Services for Supporting
Family Carers of Elderly People in Europe:
Characteristics, Coverage and Usage

EUROFAMCARE

National Background Report for Poland

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Content

Summary of Main Findings

- In Poland family carers are not registered. Detailed data concerning the situation of family carers in Poland (their number, age, gender, sources of income and education) cannot be obtained. The need for care services, including first of all family carers, can be estimated on the basis of the disability level of elderly. Taking the estimated number of disabled elderly into account it can be expected that there are at least 2 million family carers in Poland.
- Family carers generally do not profit financially from the care they provide; there are no regulations which would allow family carers to use benefits for the services they perform, they do not get any additions to their pensions. There are however possibilities of obtaining short-term financial assistance or other forms of help. Performing care by family members limits their ability to work and in consequence reduces the family's income. Therefore extending the range of help for family carers is essential.
- Family Carers in Poland have no organised representation, their problems and needs are not known to the public and they have no way of influencing the public opinion.
- Elderly have the possibility to co-operate with many NGO's, especially in seniors' clubs, self-help organisations, Third Age Universities, voluntary groups etc. Pensioners have their own trade union, which is excessively involved in political disputes and is not really a representative of the elderly.
- According to Polish customs members of the family are responsible for the care over a disabled elderly depending on the closeness of family ties. Therefore in Poland the family is the most important provider of care services. In few researches conducted until now it was observed that 92 % of elderly answered that in case of sickness they can count on the help of their families; it can be estimated that women are more frequently family carers than men, both in rural and urban communities. Carers are usually women aged 50-69.
- In Poland there is no legally determined level of dependency which would give an elderly the right to help from the state or any particular person. Generally social policy concentrates on people who are socially or economically impaired. Benefits and services for elderly and disabled are financed from public sources; care benefits are paid from the state budget, institutionalisation is financed (apart from a small payment from the inhabitants) by local authorities.
- In Poland there is no formal system of supporting family carers. Activities of the public administration in this respect are limited and inconsistent, while initiatives are undertaken mostly by local organisations or institutions.

In discussions on the directions of social policy concerning elderly the question of introducing legal regulations which would enable the state to support family carers is not raised. Usually, if it is necessary, one family member replaces another as the carer of a disabled elderly. In larger communities one can get help from volunteers (e.g. in the form of "granny-sitting"). In rural communities neighbours often support family carers.

- Because of the limited financial capabilities of elderly, using the services of private carers is infrequent and happens only in critical situations or among the relatively few wealthy people. In families with higher income sometimes illegal or temporary carers (without proper training) are hired, usually for a few hours daily. For people who are chronically bedridden a community nurse can provide help in the form of short-term help or training in nursing and regular care quality control.
- Social welfare centres and community social care are financed from the local government's budget. Nursing homes and similar institutions are financed by local governments, with a partial payment from the inhabitants or their families. There are institutions which specialise in caring for people who are physically disabled, mentally disabled, elderly and disabled or elderly and not disabled. They are subordinate to the local administration on the borough or county level. In recent years private care homes have appeared, which are not supervised by social welfare institutions. Regulations concerning professional qualifications and supervision do not apply to family carers as well. Consequently it can be stated that there are no legal regulations which would ensure a high level of private and family care.
- In Poland the problem of help for family carers is almost non-existent in political discussions, both on national and regional level. Because of the existence of many pressing problems (first of all unemployment and its social consequences) the problem of help for families with disabled elderly is treated as a matter of secondary importance. Social care agencies institutions are considered more with the elderly living alone, although in this case it is also hard to speak about the beginnings of a social policy towards elderly. Surprisingly, the situation of the elderly and their families is not an object of special interest of local politicians. Activity of local public health care and social service agencies can be evaluated much higher. However their role in supporting the family carers is dependant on their budget, which is the consequence of the strategy of solving social and medical problems on a local scale.
- Another factor, restricting the range of activities targeted at families with elderly members, is the concentration of the social policy system on material, and especially financial, aid. The social pressure on satisfying material needs, together with the permanent lack of budget sources, leads to the reduction of services. This is partly due to the fact that the elderly

(and sometimes their families) are not actively involved in electoral process, and therefore identifying and satisfying their needs is a matter of secondary importance.

