subsequently, a number of activities addressing the problem of population ageing were undertaken by the government, with the Ministry of Labour and Social Affairs, where the Department for Senior Policy was established (in 2012), playing a predominant role. However, as care services are divided into two sectors, work on the development of the LTC policy was undertaken simultaneously in both of them. Two strategic documents were prepared and published:

In 2012, the Ministry of Health published a policy paper *Facts and Perspectives of Long-Term Care Development in Poland (Stan faktyczny i perspektywy rozwoju opieki długoterminowej w Polsce)*, which included LTC definitions, terminology, and description of the LTC provision, as well as future possible developments in this field. The document describes the resources (i.e. facilities and employment), utilisation, and procedures to be used in care and treatment (including geriatric assessments). The key recommendations focus on coordination and increasing financing for and the quality of LTC.

In 2013, the Ministry of Labour and Social Policy adopted a strategic document entitled Preconditions for Long-Term Senior Policy in Poland for the period of 2014–2020 (*Założenia długofalowej polityki senioralnej w Polsce na lata 2014–2020*). The document is organised around three priority fields: the development of medical services, including geriatric services, for the older population; health promotion and prevention; and the development of social and care services responding to the needs of the older population. The document defines senior policy as the initiatives and activities of the central and local administrations as well as of other institutions focused on assuring dignified and healthy ageing. The aim of the policy is to support active ageing, good health, and the capability to lead an independent life, even in cases of disability and functional limitations in older age. The policy creates a general framework for supporting seniors in different aspects of life and is oriented towards supporting the active and independent living of seniors. It also addresses some of the features within the current provision of services related to health assessments, nursing, and care for the older population. However, it does not tackle the need for the development of a comprehensive LTC system. Comparison 1 below provides a detailed list of priorities.

Comparison 1: An overview of the areas, priorities, and objectives of the Preconditions for Long-Term Senior Policy for the period of 2014–2020

AREA	PRIORITIES	OBJECTIVES
Health and independent living	Creation of a system allowing for development of medical services for older population	1. Development of geriatrics as a medical specialty 2. Professional medical education towards a complex health care for older patients 3. Development of geriatric care centres
	Health promotion and prevention	4. Preparation for ageing, education on physical and mental aspects of ageing and consequences of different behaviours 5. Promotion of healthy lifestyle (mental health, intellectual activity, hygiene, healthy risk avoidance, and nutrition, among others) 6. Supporting physical activity
	Development of social and care services	7. Development of social services adequate to the needs and capabilities of older people 8. Development of adequate care services for dependent people 9. Development and implementation of telecare and new technologies allowing for improvements in the organisation of care for older people 10. Creation of support for informal carers, especially community level support
	Security	11. Assurance of security of older people and counteract any act of abuse
	Place of living	12. Support for planning and architecture addressing different population needs, including older people
Professional activity of 50+ population	Activities stimulating the potential and employment of older people: 50+, 60+	13. Improvement of education offer and its quality, adequate to labour market demand and responding to the needs of people 50+
		14. Supporting adequate working conditions and age management
		15. Increasing the effectiveness and efficiency of activities stimulating labour market participation of people 50+ and 60+
		16. Stimulating cooperation oriented towards increasing the employment of people 50+
Educational, social, and cultural activity of older people	Educational activity	17. Stimulation of health literacy
		18. Civic education
	Cultural education	19. Education on new technologies
		20. Increase in cultural competencies
	Social activity	21. Integrating activities of institutions and organisations
		22. Promotion of cultural animation
Silver economy	Stimulating efficient markets and activities responding to the needs of older people	
Intergenerational relations	Assuring intergenerational solidarity	

Source: MPiPS, 2014

The above-listed strategic policy documents create a general framework for governmental and local activities in the field of senior policy, they do not translate however to comprehensive activities in the field of policy towards older people, and especially development or improvement of LTC policy at the central administration level. There only two specific programmes responding to the goals – mainly in the active ageing framework – established in the senior policy: ASOS and Senior-Vigor.

Governmental programme supporting social activity of older people for the period 2012–2013, extended to the period 2014–2020 – the ASOS Programme (*Rządowy Program na rzecz Aktywności Społecznej Osób Starszych na lata 2012–2013 i 2014–2020 – Program ASOS*)

The governmental programme supporting the social activity of older people was established in 2012 for the period 2012–2013, and was further extended for the period 2014–2020. Primarily, the programme was foreseen as one of the activities undertaken within the framework of the European Year of Active Ageing and the Solidarity between Generations programme. Its long-term aim was to stimulate policy towards older people and (in the short-term) to integrate different organisations in field of actions geared towards the older population (Szatur-Jaworska, 2016). In annual editions of the programme, local activities (projects) geared towards older people are selected and supported with public funds. There are four priority areas along which projects are supported: education of older people, social activities promoting inter- and intra-generational solidarity, social participation of older people, and social services towards older people. Most of the projects supported (85%) are in the first two priority areas of the programme (Szatur-Jaworska, 2016). Thus, most of the resources are directed towards stimulating activities for older people rather than towards the support of services for older dependent people. The main beneficiaries are local governments and non-governmental organisations operating at the community level. An evaluation of the activities of community-level organisations working with older people with multimorbidities notes drawbacks to the activities funded within the programme – their short-term perspective (typically these are activities planned for one year) and lack of sustainability in the long run (Sowa & Beaumont, 2016).

