European Research Studies Journal
Volume XXIV, Issue 2B, 2021

pp. 1041-1054

Can Elderly People Afford Long-Term Care? Financing Long-Term Care in Poland and the Financial Resources Available to Beneficiaries

Submitted 26/03/21, 1st revision 29/04/21, 2nd revision 30/05/21, accepted 30/06/21

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Abstract:

Purpose: *This paper aims to assess long-term care (LTC) spending in Poland broken down into public financing and beneficiaries' contributions, which depend on the financial resources available to them. By focusing on individual expense items from the people's perspective requiring care, the author takes stock of the range of care services on offer relative to the financial resources available to those in need.*
Design/Methodology/Approach: *The study examines expenditures on LTC in the West Pomeranian Region of Poland in three social care systems. Out of the list of such expenditures correlated with the financial resources available to the elderly, particular focus is placed on residential LTC services provided in comprehensive care systems.*
Findings: *The levels of expense relative to the average disposable income of pensioners vary widely, revealing the problem of older adults having insufficient financial resources to self-finance their LTC in Poland. The variance results from system design and the principles that govern care financing. The cost of some residential LTC services is charged to beneficiaries, meaning they are required to pay for them out of their pocket, while other services are co-financed at fixed rates that vary depending on the income of the respective beneficiaries.*
Practical Implications: *The paper outlines the essential characteristics of a new LTC financing scheme that could be designed and rolled out in Poland based on research. The main idea is to establish a new dedicated source of care service funding and a new fund-collecting entity.*
Originality/Value: *The proposed method of LTC financing in Poland provides an opportunity to resolve insufficient care funding partially. It is necessary and crucial to identify a new source of funding that would feed into the system, given especially that Polish society is aging rapidly. The discussion covers multiple solutions, some of them taken from the LTC systems of other countries, and reviews viable concepts.*

Keywords: *Long-term care, healthcare management, social care, care benefits, public finance, economy, finance.*

JEL classification: *H51, H53, H55, H75, I13, I18, I38, J11, J14.*
Paper Type: *Research study.*

Acknowledgment: *This project is financed within the framework of the "Regional Excellence Initiative" of the Minister of Science and Higher Education covering the years 2019-2022, project number 001/RID/2018/19, financing amount: PLN 10,684,000.00.*

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1. Introduction

Rapid and dramatic trends transform people's lives in a variety of ways. One of them, societal aging, along with longer human life spans and relative improvements in the population's health status, has become particularly pronounced. The proportion of older people in the population is growing while the share of young people continues to decline. The model of multi-generational families living together is being abandoned, leading to a new norm of more fragmented families and more common migrations. All these trends compound care-related and other social problems faced by the elderly, making them increasingly more pressing.

Providing adequate, comprehensive care to the elderly is a daunting challenge for both the beneficiaries and the LTC system itself. In Poland, services are provided by three systems, each characterized by a set of distinctive features. The fragmentation of these systems, the multiplicity of their tasks, and their very design and financing hamper access to services. For many years, both the organization and financing of care for the elderly have been random and insufficient. This is especially true for residential LTC. It is, therefore, crucial to search for and deploy an appropriate scheme to address demographic, social, and economic changes with due account taken of the financial standings of the beneficiaries.

2. Literature Review

As used in the relevant literature, the term long-term care refers mainly to the provision of care to chronically ill people. Scopes of LTC services vary depending on the country and the system in place. As definitions of LTC generally rely on similar precepts and refer to similar aims, their wordings may be comparable. Literature provides a range of interpretations of the concept, many of them extensive and all of them pointing to the same overarching objective.

The most comprehensive definition is that provided by the World Health Organization, according to which LTC includes activities undertaken for persons that are not fully capable of self-care on a long-term basis, by informal caregivers (family and friends), by formal caregivers, including professionals and paraprofessionals (health, social, and others), and by traditional caregivers and volunteers (WHO, 2002). Such services encompass assistance in maintaining personal care, everyday activities, household chores, and home modifications to meet the needs of persons who experience functional dependence. They can be delivered in homes, in communities, or institutional settings. They are designed to minimize, restore, or compensate for the loss of independent physical or mental functioning and support the restoration of as much capacity as possible (WHO, 2002). This definition covers many aspects of the services and partially overlaps with the definition proposed by the OECD. In its extended form, it comprehensively covers a wide range of services and describes their nature explicitly.