- On the state level there are tendencies supporting the development of local social policy and transferring more power to the borough or county level. However, the decentralisation of social policy is conducted under the pressure of the immediate need to reduce state expenditures and strengthen the state's finances. While transferring to the local level the responsibilities connected with helping the elderly and their families the government has not as yet created appropriate law structures or financial possibilities to allow efficient functioning.
- Conclusions
  - The family is the main provider of care for elderly.
  - In Poland there are no registers or statistics concerning family carers.
  - Family carers do not use any particular benefits or forms of help in their work.
  - Creating a system of supporting family carers is one of the most important tasks of social policy towards elderly and disabled.
  - The forms of helping elderly and disabled in Poland show that the social help system is inefficient.

Introduction – An Overview on Family Care

In the last 200 years Poland experienced periods of loss of independence, changes of borders and large migrations and changes of political systems. All theses factors caused a diversity between various regions in material resources, customs, local traditions or even ethnic structure. This diversity influences the situation of the elderly. In consequence it also influenced the family network, frequently weakened by migrations or changing regional influences.

According to the data from the 2002 national census Poland has a total of 38,230.1 thousand inhabitants, including 4,852.6 thousand people over 65 years of age (12.7 %). The percentage of men aged 65 or more in comparison to the overall number of men is 9.9 %, while elderly women make up 15.2 % of all women. The percentage of elderly in rural communities is higher (13.5 %) than in urban communities (12.2 %), but the overall number of elderly in cities is twice as large as the number of elderly living in the country. Among elderly the ratio of men to women is 1:1.64, while the ratio of people living in the country to those living in the cities is 1:1.46. The oldest people (aged 80 or more) make up 2.2 % (in the country - 2.5 %, in the cities - 2.0 %) and there are 828 thousand of them (GUS, 2003).

Demographic forecasts predict that “by the year 2030 the number of retired people (men over 65 and women over 60) will reach over 9 million, that is by over 3.4 million in comparison to the year 2000 (an increase around 60 %). The process of ageing of Polish society will take speed in the second decade of the 21st century (2010-2020), when almost 2 million retired people will appear. This is when the generation of the post-war population boom will reach retirement age. The process of ageing of our society will also bare the features of so called double ageing, as the number of oldest citizens (aged 80 or more) will rise from 0.8 million in now to 1.8 million in 2030 (an increase of 125 %). This process is the effect of negative changes in procreation, slow but positive changes in death rate and natural shifts in age structure.” (Strzelecki, 2001)

Family ties in Poland are relatively strong. Although the number of families with multigenerational households is systematically decreasing, the family remains the main source of support both for the elderly and other family members. There is a strong tendency towards upholding the mutuality of services, i.e. the elderly help in organising the household and caring for children, while younger family members help them in managing sickness or disability. In many families, especially the unemployed, the elderly play an important role in financing the household. Old age pensions are an important source of income for many families with elderly members, which they cannot do without, and therefore caring for the elderly is sometimes a service granted in exchange for financial help in supporting the household.

Help for the elderly, as well as other citizens, is provided first of all by public institutions social assistance centres and health care centres. The latter organ-

ise medical care, prophylactics and rehabilitation, as well as nursing services. Financed from state or local sources, social assistance provides help for families with low income and care of disabled people. Access to health service on the primary care level is common. Access to the social help is dependant on the income per capita in a given household.

The care service market for elderly and disabled, as well as their families, is only developing. These services are available first of all in larger cities and consist mostly of nursing and permanent or temporary care over elderly in their homes. These services are provided either by nursing agencies or by private workers. Additionally, some of the services are provided unofficially - by nurses seeking additional source of income or immigrants, mostly from the former Soviet Union. Free medical care is guaranteed by Public Health System, but paid medical assistance help is also available from physicians with private practice. Often using private medical services is supposed to make it easier for the patient to gain access to public - unpaid - health services, such as specialist consultations or hospitalisation. The need for non-medical services (such as transport for disabled people, helping in contacts with the environment**,** supplying food, help around the household) usually exceeds its availability. The problem concerns urban and rural areas to the same extent. Because of the prices the demand for private health services is usually lower than the supply, but the demand for nursing and care taking services is rather unfulfilled.

Volunteering in Poland has been developing only for several years. Social involvement in volunteering is relatively limited. Some of the duties connected with caring over the elderly are fulfilled by informal groups - distant relatives, friends and neighbours. The help of neighbours and friends is occasional and usually results from a temporary need to replace a member of the closer family.