Senior Councils (*Rady Seniorów*)

An important element of senior empowerment and increasing the participation of seniors in the public sphere is the creation of senior councils. In 2013, within the ASOS programme, a Council on Senior Policy was established as an advisory body at

the central level of the administration. A significant moment in the history of the development of democratic civil institutions in Poland is the development of senior councils at the local (community) level. The role of councils is to recognise the needs of the older population (including health needs), advocate for them, and participate in local government decisions in response to the needs declared by older people. Senior councils began to emerge spontaneously at the end of the previous decade and in response to the new, friendly senior policy of the Ministry of Labour and Social Policy and the announcement of the ASOS programme. The direct incentive for establishing senior councils was created by an amendment to the Act on Local Government that was introduced at the beginning of the new decade (Dz.U. 2013, Item 1318). According to the provisions of the Act (Article 5), the initiative to set up a council may be entirely bottom-up. It may include both individuals and social organisations such as third age universities. The councils themselves establish their statutes and regulations and determine the main subject of their interests. It is estimated that at the end of 2016, about 220 councils were in place, operating in every tenth municipality.

Telecare Care and Support Centre for people with limitations in everyday activities in Koszalin (Zachodniopomorskie region) (Zdalne Centrum Opiekuńczo-Pomocowego Teleopieka dla osób z ograniczoną samodzielnością w codziennym funkcjonowaniu w Koszalinie (zachodniopomorskie))

A partnership of the Koszalin Senior Council with the city authorities resulted in the development of a project oriented at the introduction of telecare for dependent people with limitations in undertaking activities of daily living. In 2016, a one-year pilot project for older and dependent people was implemented. The Council plans active support for the development of telecare for other types of dependent people, also not covered by public schemes. The project enjoys high interest in the local community.

Source: Kłaman et al. (2016)

The issues of health and care for older people are two of the core fields in the activity plans formulated by senior councils. There is no statistical evidence however on the actual activities undertaken by local senior councils, nor information on the impact and effectiveness of their actions. Descriptions of small projects supported by different councils across the country point to their high interest in issues of dependency and care (e.g. Kłaman et al., 2016). The box below presents information on one activity of a senior council, which was supported by the Koszalin local government, and concerns the introduction of telecare for their dependent citizens.

Senior Vigour (*Senior-Wigor*) Project

The third priority of the Preconditions for Long-Term Senior Policy in Poland for the period of 2014-2020 adopted at the end of 2013 refers to the development of social and care services responding to the needs of older people. A governmental programme formulated in response to this objective was created in 2014 and entitled “Senior-Vigour”.

This programme, managed by the Ministry of Family, Labour, and Social Policy, is carried out during the period 2015-2020 and includes all voivodships. Under the programme, local governments organise day care/activation centres as a place for meetings of those 60+ (offering various forms of activities like: educational courses, sports exercises, rehabilitation, dance, and others). Once a local government unit receives funds for the programme, it is obliged to carry out the programme for at least 5 years.

The first edition of the programme took place in 2015. Local governments received grants for the implementation of the proposed projects aimed at the creation of day care homes for older and disabled people. Grants were mainly used for the adaptation of facilities, maintenance, and the organisation of transportation for the beneficiaries. The costs of the social and care services received within the programme can be shared by recipients; however, priority is given to beneficiaries in poor local communities (i.e. often beneficiaries living below the social assistance minimum). In 2017, a new edition of the grants for day care homes and senior clubs took place under the renamed programme Senior+.

Currently, there are no comprehensive evaluations of the programme publicly available. However, 128 day care homes were established during 2015-2016. The media mostly complained that the government spent relatively few resources on the programme (PLN 20-30 million) and, despite that, the planned subsidy was not fully allocated and used. Reasons for this include the relatively high requirement of the programme regarding the standard of equipment and activities. Day care homes operating outside the programme do not fulfil similar rigid standards. A preliminary review of the activities offered by selected Senior-Vigour day care homes suggests that their activities were more geared towards independently living older people with some health problems who may face loneliness rather than the dependent older population. Also, sustainability of created facilities was under question, as activities are financially supported at their start, further should be co-funded by local governments and clients themselves. Already in 2016, a great share of resources in the programme was used to support centres that were already brought to life. Higher subsidies for the programme are foreseen for the following years – PLN 80 million per year from 2018.