2.1 Organization and Financing of LTC in Poland

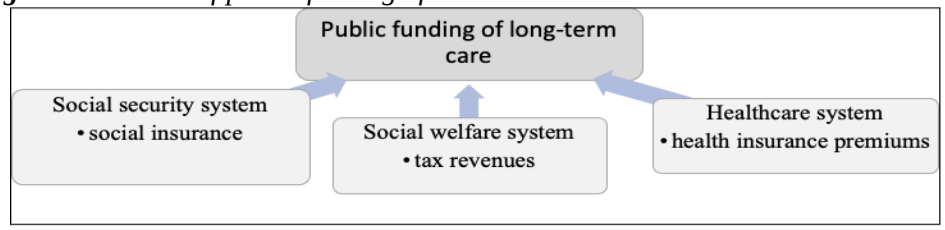
In Poland, responsibility for providing LTC to the elderly rests primarily with the family. Only in some instances is this obligation assumed by institutions operating within various schemes (Szweda-Lewandowska, 2008; Błędowski and Maciejasz, 2013). The responsibility to deliver specialized nursing and care services is divided between the health care, social insurance, and social systems, each of which offers different benefits. Long-term care can be delivered in an institutional setting, by professional caregivers, or in a home setting by family members and friends (Kozierkiewicz and Szczerbińska, 2007).

The services classified as LTC provided by the healthcare system are available under contracts concluded with the National Healthcare Fund (NHF). Such services are also the responsibility of the Ministry of Health. As part of this system, residential LTC is provided by specialist care organizations, such as healthcare nursing homes and, to a certain extent, hospital wards for chronically ill people and geriatric wards (Kozierkiewicz and Szczerbińska, 2007). Daycare is also available, delivered by community nurses and long-term caregiver teams (Szczerbińska, 2006). Home care is an ad hoc form of care provided in consultation with GPs (NHF Szczecin, 2016).

In the social system, care in residential LTC is provided in welfare nursing homes, mainly to people facing difficult social circumstances (Ministry of Family and Social Policy, 2021). This mission and support in the form of cash benefits are pursued in cooperation with social centers, which operate in each municipality. The policies of relevant local governments define these tasks. Within its scope of responsibilities, the social insurance system operates via an institution tasked with ensuring the provision of services by distributing funds and managing the scheme, i.e., the Social Insurance Authority (SIA) (SIA, 2021). The SIA provides cash benefits for LTC in the form of monetary supplements to old-age and disability pensions.

The principles of publicly-funded LTC in Poland vary depending on the system. To provide such care, use is made of a state-funded social insurance model in which services are financed with social and/or health insurance contributions and supplemented with state aid funded mainly with tax revenues (Figure 1).

Figure 1. *Sources of public funding of LTC in Poland*



Source: *Own research.*

Each system relies on its own set of rules for financial services and offers its specific scope of financing. Such parameters depend on the nature and form of the services. The healthcare system is the most diverse due mainly to its medical nature and the increased demand for such support from the elderly population.

2.2 Analysis of Unit Expenditures on LTC in Poland: The Case of a Selected Region

Studies and assessments of LTC financing commonly focus on either country-specific or system-specific statistics. This paper aims to assess unit expenditures (expenditures per beneficiary per residential LTC service); the focus is placed on individual expenses incurred by a specific individual requiring care. This enables the author to assess the cost of such services about the financial resources available to the beneficiary. To make this possible, the study is narrowed down to the Polish Region of West Pomerania, for which unit expenditures on LTC are estimated.