The role of religious organisations is surprisingly small. They concentrate on satisfying material needs, while services helpful for life organisation and keeping self-reliability remain a matter of secondary importance.

There is no legal definition of “need of care”, which would oblige the state or certain people to caring for anybody, but there are certain acts of law indirectly connected with the right to care. The Family and Care Code (Dz.U. 64.09.59) in article 133 point 2 states that “*only those living in poverty are entitled to alimony*”**.** According to article 1 of the act on professional and social rehabilitation and employing disabled (Dz.U. 97.123.776), the following definition of disability is used – *“[disabled are] people whose physical, psychological or mental state causes a lasting or periodical restriction to carrying out their social roles, especially working* (…)”. According to article 2a of the Act on Social Care (Dz.U. 98.64.414) disability is “*a physical, psychical or mental sate causing a lasting or periodical restriction of independent existence*”.

The demand for care services, particularly those of family carers, can be evaluated on the basis of the degree of loss of ability. Polish Central Statistical Office uses two indicators – the "disability indicator" based on the evaluation of the state of one's health, eyesight and hearing and the "mobility indicator" based on the ability to move. The indicator based on the ability to perform every-day activities (ADL – Activity of Daily Living) is more appropriate here. In the research done by B. Synak and co-workers (Synak, 2002) a "self-care index" based on the assessment of ADL was used. Among people aged 65 or more 36.5 % felt a fair or severe impairment. This level of disability applied to 26 % of people aged 65-74 and 52.5 % of people over 75. Such an impairment was experienced by 31 % of elderly urban communities and 42 % of elderly in rural communities. Assuming that people with this level of disability need help in every-day activities, and this is performed almost entirely by family carers, it can be estimated, that in Poland 1,698.6 thousand people aged 65 or more need help from family carers because of their physical impairments. This is just an estimate and it can show considerable differences in various regions of the country. It was confirmed by a research in six deliberately chosen country communities, representing different geographical, ethnical and cultural (customs) backgrounds, in which physical disability applied to 45 % to 80 % of elderly in various communities. This number does not include people who need help because of psychological or social problems. In the research done by B. Synak and co-workers (Synak, 2002) an indicator similar to the "mobility indicator" was presented – limitations in mobility applied to 33 % of people aged 65 or more, while severe limitation ("does not leave house or is bedridden") to around 10 %. The loss of mobility is stronger among women then among men and among people living in the country than among the inhabitants of cities. Significant regional differences in loss of mobility were discovered.

The number of disabled people according to the National Census in 2002 amounts to 5,456.7 thousand, including 2,050 thousand (37.6 %) aged 65 or more (GUS, 2003). Among the disabled inhabitants of cities elderly make up 32.1 % and among people living in the country 35.9 %. Among all disabled men people aged 65 or more make up 28.2 %, while among disabled women 38.9 %. The number of disabled is larger in higher age groups: among people aged 65-74 it is 29.4 %, while among people aged 75 or more – 41.4 %. Since every second elderly is in some way disabled, the number of needed care can be estimated on this basis. 404.2 thousand people aged 65 or more (6.3 % of all people aged 65-74 and 11.6 % of people aged 75 or more) are completely disabled, and those considering themselves to be seriously disabled – 1,246.7 thousand. This is 34 % of all people aged 65 or more (29.4 % of people aged 65-74 and 41.4 % of people aged 75 or more). The percentage of disabled among elderly women is slightly higher than among men, while more women in this age group live on their own. This causes additional problems with providing care by families, and therefore causing an increase in the expectancies towards public institutions. The main cause of disability are somatic diseases

(mostly diseases of the cardiovascular and muscular-skeletal system) causing permanent disability (Sytuacja demograficzna Polski, 2001).

There is no discussion of the subject on central level, but there has been going on a discussion among scientists and practitioners of social policy and responsible local social policy makers, who are aware of the changes in the demographic structure of the society and the lengthening of human life. This sort of discussions serve first of all the creation of a lobby supporting the needs of the elderly. Discussion is also joined by non-governmental organisations, voluntary groups and NGO organisations of the elderly.