In 2017 the government announced preparation of a new policy entitled “Social policy towards older people 2030. Security. Solidarity. Participation” (*Polityka Społeczna wobec osób starszych 2030. Bezpieczeństwo. Solidarność. Uczestnictwo*). Details of the policy framework remain however at the moment unknown.

4. Policies aiming to reduce dependency

Health promotion and disease prevention as a modern public health goal is (and should be) a common cross-sectional state responsibility (health in all policies). In reality, it is understood as an obvious responsibility of the health sector. It should be mentioned that health promotion in Poland faces difficulties, with only about 2.6% of total health expenditures allocated to this purpose. Among the major obstacles in health promotion are low funding, limited ability to coordinate cross-sectoral activities, little resources for research and new initiatives, low degree of health awareness in the general public (health literacy), and little interest in health service providers struggling with other problems related to health sector management (Sowada et al., 2017). Health promotion for older people faces an additional hurdle as there is a lot of scepticism related to the potential effectiveness of promotion activities concerning a healthy life style among the older population. It is often perceived that, from an individual life cycle perspective, it is too late for any interventions, especially when long-term care is concerned.

Although ageing-related problems are often overlooked by public policy, especially if they compete against the numerous other priorities of the healthcare sector, some elements of ageing policy were included in the National Health Programme (*Narodowy Program Zdrowia*) (NPZ) in the beginning of the new century, for the period of 2007–2015 (MZ, 2015). Its ninth operational objective included the creation of the conditions for healthy and active ageing. It was assumed that the target group of health promotion activities are people aged 60 or more and that local governments will create the conditions for stimulating health literacy, education, and campaigns on the avoidance of the dominating health risks – especially smoking – in this population. Additionally, the media were engaged by the policy in creation of an image of older, still-active people.

The new edition of the NPZ, for the period 2016–2020 (Council of Ministers, 2016), is clearly pointing with its fifth objective to the need for the promotion of healthy and active ageing. Central and local-level institutions responsible for the implementation of the policy in this field are recognised. Only one of the NPZ tasks, related to development of nursing, care, and rehabilitation institutions, directly addresses LTC issues; however, there are many tasks pointing to the need of cooperation between health and social sector institu-

tions, including local communities, in the implementation of the healthy ageing policy. The implementation of the NPZ policy is anchored in the public health law (adopted in 2015) and supervised by the Ministry of Health.

Comparison 2: Tasks identified within the healthy and active ageing objective of the NPZ

TASK	PRIORITIES	OBJECTIVES
Senior policy stimulating the social, professional, and family activity of older people	Creation of senior and disability-friendly public spaces	Ministry of Family, Labour, and Social Policy (MRPiPS), Central Institute for Labour Protection (CIOP-PIB) in cooperation with the Ministry of Culture and National Heritage (MKiDzN), 14, local governments, third age universities
	Supporting the activity of older people at the community level	MRPiPS, local governments
	Supporting the use of new technologies and preventing the e-exclusion of older people	MRPiPS and Ministry of Digitisation
	Promoting health behaviours in the pre-retirement age (at the workplace) and in post-retirement	Ministry of Health (MZ), MRPiPS, CIOP-PIB
	Prevention of poverty and social exclusion of older people	MRPiPS, local governments
	Creation of social and family policy aimed at reduction of health inequalities	MRPiPS
	Promotion of inter-generational activities	MRPiPS
Adjusting the healthcare sector to the needs of older people	Preparation of healthcare sector to provide services addressing multimorbidity	MZ, MRPiPS, local governments, National Health Fund (NFZ)
	Incorporation of health literacy, especially related to nutrition, in medical services	MZ, NFZ, National Institute of Geriatrics, Rheumatology, and Rehabilitation (NGRiR)
	Access to medical services allowing for early detection and prevention of diseases in older population	MZ, NFZ, NGRiR
	Creation and implementation of health check-ups for 60 year olds	MZ, NFZ, NGRiR
	Development of geriatric services, also in primary care	MZ, NFZ, NGRiR
	Development of nursing, care, and rehabilitation services for older dependent people	MZ, NFZ, NGRiR, MRPiPS, local governments
	Fall prevention in older people	MZ, NGRiR
Education activities	Education of health sector employees on geriatrics, care, and prevention in older population	MZ
	Education of dietary needs in older population, prevention of weight-loss and metabolic diseases	MZ
	Education in fall prevention	MZ
	Improvement in adherence to medical recommendations by patients	MZ
	Education of employers on health protection	Nofer Institute of Occupational Medicine (IMP), MZ

TASK	PRIORITIES	OBJECTIVES
Scientific research and international cooperation in research on problems related to health in the older population	Research on medical services provided to older people	MZ, NFZ
	Research on health and quality of life of older people	MZ, research institute or university
	Innovations in pharmacotherapy and health promotion activities	research institute or university, MZ
	Analysis of effectiveness of medical services provided to older people	National Institute of Public Health (NIZP-PZH), MZ
	International cooperation on prevention in older people	MZ