Long-term care spending per beneficiary: The financing of LTC from the perspective of a single beneficiary depends on the financial standing of the concerned individual. The parameters considered first are the expenses made by the actual recipient of welfare and the services' scope, form, and frequency. Such data have been collected from a range of sources that vary by benefit type. To assess unit expenditures, specific caveats need to be added for each benefit type. The assessment result shows a marked rising trend in the number of LTC users (except for care allowance). The trend is driven by changes in demographics and continuing societal aging.

The financing of the care services used by an individual beneficiary can be seen more directly based on the order of magnitude of service costs (Table 1). The most expensive residential LTC in Poland, specifically in West Pomerania in 2012-2016, was offered by social (welfare nursing homes) and healthcare (healthcare nursing home) systems. The cost of a stay of one year in duration in a welfare nursing home during that period ranged between PLN 27,200 and PLN 33,700. During that time, the cost of the services commissioned by the National Health Fund to healthcare nursing homes alone ranged from PLN 27,500 to PLN 28,600 per year per person (District Chamber of Auditors Szczecin, 2012, 2013, 2014, 2015, 2016; NHF Szczecin 2012, 2013, 2014, 2015, 2016). This calculation is subject to specific caveats.[1]

In the day-care service arm of the system, unit expenses are not fully comparable due to their ad hoc nature and certain caveats. During the period in question, the National Health Fund commissioned between PLN 10,300 and PLN 11,700 worth of long-term care services annually (NHF Szczecin 2012, 2013, 2014, 2015, 2016). Meanwhile, the annual spending on care services in the social (welfare) system ranged from PLN 4,600 to PLN 5,400 (District Audit Chamber of Szczecin, 2012, 2013, 2014, 2015, 2016).

Table 1. *Annual unit cost of LTC services per beneficiary in the West Pomeranian Region of Poland between 2012 and 2016 [in PLN]*

System responsible/service type	Expense per beneficiary per year				
	2012	**2013**	**2014**	**2015**	**2016**
1. WELFARE SYSTEM					
Welfare nursing home services	27 234	27 634	29 222	29 095	33 662
Nursing and specialized care services	4 552	4 758	4 865	5 061	5 354
Care allowance		1 836	1 836	1 836	1 836
2. HEALTHCARE SYSTEM					
Healthcare nursing home services	27 512	27 463	27 477	27 894	28 668
Long-term nursing care	11 362	11 738	10 318	10 406	11 286
3. SOCIAL INSURANCE SYSTEM					
Care benefit – person aged 75 years or over (entire region)	no data	no data	2 481	2 498	2 504

Source: *Own calculations based on data from the District Audit Chamber of Szczecin, the District Center of Social Policy in Szczecin, the National Health Fund for 2012-2016 and the Social Insurance Authority for 2015-2016.*

As for cash benefits, the combined value of the disbursements of the care benefit (a benefit available in the social insurance system) exceeded that of the care allowance (a similar benefit available from municipalities). The recipients of the care benefit received an average of PLN 2,494 per annum (SIA, 2014, 2015, 2016), while the amount of the care allowance remained at a constant PLN 1,836 per year (District Social Policy Center Szczecin, 2012, 2013, 2014, 2015, 2016). Pecuniary benefits from the Social Insurance Authority (SIA) were more popular as their monthly amount slightly exceeded that of the care allowance.

The unit costs (per beneficiary) of residential LTC are higher due mainly to the sheer complexity of such services. Other services constitute ad hoc and additional assistance that only complements the core care benefits system. Therefore, the remainder of this paper focuses mainly on residential LTC services. This is done chiefly given their more comprehensive scope and the growing demand for such services from families grappling with the dependency of a close older adult.

Residential LTC expenditures per service: One of the assessment goals was to ascertain the cost of a single LTC service, which was additionally hampered by multiple units of measure. A specification of such units was used to assess the cost of individual services. Given the relevant caveats regarding the number of services provided, monthly spending on residential LTC services was assessed as shown in Table 2. This specification includes neither income-tied financing nor the portion charged to the beneficiary by healthcare nursing homes.