To evaluate the situation of the elderly using the help of their families and their family carers it is important to stress that in Poland there are practically no programs addressed directly at family carers. In most cases family carers make use of generally available services of health service, while social assistance is addressed mostly at the disabled themselves. The demand for help is visible in the attempts by family carers to organise themselves into self-help groups, consisting of people having to solve similar problems connected with organising and providing help for elderly family members (e.g. carers of Alzheimer victims). The problems of family carers are less visible in rural areas where the number of family members is usually slightly larger than in cities, which makes it easier to stand in for each other, but, on the other hand, the access to medical and social services is worse.

The process of demographic ageing of the population leads to the increase in the number of people requiring long term care. Basically such assistance can be granted in medical care centres financed by the National Health Fund (health insurance), but the accessibility of those services, as well as their range, is insufficient. The majority of people in need of such aid, stay at home and require help almost throughout the whole day. Public health or social institutions are not capable of providing such services, and it is increasingly difficult for the families to care for their elderly. Therefore families are often forced to finance help granted privately (or no so often by organisations) of their own sources. In the future this problem may need to be solved by increasing the scale of financing support by the National Health Fund, or by introducing a system of social nursing care insurance.

1 Profile of family carers of older people

The information on demography and sociological characteristics of elderly in Poland included in this report are based on three contemporary sources – data from the Central Statistical Office (GUS, 2001), research conducted by Brunon Synak and co-workers at the suggestion of the Polish Gerontological Society on a representative randomly chosen group of 1,821 people of 65 years of age or more (Synak, 2002), research done in the Institute of Public Affairs by Janusz Halik and co-workers on a randomly chosen group of 1,000 people of 65 years of age or more (Halik, 2002). These three sources also allow to estimate the need for help and care over elderly, indirectly also family carers. The initial results of the 2002 national census were also used (GUS, 2003). The nationwide demographic studies mentioned above relate to a broad range of health and social problems of the elderly and do not directly apply to the problems of family carers, they can however be helpful in drawing conclusions on the conditions and possibilities of giving help by family carers[1].

In Poland there exists no country-wide register of family carers, nor are there similar registers on the regional level. Although there is the possibility to acquire some information on caring services in particular towns / communes, they are aimed at helping the elderly not supporting family carers. It is therefore impossible to give definite answers in the subject of the situation of family carers in Poland, their number, age, gender, sources of income and level of education.

Sparse Polish research on the situation of family carers of elderly are not fully adequate to the guidelines of NABARE, because they apply to small communities, take into account different age groups of the cared for people and use different criteria of evaluation of care needs. Because no country-wide research on family carers has as yet been done in Poland, the only source of data are the results of regional research conducted by the team directed by B. Bień (Bień, Wojszel, Wilmańska, Sienkiewicz, 2001), which are dedicated to specific questions of work conditions of family carers, apply to only one city and one country community in Podlasie region and to people of 75 years of age or more. Similarly Z. Kawczyńska-Butrym and her team (Kawczyńska-Butrym, 2001a) analysed the problems of family carers of people over 60 in the specific community of unemployed farm workers. Due to the lack of other sources we

[1] For the proper presentation of the subject of family carers and the need for those services it is necessary to specify the meaning of the words – *help* and *care* and the derived terms – *helper* and *care*r, *caregiver*. The word care comes from the Latin word *cura* (taking care of, caring for), from which also comes the word *caritas* (charity). Both these phrases have a material, psychological and moral dimension, however they are not equivalent. Not every help given to an elderly is taking care of him; not every need for help is equivalent to a need for care. The number of hours spent on giving care or help cannot be sole differentiating factor and is less important than the nature of this activity. Differentiating these terms influences the quantitative evaluation of the need for help versus the care for elderly.

must base on the information from these to research projects, applying it, as far as it is possible, to the country-wide situation.

1.1 Number of carers

There are no statistical sources allowing the assessment of the number of family carers in Poland. Taking into account the estimated above number of disabled elderly it can be assumed that the number of family carers in Poland is about 2.0 million (as mentioned above). The vast majority of them are taking care of elderly people with motion organs disease (Seniorzy w polskim społeczenstwie, 1999).

1.2 The age of carers

The age of carers, judged on the basis of research done in a few communities (Bien, Wojszel, Wilmańska, Sienkiewicz, 2001) is between 20 and over 75, usually over 50.

1.3 Gender of carers

Women dominate both in the country and in cities. It is commonly assumed that the responsibilities of family carers are taken mostly by women aged 50-69 whose children are already independent (Błędowski, 2002). In Poland the relation between the number of such women and the number of people aged 70 or more in the year 2000 was 126 : 100.