Source: Council of Ministers, 2016

As the above comparison shows, the programme assumes that activities in health promotion and the primary prevention of chronic diseases will be undertaken primarily in the health sector. Additionally, it points to institutions in other sectors, especially operating at the level of state regulation, that should be involved in this field. At the same time, while specific activities are concerned, it is very difficult to achieve integrated activities at the local level. The health sector, facing difficulties in employment in medical and paramedical professions and low financing, is hardly involved in the initiatives of local governments and non-governmental organisations. Some tasks identified in the NPZ are similar to those listed in the Preconditions for Long-Term Senior Policy, where health promotion and prevention are also on the list of priorities. In fact, some of the activities listed in the NPZ and the Preconditions for Long-Term Senior Policy (e.g. health education of older people and supporting their social activity) are already implemented on daily basis by local governments or non-governmental organisations (including third age universities) operating at the community level and are sometimes supported with public funds.

Activities in health promotion among seniors, especially for the oldest old and those with multiple morbidities and often disabilities, are much less common than those for the younger population and younger seniors. There are no legal regulations nor common practices related to health promotion in LTC services. It is perceived that for them it is too late for prevention as they are already dependent. However, there is some, although limited, evidence of health promotion activities undertaken by LTC institutions (Sowa-Kofta et al., 2017). They are neither regular nor implemented on a large scale, depending on individual incentives and available – and often limited – professional staff and financial resources that could be used for health promotion and further dependency prevention. In home and nursing care, health promotion might take place in the form

of advice and education or stimulation of healthy behaviours, while in day care, the stimulation of physical and social activity takes place. In long-term institutions, health promotion is more difficult, as a large share of residents are already in very poor health and are often bed-ridden; however, some activities – especially related to rehabilitation – are provided. There are cases of activities related to the prevention of addiction among residents of DPS (ROPS Rzeszów, 2016), the stimulation of mental health, or projects oriented at fall prevention reported in the literature. These activities are stimulated and funded by local communities and undertaken within governmental programmes or international projects. Examples of such projects include the European Network on Safety Among Elderly (EUNESE) (Petridou, 2006) aimed at promoting fall prevention measures in nursing and care institutions or the Pro Health 65+ project,² coordinated by the Institute of Public Health at the Jagiellonian University, which provides workshops on prevention methods for older population, including recipients of LTC services. Advocacy and health education is also an important part of local communities' activities aimed at older people as well as an important part in providing support to informal carers, including through dedicated programmes in local community activity centres and non-governmental organisations or through the educational programmes of the increasingly popular third age universities. These activities are usually bottom-up and are not reported on a regular basis.

² http://www.pro-health65plus.eu/?Home_page

5. Informal care support

Care of dependent people is perceived and anchored in legal regulations as primarily a family obligation, with institutional services caring for those who cannot be cared for at home due to medical or other specific conditions (i.e. those who live alone) (Golinowska, 2010). According to various estimates, from 80% to over 95% of care is provided informally, within the family (Łuczak, 2013; Wóycicka & Rurarz, 2007). A Central Statistical Office survey notes that every fifth person in Poland is engaged in the care provision of a close family member (GUS, 2016). Typically, carers are women in their fifth and sixth decade of life, often resigning from work and entering retirement as early as possible to care for their older parents, spouses, or grandchildren.

Informal care is also often provided by migrants, either young women in their 20s – often students – or women in their 50s and 60s – often retirees – coming from Ukraine. Care is organised in turns, in the form of the cooperation of several (two or more) informal carers who come every three months and typically live with older dependent people (live-in). In such cases, they provide full-time support, 24 hours a day. In most cases, this work is not registered; thus, the actual number of migrants working as carers is difficult to estimate. In many cases, carers are professionals, sometimes with a medical (nursing) background, and care work is below their actual skill level and qualifications. There is no policy support for informal migrant care and the problem is hardly perceived in political debates (Sobiesiak-Penszko, 2015).

Current state support for informal care is mainly cash benefits provided either to the family carer or to the dependent person, although benefits are typically low and unequally distributed, with preferences for supporting carers of disabled children rather than dependent older people (Sowa & Topińska, 2016). Indirectly, carers might be supported by tax reliefs (i.e. in cases of the rehabilitation of disabled children), formal care services provided at home or at the day care or rehabilitation centre, or by programmes provided on a project basis by non-governmental or religious or charity organisations, which are often supported by public funds.

Cash support for carers includes various benefits, with the amount depending on the occurrence of the disability and its period (e.g. if the disability occurred in childhood),

the age of the dependent person, and the labour market status of the carer. The first group of cash benefits are benefits granted within family support. They are granted to families providing care to dependent people (holding a disability certificate). There are two benefits available for carers of disabled people:

- The nursing benefit (*świadczenie pielęgnacyjne*) is available to carers (parents) of disabled children or adults whose disability occurred in childhood. The benefit was introduced in 2013 in response to the protests of parents of disabled children. The benefit amounts to PLN 1,406 in 2017. Between 2013 and 2017, the amount of the benefit increased by PLN 100 each year. From 2017, the benefit will increase in line with wage increases. The benefit cannot be combined with employment and is, in fact, a wage replacement.
- The special care allowance (*specjalny zasiłek opiekuńczy*) is an income-tested allowance³ available to carers of disabled adults. This allowance was also introduced in 2013. The amount of the benefit equals PLN 520. Again, the benefit cannot be combined with employment.