Table 2. *Unit cost of residential LTC services in the West Pomeranian Region of Poland between 2012 and 2016 [in PLN]*

Service type	Unit of measure	Expense per service				
		2012	**2013**	**2014**	**2015**	**2016**

WELFARE SYSTEM						
Welfare nursing home services	per month of stay*	2 689	2 774	2 816	2 874	3 067
HEALTHCARE SYSTEM						
Healthcare nursing home services	per person per day	75.38	75.24	75.28	76.42	78.54
	per month of stay**	2 261	2 257	2 258	2 293	2 356

Note: **) monthly fee for residential LTC in welfare nursing homes in West Pomerania, calculated on the basis of a weighted average, the weight being the number of slots assigned to an agreed service price in a given welfare nursing homes. The assessment takes into account the welfare nursing homes that accommodate elderly and chronically-ill patients and patients with somatic conditions, as well as annual ordinances from starosts (district administrators) on the monthly cost of living in welfare nursing homes. **) a month is defined as a 30-day period.*

Source: *Own calculations based on data from the Regional Audit Chamber of Szczecin, the Regional Social Policy Center in Szczecin, the National Health Fund for 2012-2016; and data from the Social Insurance Authority for 2015-2016.*

In 2016 in the West Pomeranian Region, the average monthly cost of stay by an elderly or chronically ill person in a welfare nursing homes ranged from PLN 2,689 in 2012 to PLN 3,067 in 2016. Such cost is first charged to the beneficiaries and their families. Only when the concerned person is unable to make the payments does the local government step in.

The cost of the residential LTC services offered by healthcare nursing homes is assessed based on applicable rates per person per day. During the years in question, the NHF contracted patient stays at rates ranging from ca. PLN 75 per person per day (NHF, 2016) to PLN 78.54 per person per day in 2016. In 2016, the monthly rate per person per day of a stay in a healthcare nursing home, as contracted by the NHF, ranged from PLN 2,261 to PLN 2,356 (NHF Szczecin 2012, 2013, 2014, 2015, 2016). This portion is financed by the National Health Fund, with the beneficiary paying an "accommodations" fee tied to his/her income.

2.3 Financing of Comprehensive LTC and the Financial Resources Available to Elderly People in Poland

The analysis of LTC financing in West Pomerania at the unit level shows wide divergencies in the costs and scopes of each service type. It is reasonable to show the cost of services, especially residential LTC cost, as borne by individual beneficiaries, concerning their financial standings. The older adults form the most prominent target group for LTC. The people who receive old-age and disability pensions are the most likely to become functionally dependent and require care. Therefore, the amount of their average income about the cost of residential LTC is paramount, mainly for self-sufficiency. This fundamental consideration defines access to services. The period in question saw a rise in the average disposable income. The statistical income of old-age and disability pensioners totaled PLN 1,499 in 2016 (Central Statistical Authority (GUS), 2012, 2013, 2014, 2015, 2016).

Table 3. *The monthly cost of residential LTC offered to old-age and disability pensioners in the West Pomeranian Region of Poland between 2012 and 2016 [PLN]*

	2012	2013	2014	2015	2016	Average
1. Welfare nursing home services	**2 689**	**2 774**	**2 816**	**2 874**	**3 067**	**2 844**
2. Healthcare nursing home services (2a plus 2b)	**3 163**	**3 187**	**3 226**	**3 300**	**3 405**	**3 256**
2a) healthcare nursing home services (financed by the NHF)	2 261	2 257	2 258	2 293	2 356	2 285
2b) accommodation fee charged to patient, amounting to 70% of monthly income	902	930	968	1 007	1 049	971

Source: *Own calculations based on data from ordinances specifying the average monthly cost of living in welfare nursing homes per resident in 2012-2016, issued by Poviat Starosts (District Administrators) in West Pomerania; the National Health Fund for 2012-2016; Central Statistical Authority (GUS), Department of Social Research and Living Conditions, household standings in 2012, 2013, 2014, 2015, 2016 based on household budget survey, Warsaw 2012-2016.*