1.4 Income of carers

The main source of income of family carers in cities is pension, and in the country work in farming or elsewhere. Most carers thing that their financial situation is good (in relation to the general living standards in Poland) (Bień, Wojszel, Wilmańska, Sienkiewicz, 2001).

1.5 Hours of caring and caring tasks, caring for more than one person

In Poland the information about the time family carers spend on their tasks is practically unavailable. There are only data from researches conducted in local communities, but thy are not representative of all carers. Some studies stress that the time used for completing all the tasks connected with caring over a disabled elderly is over 100 hours a week, i.e. far more than the maximum working time in any profession (Balcerzak-Paradowska, 2004). In case of carers cohabiting with the elderly measuring the actual time consumed by care duties is very hard because it is connected with other household jobs.

1.6 The level of education

The level of education of carers is usually equivalent to the level of education of the people they care for. In cities it is usually secondary education and in rural area primary As a rule the family carers have no qualifications in nursing chronically ill. Only some of the carers in Alzheimer families have received a short training to their tasks.

1.7 Generation of carers; Relation of carer to OP

There were attempts at identifying the family ties between the carers and the cared for (Synak, 2002). The family carer is usually a daughter (37.1 %), or a spouse (29.2 %), son (20.9 %), or grandchildren (15.5 %), rarely is it another member of the family. In country communities the carer is usually the spouse, or son or daughter. Research on family carers shows similar percentages (with minor regional variations) (Bień, Wojszel, Wilmańska, Sienkiewicz, 2001, Kawczyńska-Butrym, 2001a). In research conducted in selected cities in Poland (Kurzynowski, 1998) among of people forced to constantly use the help of other people family members were almost always mentioned as the carers.

1.8 Residence patterns (household structure etc.)

Family is the main provider of care in Poland. Such is the opinion of 88 % disabled people in late old age in the country and 86 % in cities. (Bień, Wojszel, Wilmańska, Sienkiewicz, 2001) Cohabitance is the effect of family ties between carers and the cared for. In questionnaires carers state that they mostly take care of their parents (40 %), or step parents (10 %), spouse (12.5 %), or grandparents (5 %) (Kawczyńska-Butrym, 2001a). 92 % of elderly in Poland believe that in case of sickness they can count on help from their families (Halik, 2002).

1.9 Working and caring

Although there is hardly any data concerning the situation of family carers, one can assume that a large number - at least one third of them – hold regular jobs. In Poland there are no regulations allowing a reduction of working hours for carers. Only parents caring over disabled children are entitled to social benefits connected with leaving work to care over them. The remaining carers – about two thirds – are probably elderly, or do not work for other reasons than care duties (e.g. unemployment)

1.10 General employment rates by age

According to the data from the National Census of 2002, the work activity factor for total population of people aged 15 or more it is 55.5 %, while among

people in the post productive age is 7.9 %. Relatively high employment among elderly (11.6 % for people aged 65-69, 7 % for 70-74, and 5.3 % for people aged 75 or more) is due to high employment of elderly in farming. In the eastern part of Poland around 40 % of individual farms is managed by people aged 65 or more. Contrary to farming other forms of employment or self-employment are of marginal importance.

1.11 Positive and negative aspects of care-giving

Carers' health problems and the possibilities of help or support have been presented at other points of the report.

There are no data concerning the elderly abuse or neglect by the family carers, however, that situation is likely to occur in problem families. Cases of extreme neglect have been observed in some private homes for the elderly.

1.12 Profile of migrant care and domestic workers (legal and illegal). Trends in supply and demand

Foreigners employed to care over disabled elderly come mostly from countries, which are former Soviet republics, especially Ukraine, Lithuania and Belarus, where a large number of inhabitants has some basic knowledge of Polish. Foreign carers usually do the least complicated jobs connected with the household rather than nursing work itself. Such workers are usually illegal, i.e. without the right to work or social security. Such a carer is usually paid in big cities an equivalent of € 10 a day.

1.13 Other relevant data or information

No relevant data recorded.

2 Care policies for family carers and the older person needing care

2.1 Introduction: Family ethics and expectations – the national framework of policies and practices for family care of dependent older people

“The elderly in a family less frequently became a point of interest of policy makers, because of the stereotypical misconception that the family is capable of caring for its senior and because of the prevalent and, in many communities, socially sanctioned moral obligation to care for one’s parents, which is supported by the strongly stated in sociological studies common expectations in regard to family care over elderly.” (Kawczyńska-Butrym, 2001b)

2.1.1 The expectations and ideology about family care - Is this changing? How far are intergenerational support and reciprocity important? Do minority groups have different ideologies?