The introduction of a benefit that is income-tested and dependent on age of disability occurrence was strongly criticised as it excluded a group of potential beneficiaries (i.e. carers of persons whose disability occurred in adulthood). According to a decision of the Constitutional Tribunal, the government is obliged to equalise access to the benefit for carers of different groups of disabled people. Responding to the Tribunal's decision, an allowance for carers (*zasiłek dla opiekunów*) of PLN 520 was introduced in 2014 and addresses carers who were eligible for the benefit before 2013. A former government prepared a regulation equalising the rights of different groups of carers, which, however, was criticised and subsequently abandoned by the new government led by Law and Justice party, which has been in power since the autumn of 2016.

A second group of benefits are cash allowances which are provided almost universally to older people. The nursing supplement (*dodatek pielęgnacyjny*) is a supplement to the retirement or disability pension granted to all people aged 75 or more who are entitled to social insurance. Individuals aged 75 or more who are not entitled to social insurance, as well as people with a disability certificate, may be eligible to receive a nursing allowance (*zasiłek pielęgnacyjny*). Benefits amount to PLN 208 and PLN 153 per month, respectively. Benefits are, in principle, supposed to support the provision of informal or formal care services; however, they are very low, hardly allowing beneficiaries to cover the actual costs of care.

Non-cash informal care support, if it exists, is rare, whilst studies conducted by regional governments (ROPS Kraków, 2015) and research institutes (Janowicz, 2014) note that

³ Income threshold for the family of a carer and the person in need equals PLN 764 per capita.

the actual needs of carers are beyond the existing cash support. Carers complain of a lack of psychological support and medical training, difficulties in the reconciliation of work and care responsibilities, and a lack of ability to meet their own needs, all of which contributes to burn out or even depression. They report a need for more education on medical and care provision methods, rehabilitation methods, respite care, and psychological support. Local governments, often cooperating with non-governmental organisations, occasionally provide programmes and projects that address these needs. However, being project-based and, in most cases, supported by external (often EU) funds, this type of informal care support is neither comprehensive nor sustainable.

Overall, current informal care support in Poland is poorly developed, with a lack of coordination between different policy measures. Cash support, which is the most evident type of support, is concentrated on support of families with disabled children – and eventually disabled adults – rather than older people with health problems and limitations due to chronic conditions. There is little support for the reconciliation of work and care, as benefits cannot be combined with work, and family carers are not subject to extended care leaves due to their home care responsibilities. Non-cash support is incidental. In the face of the emigration of young people, the increasing labour market participation of women in their 50s and 60s, and underdeveloped care services, migrant care is becoming a more widespread option for care provision, though it is mostly located in the grey economy.

Despite the segmentation of cash support for carers, the coordination of support and the possibilities for the reconciliation of work and care are not under policy debate. Informal care support is mentioned among the objectives of senior policy (Preconditions for Long-Term Senior Policy in Poland for the period of 2014-2020) with respect to improvements in the quality of care. Policy directions identified in the document include:

- Creation of an information and education system for informal carers allowing for the exchange of information and experiences related to care;
- Education, training, and workshops on informal care provision involving family carers local communities and volunteers; and
- Introduction of recognition of skills system, registries, and certifications for formal and informal carers as a quality control mechanism.

Although adopted in 2014, the programme is not directly linked to governmental or regional policies supporting informal care, which questions the potential for its actual implementation.

6. Information policy and new technologies in LTC

The development of information policy in Poland is shaped by several regulations and policy documents. In general, information policy is perceived as an important tool to increase the efficiency of governance in almost all sectors. However, almost none of these documents addresses directly LTC, what might be related to the fact that provision of services is cross-sectoral, while information policies are typically sectoral ones. Only the document Preconditions for Long-Term Senior Policy in Poland for the period of 2014–2020 directly addresses opportunities for the use of telecare and other information and communication technology (ICT) tools in improving the efficiency and quality of care services.

The main policy documents on information policy refer to:

- Information needs and reporting in relation to population ageing;
- Data collection, organisation and management in the health and social systems, and access to information systems for citizens; and
- Computer literacy for the older population.

Reporting on the situation of older people

The Law on older people (*Ustawa o osobach starszych*), aimed at improving data collection and information on the situation of older people, was introduced in October 2015. The law imposes on the public administration an obligation to monitor the situation of older people (60+). In practice, the Central Statistical Office (*Główny Urząd Statystyczny- GUS*) regularly publishes reports covering information on demography, epidemiological, and survey-based statistical information on the health status of older people, their incomes, labour market activity, and access to services by dependent (disabled) people. Reports summarise public statistics collected in various fields in relation to the situation of older people. They do not, however, report comprehensively on the use of LTC services by the older population.