The welfare nursing home ordinances were used to compute the average cost of a monthly stay of a single person in a welfare nursing home during the period in question. Such cost was found to be ca. PLN 2,844. For healthcare nursing homes, this average was estimated at ca. PLN 3,256 (Table 3). The earlier compilation of the unit costs of residential LTC did not take into account the total cost, including the cost to the patient of a stay in a healthcare nursing home, which amounted to 70% of a patient's (old age and disability pensioner's) monthly income (Journal of Laws of 2004). After determining the average amount of old-age and disability pensions, own contributions of old-age and disability pensioners during the period in question were found to amount to ca. PLN 971 per month. The financing of healthcare nursing home services and the patient's contribution offer a comprehensive view of the cost of a monthly stay, which was an average of PLN 412 higher than the cost of a monthly stay in a welfare nursing home.

Under the rules of financing healthcare nursing home services, the own monthly contribution amounts to 70% of a person's income. This amounts to ca. 29.8% of the total costs of providing a residential LTC service. This means that a significant proportion of the beneficiaries' income only covers a small fraction of the cost of their stays in healthcare nursing homes and that their incomes are insufficient to pay the total cost of the service. The supplementary use of own contributions to finance services otherwise paid for by health insurance funds is a specific approach to the excessively high cost of specialized services about widely diverse income levels of the beneficiaries. The accessibility of residential LTC services also depends on the system responsible for their financing. While the healthcare system is predicated on dividing the burden between the system itself and the beneficiary, the social (welfare) system is designed to have stayed in welfare nursing homes paid for by

beneficiaries, with local government contributions only becoming available in extraordinary circumstances.

A comparison of the monthly cost of residential LTC with the average disposable income of old-age and disability pensioners shows a deficit in their financing (in the social system) and only a modest surplus left over at the beneficiary's disposal (in the healthcare system). The shortage of financing in the social system is particularly pronounced (Table 4). The average old-age and disability pensioner came up short by an average of ca. PLN 1,457 per month, with the cost of a monthly stay in a nursing home amounting to 205.2% of the disposable income of members of this group during the period in question.

Table 4. *Difference between the unit cost of services and monthly income among old-age and disability pensioners between 2012 and 2016 in the West Pomeranian Region of Poland [PLN]*

	2012	**2013**	**2014**	**2015**	**2016**	**Average**
1. Welfare nursing home services	-1 401	-1 446	-1 433	-1 436	-1 569	**-1 457**
2. Healthcare nursing home services	386	399	415	431	450	**416**

Source: *Own research.*

The only reasons why the users of healthcare nursing home services are left with a certain proportion of their income after paying for the services is the cap on the share of income that can be charged with the beneficiaries and the substantial contribution of the National Health Fund to financing such services (needless to say, this only applies to persons entitled to receive health benefits). Thus, an average old-age and disability pensioner would retain PLN 416 per month from his/her monthly income. However, the average cost of the services during the period in question would be 165% of the total National Health Fund's contribution and the monthly income of old-age and disability pensioners. This staggering proportion significantly exceeds the financial resources available to pensioners, which only demonstrates that the income of seniors is insufficient to finance LTC fully.

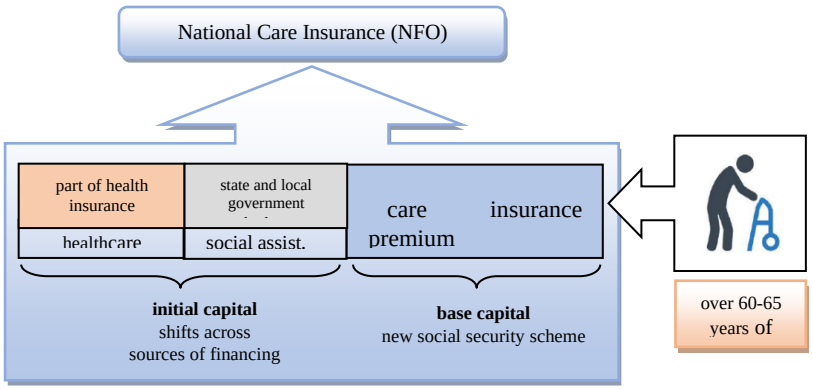
In conclusion, whether provided by social or healthcare nursing homes, public residential LTC services are paid for by beneficiaries either in whole or in part, depending on the type of care they select and the financing system they use. Average incomes are insufficient to pay for both the care and the beneficiary's everyday needs and expenses. Therefore, the financing falls on the closest family members, which can be highly challenging. Often, relatives move away while the elderly remain reluctant to change their residence place, leaving the latter lonely and excluded, with limited access to care to ensure decent living conditions in their old age.