In questionnaire studies elderly, regardless of their gender, regional and social background, stated that in case of a detriment in their health or social situation they expect help first of all from their family (over 90 % of answers), firstly from spouse or children, than from other family members, neighbours, health care workers (community nurse), social care workers, charities and the church. Therefore from the customary and ethical point of view family is responsible for the care over an elderly relative. This situation could partly be the effect of failures in the social care system and the underdeveloped and an unevenly spread network of non-governmental organisations. Therefore “even though more and more elderly people live alone, the family is the most important source for the providing for their needs, support group, aim of activity and source of life satisfaction.” (Synak, Czekanowski, 2000) Such an opinion has been held unchanged for many years, regardless of political or economic situation. Recently, due to the increase of the unemployment and difficult economic situation care within families is increasingly reciprocal. This may be exemplified by the support of the families of the unemployed by the elderly in the family who has a permanent source of income through retirement or pension benefits. Ethnic minorities, in Poland low in number, express a similar view of the dominant role of the family in providing care to disabled elderly. German ethnic minority in Silesia region is often provided with help by relatives living in Germany, but this form of support is not directed at chronically ill or disabled members of the family.

2.1.2 Are there any legal or public institutional definitions of dependency – physical and mental? Are these age-related? Are there legal entitlements to benefits for caring?

There is no legal definition of dependency, as well as the legal connection between age and dependency. The term “dependency” was introduced to gerontology as a term meaning that a disabled (elderly) person is dependent on another person’s care. The English term “dependence” is understood as being addicted to tobacco, drugs, alcohol etc. There are inconsistencies in the use of these two words.

In intergenerational relations, especially in families, the situation of interdependence is frequent, when various members of the family do certain things for each other (e.g. the grandfather takes care of the grandchildren, while his daughter prepares meals for him and helps him with the household). Such a situation is very positive from the psychological point of view, allows the grandparents to maintain their position in the family and in the same time guarantee proper care. In this very frequent situation it is hard to say if the younger member of the family is a family carer. The disability criteria and legal entitlements to benefits for caring were based on Polish act of law (Dz.U. 97.123.776) which applies first of all to disabled middle-aged people, the possibilities of employment for them and the use of the National Disabled Rehabilitation Fund.

Caring for disabled elderly is left in the hands of Health Care and Social Care authorities. Services such as partial payment for equipment for disabled or adaptation of houses to their needs can be paid by the Rehabilitation Fund depending on the income of the disabled. A lot of attention is put on architectural and communicational barriers. Polish law applying to Social Care (Dz.U. 98.64.414) guarantees that “ *the objective of social assistance is to meet the necessary needs of persons and their families and to open for them the opportunity to live in decency and dignity. Social welfare should lead to the independent livelihood of persons and their families and their integration within the environment”* (Council of Europe). This gives a possibility to apply for a wider range of forms of support for family carers and can be the basis of further initiatives.

2.1.3 Who is legally responsible for providing, financing and managing care for older people in need of help in daily living (physical care, financial support, psychosocial support or similar)?

According to the Polish law adult children have financial obligations towards their elderly or disabled parents, similarly to their obligations towards their children. The realisation of this obligation can be vindicated by court (Dz.U. 64.09.59). Article 908 of the Civil Code includes the possibility of jointure agreement in which in exchange for the ownership of a real estate the purchaser commits himself to assure, among other things, appropriate help

and nursing in sickness (Dz.U. 64.16.93). Besides that the government has an obligation to provide care on the basis of international and national regulations. This obligation is put forward by the Constitution of the Republic of Poland (Dz.U. 97.78.483), which in article 71 of act 1 states that: "*families with difficult material or social situation, especially incomplete or with many children, have the right to special help from the state".* According to article 3 of the act on social care (Dz.U. 98.64.414), *"social assistance (…) is granted to people and families, especially in cases of: (…) 6) disability, 7) prolonged sickness, 8) inability to handle care and educational problems and run a household, especially in families which are incomplete or have many children".* The realisation of this obligation was transferred to local authorities - Social Care Centres.