Information systems in healthcare and the social sector

Information and digitisation policy in Poland is shaped by several strategies and policy documents. An umbrella policy document responding with its objectives to the goals of the European Digital Agenda is the Country Development Strategy 2020 (*Strategia Rozwoju Kraju*), adopted in 2012 and supervised by the Ministry of Regional Development. This document was followed by the Effective State Strategy (*Strategia Sprawne Państwo*).⁴ These documents describe the main state policy directions aimed at strengthening the economic, social, and institutional potential of the country using instruments of competitive and innovative markets and assuring social cohesion. An important aim of strategies is to strengthen public administration using adequate tools of information policy: databases and user-friendly interfaces, among others. With their objectives, these strategies point to the need for the development of e-governance, enabling easy access to services via the internet for citizens, and the creation of a comprehensive databases on social services as well as improving computer literacy of groups vulnerable to exclusion, including older people aged 50 or above.

The Ministry of Digital Affairs is responsible for priority setting and the coordination of the introduction of information systems in public administrations. The policy directions are described in the Programme of Integrated State Digitization (*Program Zintegrowanej Informatyzacji Państwa*) (PZIP)⁵ and the Strategy of State Digitization (*Strategia Informatyzacji Państwa*).⁶ The Strategy of State Digitization covers eight priority areas:

1. Creation of a user-friendly interface describing the main public institutions of the state and providing links to e-services;
2. Creation of a national and international system of e-identification (e-ID) enabling access of citizens and entrepreneurs to public services;
3. Creation of a system of national registries;
4. Creation of a unified system of management of public administration registries and documents, also across sectors of administrations;
5. Creation of a platform of integration of services and data allowing for the technical integration of different sector-oriented systems;

4 <https://mac.gov.pl/files/wp-content/uploads/2011/12/SSP-20-12-2012.pdf>

5 <https://mc.gov.pl/konsultacje/program-zintegrowanej-informatyzacji-panstwa/zalacznik-1-strategia-informatyzacji-panstwa-plan-dzialan-ministra-cyfryzacji>

6 <https://mc.gov.pl/konsultacje/program-zintegrowanej-informatyzacji-panstwa/zalacznik-1-strategia-informatyzacji-panstwa-plan-dzialan-ministra-cyfryzacji>

6. Creation of an integrated analytical platform as a tool of state information policy management;
7. Supporting common state infrastructure, including the General State Information; and
8. Supporting digital qualifications in public administration.

The strategy does not directly address certain sectors of public administration, including sectors important for LTC (e.g. health, social assistance, and social insurance); however, in principle, the creation of a unified platforms of administration, management, and the analysis of data across sectors and between central and territorial administrations should allow for the recognition and integration of information on the functioning of LTC. Currently, information systems covering LTC services exist separately in the three sectors: healthcare, social assistance, and social insurances.

The main regulation describing the organisation and management of data in the health care sector is the Law on information systems in the health sector (*Ustawa o systemie informacji w ochronie zdrowia*), adopted in 2011, with further amendments. It describes the conditions for the implementation of a comprehensive information system in healthcare that includes the various existing databases (medical registries, healthcare statistics, healthcare employment data, and pharmaceutical reimbursement data, among others), obliges providers of healthcare services to collect and submit individual level data on the scope of medical services received by the insured population, and supports the introduction of telemedicine as a tool to improve the efficiency of medical treatment. The Center for Information Systems in Healthcare is responsible for the implementation of the health information system. In 2012–2013, the information system in the healthcare sector was partly introduced (e-health) and was aimed at improving the efficiency of healthcare service provision. The system allows for the collection of information on the volume, type, and cost of medical services provided to the population, including older people. It allows for identification of the specific medical services used by older people in tertiary, secondary, and LTC facilities paid from public sources. The data is managed by the NFZ. Further, registries of medical institutions – service providers, pharmacies, diagnostic facilities, and registered pharmaceutical products, among others—were created and are managed by the Center for Information Systems in Healthcare (CSiOZ). The introduction of medical registries was supported by the European Social Fund (ESF) for the period 2007–2013. There were however delays in the implementation of the IT system in healthcare units. The system is not as comprehensive as expected, does not allow for creation of patient digital record across different services and certain elements (e.g. implementation of e-prescriptions) are only expected in the years to come. Currently, CSiOZ runs the e-health project, which

consists of several components: the creation of an electronic platform for the collection, analysis, and sharing of medical data and improving the quality of healthcare management by promoting ICT using e-learning tools. These projects are also supported by the ESF. The healthcare information systems are not specifically oriented at the older population or LTC services; however, they cover information on providers of services to older people, the types and costs of services provided to the older population, the main diseases treated in older people, and the consumption of reimbursed medical products by older people.