3. Findings and Recommendations

The existing distribution of LTC tasks among the three funding systems is a starting point for developing a comprehensive concept of care financing through broader research and analyses. The concept should improve and better coordinate the tasks of institutions pursuing identical or similar goals and take proper account of the existing schemes and organizations within the healthcare, social welfare and social insurance systems.

The main purpose of the concept would be to define the basic source of financing covering the widest possible scope of nursing and care services delivered to the elderly population. Such a specially-designed fund would both collect and distribute funds to finance LTC. The body, named here the National Care Fund (NCF), would manage resources allocated for nursing and care services by law. The NCF would collect funds in a single institution under the supervision of a single decision-making body and have the authority to define the source of financing for specific services that would be offered to any elderly people at risk of becoming functionally dependent. One of the main expectations for the system of acquiring earmarked funds would be to design a new contribution scheme and copy existing schemes, including those in place in other countries. As a body designed to finance care services, the scheme would accumulate funds as initial and base capital. A detailed proposal for the financing structure of the fund is shown graphically in Figure 2.

Figure 2. *Sources of financing of the National Care Fund (N*



Source: *Own research.*

The adoption of a new employee levy in the form of a dedicated contribution for elderly care is designed to gather base capital and make it the main source of its financing. The levy would provide a special-purpose source of funding, and, as such, create a safety net for elderly people becoming functionally dependent. The range of the new scheme would enable the financing of services across existing systems.

The new contribution would be withheld from wages. It would be technically possible to have both the employee and the employer share the burden, as in the case of existing solutions. The amount of the contribution and the specific design of the

scheme and of rules of participation should be analyzed at greater length by competent ministries. It is also essential that the gross wages be increased accordingly to prevent the diminishing of net wages. The fact that such additional contribution will increase labor costs will possibly draw criticism from both employers and employees. Another reason why the proposal may spark controversies is that people tend to fail to recognize the need to finance services in retirement age, which many consider to be a distant future.

As part of the proposed solutions, some funds that have so far been allocated to LTC in both the healthcare and social (welfare) schemes would be migrated. The existing solutions, i.e., funds from healthcare insurance premiums and state and local government budgets should feed into the NCF. The NCF's initial capital can be raised by diverting the existing sources of LTC funding to support the existing two systems. In the healthcare system, the applicable health contribution ensures the financing of medical services, including LTC. Its share in total healthcare services is minuscule, at 1.83% in 2016 (NHF, 2016). The proposed shifts in the financing of services presume the migration of the part of LTC financing that is currently available in the National Health Fund to the new fund (the NCF). Meanwhile, the range of healthcare services financed by the National Health Fund would be reduced by removing LTC services. On the other hand, in the social (welfare) system in which financing relies on public budgets, the funds allocated to LTC should supplement the NCF. Local governments would receive funds reduced by the current value of the aforementioned services and directly allocated to the creation of initial care capital.

The size of the contribution should be determined precisely by way of analysis to ensure that it can be effectively collected and that it reflects the financial resources available to employees and employers. Once the amount of the contribution is agreed, it should be phased in gradually accordingly to the needs and public sentiment.