It has to noted that "even before the 2nd World War – in the traditional family model – the elderly had a clearly set place and was useful to the family. However if the family failed, he could count on the help from the state. The Act on social care of 1923 clearly stated that it contains regulations concerning 'care over elderly' (article 2, point c). These two systems, family and state, supplemented each other" (Synak, Czekanowski, 2000). In the post-war period, in the socio-political system based on Marxist socialism, the state had to provide the realisation of all the needs of its citizens, including care over elderly. The realisation of this rule was restricted by economic possibilities, but among elderly it is treated as the theoretical basis for social claims. After the recent political changes, in the new act on social care from 1990 elderly are not mentioned as a separate subject of social care. "Not calling this group (elderly) by name leads to its exclusion and will influence the accessibility of services from the social care sector." (Synak, Czekanowski, 2000)

The rural population obtained access to unpaid health care and pension system as late as in 1972 (Dz.U. 71.37.345). This influenced the change of attitudes among the people living in the country, but did not change the family structure and the actual state of care provided to the elderly by their families. However the welfare state mentality still dominates the thinking of many people especially the less educated ones.

According to the current law the state is responsible for the unpaid health care (this is a constitutional obligation, it is restricted by the state's economic situation, but never denied) and the care over those citizens who did not acquire the right to social security and pension benefits or are in an extremely social or economic situation (financial help, or help in goods). Theoretically such help (paid from community sources) includes also nursing care, or more broadly understood social care (financial help, help in services), which is, however, not fully realised and blocked by bureaucratic procedures. In reality care over disabled people staying at home is almost entirely provided by the family.

2.1.4 Is there any relevant case law on the right and obligations of family carers?

There are no regulations directly applying to the rights and obligations of family carers. So far law regulates only the obligation to provide care, transferring it to public administration. Article 17 of the act on social care (Dz.U. 98.64.414) states that *"1. Lonely people who because of age, sickness or other reasons require the help of others, and do not receive it, have the right to help in the form of care services. 2. Care services can be also received by people, who need help, which family cannot provide."* Article 18 states more precisely that *"Care services include help in providing for daily needs, hygiene care, nursing care recommended by a physician and if possible providing social contacts…*"

A little over 6.5 thousand people carrying out care services in Social Care Centres are employed by. This group is supported by numerous voluntaries and workers employed by non-governmental organisations. Besides that Social Care Centres employ 1.1 thousand employees carrying out specialised care services.

There is also the possibility of institutional care (nursing homes, residential care homes), aimed at people whose state is so severe that providing care for them at home is impossible and for people who, for social reasons, have to be institutionalised (loneliness or extreme poverty).

As a rule services are paid from public sources – nursing allowances are paid from the state budget, nursing homes (besides a relatively small payment from the inhabitants) are financed by local authorities while the stay in nursing homes and terminal care institutions – by the National Health Fund (Błędowski, 2003).

2.1.5 What is the national legal definition of old age, which confers rights (e.g. pensions, benefits, etc)?

There exists the term "retirement age" (age when a person can become retired), which is misinterpreted by employers as the age when a person must become retired. It usually applies to women of 60 and men of 65 (Dz.U. 97.139.934)**.** The level of the old age pension depends also on the number of years a person has worked and other regulations. The discussion on introducing an equal retirement age for men and women has been going on for many years but the public opinion is unclear on this point.

Discussed at the beginning of the 90's suggestion of introducing a social pension to all people of certain age has not as yet been included in legal regulations. As yet the social pension is paid to people with low income.

2.2 Currently existing national policies

2.2.1 Family carers

As far as any activity to the benefit of family carers is concerned it is only in the form of unorganised, often accidental actions undertaken by local non-governmental organisations (e.g. help to families caring for disabled elderly). It seems that any actions towards elderly and their carers are inspired by local and non-governmental policy makers; central government is passive in this respect.

2.2.2 Disabled or dependent older people in need of care / support?

Generally it can be stated that policy towards older people concentrates first of all on the people who are socially and economically weakest, but it does not solve all their problems. This policy concentrates on providing financial help, which is usually not enough to support all the needs of an older person's household (Błędowski, 2002).

