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Contracting Involvement – The Impact of Care Commodification into Long-Term Care Policy in Poland

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Research background

This article is associated with an ongoing research grant no. 2011/03/B/HS4/05495 titled

"*From the family to the market? The dilemma of financing care delivered to the disabled as an element of cost of disability*",

financed by the Polish National Science Centre – 2012-2015

(2013) Rationality of Public Expenses Dedicated for Disability Policy in Poland (in Polish only)

(2014) Evaluation of Disability Policy Goals – Recommendation For The Financial Analysis – for The State Fund for the Disabled and Rehabilitation in Warsaw.

Poland is the largest country in central and eastern Europe in both population (38.1 million) and area (312 685 km2).

After independence was achieved in 1989, Poland experienced a brief but intense period of economic decline. The transformation from a centrally planned to a market economy was accompanied at the outset by a severe downturn, with a considerable fall in GDP, and inflation reaching 70% a year. The Polish Stabilization Programme, implemented in 1990, entailed far-reaching consequences for the country's economy, including heavy social costs with rising poverty levels. However, by the mid-1990s, the economy showed signs of recovery, with GDP growth at 7%. Inflation also declined steadily, dropping to 1.9% in 2002.

By 2009, the GDP per capita was more than three times greater than in 1990, reaching US$ 18 926 purchasing power parity (PPP). Although other central and south-eastern European countries admitted to the EU at the same time as Poland have achieved substantially higher GDPs per capita, including the Czech Republic, Hungary and Slovakia (World Bank, 2011), Poland fares better in terms of the Human Development Index.

Long-term care

unavoidable challenge

LTC and disability policy overlaps

Following a discussion over the problem of LTC financing, it is worth looking at the **former experience of disability policy** and welfare finance, which were the basis for the current solutions.

We can expect people not only to live longer but can expect them to live, excluding a few countries, in **temporarily worse health conditions**.

This is why, when researchers and decisions focus on LTC dedicated to older people, it should be taken into consideration, as not to neglect the problem of younger dependents and the **long-term assistance** (LTA) understood as support services delivered to people with limited ability in every sense.

HLY and life expectancy changes between 2000 and 2010 in selected European countries (gender division)

Country	Life expectancy change		HLY change	
	F	M	F	M
Austria	2,73%	3,49%	-10,74%	-7,89%
Belgium	2,24%	3,92%	-9,41%	-2,59%
Cyprus**	4,53%	4,81%	-7,76%	-4,82%
Czech Republic*	2,96%	3,80%	1,90%	-0,96%
Denmark	2,67%	3,38%	-0,81%	-0,95%
Finland	2,86%	3,54%	2,46%	3,91%
France	2,67%	3,88%	0,32%	2,83%
Germany	2,11%	3,76%	-9,13%	-8,39%
Great Britain	2,89%	4,00%	7,19%	6,04%
Greece	2,62%	3,60%	-0,73%	0,00%
Hungary**	2,90%	4,32%	1,38%	5,23%
Ireland	4,96%	6,12%	0,15%	4,11%
Italy	2,56%	3,81%	-7,27%	-3,01%
Malta*	3,88%	4,10%	8,98%	9,52%
Netherlands	2,88%	4,27%	0,00%	-0,16%
Poland*	3,22%	3,32%	-9,58%	-6,40%
Portugal	3,02%	4,40%	-9,00%	-1,50%
Spain	2,92%	4,26%	-7,79%	-3,16%
Sweden	1,85%	2,74%	14,86%	13,63%

How can LTC be financed?

Social (mandatory) insurance

Taxes

} Separated/mixed method usually overlapping with health care funding

Private (voluntary) insurance

Self insurance and/or out-of-pocket money

„The level of expenditures does not depend on the method it is financed with but on the range and the level of benefits and services" .

Obligatory burdens	
CONTRIBUTION	TAX
labor costs' connected not general coverage arousing expectations directly linked	strongly GDP dependant politically influenced (in general) universal simpler to introduced

LTC in Poland – factors affecting negatively

- Aging – much faster than UE average;
- "Contribution gap" – high migration, high unemployment, strong avoidance of permanent contracts connected with social contribution payment (23,8 % of GDP);
- "Care gap" – high migration of women (40-60 age) – the main source of well-skilled care services for Germany, Italy or UK; families structures polarisation.