Another solution to complement the functioning of the NFO would be to adopt a minimum age requirement, set e.g. at the legal retirement age, as a condition for access to the services offered by the special purpose fund (NFO). To ensure a fair level of funding of the services that is commensurate with the accumulated contributions funds, a record of such funds (which are to be held in individual accounts) should be maintained. The NFO would be responsible for keeping records of any fund units credited to the accounts of the insured.

Another option is to adopt the senior care solutions employed in other countries. Germany, for instance, relies on a separate dedicated source of service financing based on nursing insurance (Rothgang, 2003; Rothgang, 2010; OECD, 2011a). Due to its universal and mandatory nature, nursing insurance reliably secures members of society who grow dependent by guaranteeing funding from a specific source. The contribution is fixed and withheld from the wages. This solution guides the proposed

Polish concept and may be a good example. Another part of the German system that is worth copying is the varying of the level of financing depending on family circumstances. Such differentiation is achieved by adjusting the burden of financing to family size. The required contribution is lower in the case of families with children and higher for childless individuals. Currently, childless people are subject to deductions at the rate of 3.05% and 3.3% (Bundesministerium für Gesundheit, 2020).[2] This increases revenues from nursing care insurance premiums and seems to be the right approach. However, the difference between such contributions should not be excessive so as not to discriminate against some social groups relative to others.

The United Kingdom, in its turn, makes service accessibility dependent on income levels (Comas-Herrera *et al.*, 2010a; Comas-Herrera *et al.*, 2010b; OECD, 2011b). In practical terms, this means that services are available to people who do not exceed a specified income threshold but inaccessible to wealthier individuals who can afford to pay for their care. This solution protects low-income people in the name of social solidarity. As always, such a system runs the risk of increasing social inequality, further stratifying society and creating additional divisions. However, from the perspective of the benefit financing system, the solution partially relieves the burden on the system itself, which is the main idea behind the British model.

4. Conclusions

A study of the Polish LTC system shows deficiencies vis-à-vis the financial resources available to the elderly. The cost of using the system is fundamentally mismatched with the average disposable income of a retiree, demonstrating that the financial resources allocated to the financing of services in the system, and especially in welfare nursing homes, are grossly insufficient. Under the existing rules of financing residential LTC services in the healthcare system, which include a cap on the share of the patient's own contributions, services in that system are more accessible to beneficiaries. In the majority of cases in the social (welfare) system, the beneficiary and/or his family (or alternatively the commune) must finance the entire stay using their own resources. As self-financing of care by retirees and their immediate family members becomes increasingly less feasible, the design of an integrated system of financing these social needs is imperative and likely to pose a challenge in the long run.

Studies suggest the need to adopt a solution that could facilitate the financing of LTC. The crux of the proposed concept is to finance the services through a special body tasked primarily with gathering funds. The funds would come from a new contribution scheme as well as existing solutions used currently to finance LTC.

The key arguments for establishing a separate fund include its potential to support the efficient management of resources for a designated purpose (such as LTC for the elderly) by way of concentrating all funds in a single place. This would help to

coordinate activities more effectively, finance them out of a clearly defined source, and improve expenditure monitoring. In addition, having the services financed out of a single fund will facilitate spending oversight, helping to channel the funds to the right places and to the people who really need them. The functioning of such a dedicated fund will prevent unjustified cuts in spending on the needs of an aging society by diverting funds to other causes, as is possible in the current system of state or local government financing. The Polish society is certain to continue ageing well into the future, which is why preemptive action is urgently in demand to satisfy rapidly growing needs and prevent rapid declines in the quality of life of the growing elderly population, the overstraining of state or local budgets and future social tensions.

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Notes:

[1] *The data on welfare nursing homes include the general cost of running the facilities, which is borne mainly by local governments (poviats). The figures for healthcare nursing home services reflect exclusively the amounts contracted by the National Health Fund. Note that the general healthcare and healthcare nursing home service section does not include patients' own contributions. The figures concerning welfare nursing home services reflect total unit costs of operating such facilities.*

[2] *The higher contribution rate applies to childless people over the age of 23. Such a contribution is shared between the employee and the employer.*