In the social assistance sector, where care services and residential services are provided, a separate reporting system has been introduced over the years (since the 1990s). In 2014, a Central Statistical Application (*Centralna Aplikacja Statystyczna*) (CAS) was brought to life, combining statistics collected in various databases and enabling the analysis of data in the social policy field, which covers social assistance, family policy and benefits, and public employment services. In the system, the volume of home care services and residential care services can be identified and monitored.

Information on cash benefits provided to the older or dependent population is collected in the CAS specifically, benefits from social assistance or family benefits and within the system of social insurance institution (*Zakład Ubezpieczeń Społeczny*) (ZUS) statistics.

Currently, neither at the central nor local administration level is it possible to combine different statistical systems and tools and identify the recipients of different types of services related to LTC (healthcare, care services, residential care, or cash benefits), which would serve to improve the monitoring of LTC and the analysing of the services provided and would potentially result in increasing the efficiency of care.

Use of new technologies (ICT) in care services

The use of new technologies in LTC services is supported by the policy document Preconditions for Long-Term Senior Policy in Poland for the period of 2014–2020 (*Założenia Długofalowej Polityki Senioralnej w Polsce na lata 2014–2020*).⁷ One of the priorities of the document is oriented at the creation and implementation of a telecare system and the use of new technologies in the organisation of care services in Poland. The objective is quite general, but is followed with several recommendations for interventions:

7 <http://www.mpips.gov.pl/seniorzyaktywne-starzenie/zalozenia-dlugofalowej-polityki-senioralnej-w-polsce-na-lata-20142020/>

- Development of minimum telecare standards and other indirect forms of care using new technologies (ICT);
- Defining sources or potential sources of telecare or other forms of ICT-based services financing;
- Activation of local communities in organising neighbourhood self-care with the use of ICT;
- Support for telecare implementation programmes; and
- Use of new technologies in prevention policy and support for healthy behaviours.

Activities in telecare promotion and implementation are geographically diverse and take place in local communities, often with support from the regional programmes funded by European Commission funds or through the resources of local governments. It is extremely difficult to track these activities, as they are often not publicly reported, with only some information on their scope or results available in the media (i.e. newspapers or the internet) or during subject-oriented conferences. Examples of telecare use in pilot projects concerning health promotion or the management of residential care may be provided.

Pilot project of telecare use in Małopolska region In an international ADAPT2DC project undertaken in the period of 2011-2014, a pilot project of telecare use was implemented in several communities (counties) in the north-west Małopolska region (Miechów, Chrzanów, Olkusz, and Proszowice). The goal of the project was to improve access to care in depopulated areas, decrease the costs of high quality care, and reach patients at risk of exclusion. During the project, 100 patients aged 55 or more were provided with free tele-medical services (tele ECG) for a month and requested to register at least three times a day and record as many ECG events as needed. After one month, each patient received a diagnosis and recommendations by a physician and dietitian. There were 97 patients that completed the pilot project.

Source: <http://www.adapt2dc.eu/adapt2dc/Poland.htm>

Pilot project of ICT use in a social assistance residential care facility (DPS) in Warsaw

A pilot project focused on improving the efficiency of work in a social assistance residential care facility in Warsaw-Wola was introduced in 2016. The project consisted of several components, including installing ICT and software allowing for the monitoring of the activities of nursing and care personnel in DPS, followed by rationalising and allocating the time of the provision of services across the day based on monitoring data. During the pilot project, only one facility was included, but in the following years, other facilities located in Warsaw are foreseen to be included in the programme.

Source: Interview with the Director of the Office for Assistance and Social Projects in Warsaw

There is a visible interest of private telecare providers in the promotion of these typed of services, supported by the fact that in the period of 2014-2020, about PLN 3 billion is foreseen for projects in e-health and care services. The government also supports with the ESF funds projects oriented at introducing standards of care with the ITC support.

7. Coordination in LTC

Problems with coordination concern the whole public sector. Weaknesses of coordination are nowadays interpreted as one of the specific features of governance following the period of central planning. In the first period of transformation, it was justified by the need to transform a centrally planned economy into a market economy. It had been argued that apart from the privatisation of different spheres of life, sectors and large organisations should be divided in order to stimulate competition and increase management efficiency. It was assumed that the time for coordination would come later.

Several years after the implementation of market-oriented reforms, disincentives arising from a lack of or insufficient coordination arose. Scientific research devoted to good governance (Wilkin, 2016) pointed to the main areas of inefficiency attributable to weaknesses in coordination.

The coordination of activities between sectors has been hampered by different governance priorities whenever the political affiliations of ministers differs. Coalition governments dominated by 2015, with the Minister of Labour and Social Policy coming from a different political party than the Minister of Health. The current government, supported by a single political party, has undertaken some coordination activities in the health sector, but not in the field of common health and social sector issues.