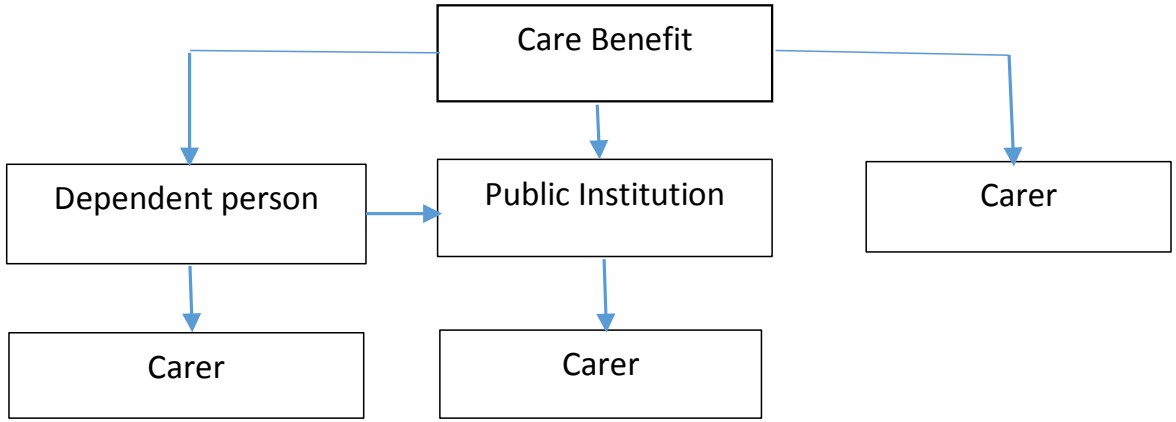
LTC in Poland - features

- There is no coherent system – the care services are delivered through health care system (managed on central level) and social protection system (managed at local level);
- It is tax based;
- The care delivered is highly limited or/and inadequate;
- Family is the primary entity responsible for care delivery and, if not performing personally, responsible for care financing;
- The long term care obligation (especially over a child) is the main cause of poverty and social exclusion as well as financial deprivation;
- Low benefits for carers (with preferences for child carers), the carer is expected to resign from professional occupation rather than to maintain professionally active.

Benefits for carers

As there are different statuses or forms of carers and different ways of delivering benefits, in almost every European country the implemented solutions differ.

The safety net for carers reflects the social perception of their work importance, as well as the level of disability policy development.



Graph: Paying-for-care patches

Benefits for carers

Characteristics of the decision-maker	Characteristics of the legal status	
	Employment (wage)	Provision (benefit)
Individual (dependent person)	PRIVATE SERVICE Austria, France(I), Belgium, Luxembourg, Cyprus, Spain, the Nederland	PRIVATE SUBSIDY (transfer) Czech Rep., Estonia (II)
Institutional (administration)	PUBLIC SERVICE Finland, Bulgaria, France (II), Denmark, Germany, Romania, Sweden,	PUBLIC SUBSIDY (transfer) Ireland, Croatia, Poland, Estonia (I), Latvia, Hungary, Malta, Slovakia, Slovenia, Great Britain

There are no benefits for carers in Greece, Lituania, Portugal and Italy

The level and the structure of disability policy expenses in Poland in 2010

Type of expenses	Structure of direct expenses	Structure of all expenses
Disability pensions	70,26%	63,92%
Social pensions	2,54%	2,31%
Labour support	6,28%	5,71%
Education	4,37%	3,97%
Rehabilitation	5,50%	5,00%
Social protection	9,60%	8,73%
Care benefits	0,71%	0,65%
NGOs support	0,74%	0,67%
Total integration expenses (1-8)	100,00%	90,98%
Sickness benefits		9,02%
Total (10-11)		100,00%

Survey on carers in Poland, May-July 2015

Goals:

- **Identification of legal and economic forms of care and social security implications for caregiver;**
- **Diagnosis of carers' households budgets;**
- **Evaluation of forms and a scope of support offered by institutions to carers ;**
- **Assessment of the tendency to professionalization of care.**

Scope 768 persons of three groups:

- **Not employed carers of children – 88 persons**
- **Not employed carers of adults – 296 persons**
- **Working persons who pay for delivered care – 384 persons**

Who delivers care?

- Women (75 percent)
- In case of adult dependants, a half of carers is over 51 years old;
- Adult dependants are: children, parents, spouse, brother or sister, a neighbour or a friend;
- A half of carers deliver care for longer than 6 years;
- In case of adult dependants carers usually do not hold a legal status for representation.

Care distribution

- In case of a half of households there are other inhabitants beyond a dependant and a carer (but not a disabled one);
- Half of carers do not share care with anyone but only 25 percent do not share a financial burden;
- Up to 87 percent of carers covers costs of care.

Incomes of carers

- In case of children carers 50 percent indicate the care benefit as the main source of income, in case of adults' carers - only 8 percent. The second group receives pensions and have occasional/unregistered incomes. 10 percent have no income at all;
- Half of carers have no other/additional incomes at all;
- The dominant level of income equals 300 euro for children carers, and 400 euro for adults carers;
- Carers are covered with public health insurance but much less with social security

Quality of life

- Even they evaluate their situation as "average" carers declare that first of all they need more money for personal expenses and that they have to limit their consumption (40 percent);
- The help/relief time is needed but not the most;
- Children carers are rather satisfy with money received for dependant care while adults' carers are definitely not;
- Even they were usually not train in caregiving (by doctors or any professionals) the carers do not feel they need it;
- 80 percent of carers have access to internet but they do not use it much;
- Dominant level of life satisfaction 8 points for 10.

Labour market involvement

- Half of carers had been employed before they started to take care but only for children carers the obligation of care delivering was the main reason of giving up employment;

- Almost half of carers declare readiness to become a professional, employed carer but rather not for another dependent person than they care now.

Institutional services

- 60 percent of carers have no support from a local social centre as well as from a dependent person's GP nor NGOs and a parish;
- They are heavily supported by families;
- The support from schools or educational centres is poorly evaluated.

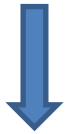
Is there anything else exept the matket philosophy?

how to rebuild/create a public dialog and solidarity

STEP 1- FUNDS

OPTIMAL SCENARIO

Tax based system (up to 3 years)



Insurance + tax relief

STEP 2 - RULES

- **CONNECTION** - LTC as an element of (preferably) disability policy than (exclusively) senior policy
- **COMMODIFICATION** – simple, flexible contracts for carers (no matter the ties), tax preferences for LTC insurances
- **COORDINATION** - The State Fund for the Disabled and Rehabilitation as a central supervisory institution

STEP 3 INSTITUTIONS

Carers employed by social work cooperative