Problems of coordination in the health sector increased after the reform of 1999, when sickness funds were introduced. A concept of care coordination was developed (in a pilot project) based on the integration of activities of one insurer (sickness fund), similar to the American concept of the health maintenance organisation (HMO) (Kowalska, 2009). The liquidation of sickness funds and the centralisation of health insurance resources derailed efforts undertaken in this direction.

Further, additional types of coordination were introduced – namely, those related to integrated management. Specific forms of coordination related to disease management were implemented in the health sector – for example, “oncology package” (*pakiet onkologiczny*). The aim of this policy is to introduce a short path from diagnosis to treatment for patients with cancer and to support them throughout the treatment. A focal point is the treatment process coordinator who assists the patient from the

diagnosis to the last treatment. Currently (2017), other disease management programmes are being prepared—for example, a programme concerning care for patients after a myocardial infarction. There are also – at the local level, but supported with ESF – pilot projects of integrated care for specific groups of older people planned (e.g. older people after hospitalization).

Another approach proposed under the current health policy reforms is the strengthening of primary care institutions and coordination with other healthcare sector institutions in order to introduce patient-centred and community-rooted complex care.

Healthcare sector reform plans oriented at integration do not cover the problem of the integration of health and social care services. In this field, strong differences in organisation and approach are observed, arising from the communist period. Social care in Poland was traditionally situated in the healthcare sector. In the transformation period, since 1990, when social assistance was separate and poverty and unemployment relief policies were introduced, tasks concerning the care of vulnerable populations were in the labour and social policy sector.

The strict separation of health and social care was, however, difficult in practice. Generally, people in need of care services were in poor health and, additionally, needed financial support. Thus, to address the health needs of dependent people, physicians and nurses were employed in the social sector, primarily based on contracts funded from the social assistance budget, and further based on civil contracts. Tensions between sectors were observed, and for the medical staff, the prestige of employment in the social sector was lower, along with the remuneration. Also, while dependent people often face similar health and care needs, despite the sector in which care was provided, the eligibility criteria, services assured, and financing rules are different in the two sectors, thus creating adverse incentives to use services in the system where they are more affordable (related to lower fees). At the same time, inequality in type and quality of care provided to patients with similar health needs is observed between the sectors, especially in residential care services (Golinowska & Sowa, 2010).

8. Conclusions

Poland's policy on older people is at odds with its policy on ageing. The distinction between these two policy directions was identified in a report prepared by the experts' committee supervised by Professor Barbara Szatur-Jaworska (2014) and in collaboration with the Ombudsmen's office. Ageing-oriented policy covers activities oriented at influencing the future demographic structure of the population through measures oriented at increasing fertility. In 2016, an almost universal and relatively high child benefit was introduced for every second and further child in a family, along with a benefit for a first child if the family's income is low. The programme is expensive, resulting in decreased attention given to other health and social policies, including LTC and palliative care policy.

Recent policy towards older people implemented by the health sector includes the programme supervised by the Ministry of Health aimed at increasing the refund for pharmaceuticals related to the treatment of common chronic diseases and used by older people (75+). Beside this, in LTC, previous policy directions and programmes are continued, without major changes.

Competences in policy towards the older population are shared between the social and health sector. The latter concentrates on the long-term goals formulated in the NPZ, the implementation of which should be financially based in the law on public health implemented in 2015. In the social sector, "senior policy" was formulated oriented at the activation and social integration of older people, initially accompanied by an increase in the retirement age and now (after the withdrawal from the systematic increase and equalisation of retirement age for men and women) placing more attention on social activation and inclusion.

In the policies of both sectors, local governments are the main institutions responsible for activating seniors in the community, supporting informal carers, and implementing health promotion programmes, as well as those responsible for preventing selected diseases and limiting health risks specific to older age people (i.e. fall prevention programmes).

Most activation and social integration programmes are stimulated by the social sector (Ministry of Family, Labour, and Social Policy) and its programmes, such as Senior-Vigour and Senior + (from 2017).

Regardless of the centrally-driven public policy, many valuable bottom-up local initiatives geared at supporting families in the provision of care towards their dependents are organised and implemented. The fact is that families in Poland also need support in the form of institutional or semi-institutional care, preferably in small homes, close to their residence. The level of the provision of institutional care is relatively low, and too low given the abilities of families in times of the transformation of traditional family functions and high emigration. The term deinstitutionalisation of care, popular in other countries, does not find proper grounds in Poland.

Non-governmental organisations are active in the implementation of actions for older people—namely, in supporting hospitals, care, and nursing facilities (i.e. ZOL and ZPO). One of the most popular actions in the collection of financial resources for adequate care equipment and nursing facilities for older people is organised by the foundation Great Orchestra of Christmas Charity (Wielka Orkiestra Świątecznej Pomocy). This action has brought a significant improvement in equipping hospital geriatric departments and nursing and care facilities in beds suited for the needs of care for dependent people.

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