Benefits, which are dependent on the disability level of elderly and are aimed at meeting their specific needs, have the form of services or help in goods. The range of benefits in the form of services is relatively small. Although the frames of this policy make the activity of non-governmental or self-aid groups possible, current legal and financial regulations do not allow a fast development of these organisations. In consequence public administration first takes care of satisfying material needs, connected with the elderly's low income, often leaving the needs coming from health problems and disability unsatisfied. Policy is therefore partial, with no rational basis (full social diagnosis) or rationally set long-term goals.

Benefits paid from public money have the character of financial assistance (mostly social care and nursing pensions), help in goods (e.g. help in equipping households) and services (health care, community nursing service, day care) especially help in running the household and nursing bedridden people).

Although one can hardly talk of policy for disabled or dependent elderly, one can point out some activities, making up the beginnings of such policy. As yet this group is treated rather objectively than subjectively, which means that it is the object of social policy in the context of disability (e.g. organising care services and household help for disabled, who are officially classified as such) or needs (e.g. organising terminal help institutions for chronically or incurably ill, regardless of their age).

Generally activities to the benefit of elderly can be divided into those which are granted on the base of age (assuming that over a certain age various forms of disability are so common that some services can be treated in this age group as common) and those which take into consideration the disability level of the

elderly. An example of an activity from the first group is granting a nursing benefit (attendance allowance) to all people above 75. According to the act on family, nursing and parental benefits (Dz.U. 98.102.651), the nursing benefit is granted to a person who is over 75 (article 14, point 3), with the exception of those who are institutionalised in unpaid institutions. Which is valorised like the pension. The actual nursing benefit however is in fact so low that it does not allow the satisfaction of even the most basic needs of nursing care. The fact that this benefit is granted to all people above 75, regardless of their health, gives the impression that – contrary to its name – its aim is not to solve all problems of nursing.

2.2.3 Working carers: Are there any measures to support employed family carers (rights to leave, rights to job sharing, part time work, etc)?

There is one legal regulation, which grants the family carers of disabled people (regardless of their age) the right to a two-week leave, if the carer is employed on the basis of an employment contract. This does not apply to people having their own business (among others farmers). Family carers can also (to some extent) use the social assistance granted to the elderly (e.g. financial help) or the help granted on the basis of the age or health of the carer himself.

The act on the organisations of public benefits and voluntary organisations (Dz.U. 03.96.873) creates (in article 46) the possibility of granting voluntary carers working for public administration health and accident insurance. Potentially such possibilities exist also for family carers: such possibility may appear when they report themselves as voluntary workers and provide care to at least one more person in need of care.

Research done by the Warsaw School of Economics (Kurzynowski, 1998) has shown that, in case of the poorest elderly and their families, social care centres try to support the family carers financially by single aimed benefits, so that they do not give up their work in search for another source of income.

2.3 Are there local or regional policies, or different legal frameworks for carers and dependent older people?

Local or regional policies for family carers and dependent older people are based on nation-wide regulations. However depending on local initiatives and financial abilities of local communities initiatives can be undertaken leading to the improvement of the quality of care and work conditions of family carers (e.g. initiatives of the local government in city Poznań). Observations show that the relatively highest number of such initiatives appears there, where there are well organised self help groups and non-governmental organisations of elderly. They force local institutions to assign appropriate funds (Halicka, Pędich, 1997).

In Poland one can hardly talk about regional policy. Creating infrastructure of social policy and training staff done mostly on the county level (Błędowski, 2002). On the local scale the range of actions undertaken by social policy institutions is dependent on the local budget and the understanding of social needs shown by the local government. Social laws passed by the parliament and the financial policy make a certain frame for the minimum level of benefits guaranteed by the state, but the act on local government allows its institutions a certain amount of freedom by dividing tasks into obligatory and facultative. According to this division, local government institutions have the possibility to undertake initiatives aiming at solving pressing local social problems (e.g. support of families providing care to disabled people).

2.4 Are differences between local authority areas in policy and / or provision for family carers and / or older people?

Differences in regional social policies for family carers depends not only on financial possibilities but first of all on the awareness of citizens, activity of local authorities and efficiency of non-governmental organisations. The differences are great, as far as the scale of awareness and articulation of desires is concerned, but smaller in the field of satisfying needs by the local government. Local social policy realised with not enough funds and under strong social and political pressure of unemployed and low-income social groups concentrates on satisfying current needs of the long-term unemployed. Elderly, especially disabled, are a socially weak group with not enough influence to present its needs before local authorities. Research on local social policy in chosen boroughs of Mazowsze (Mazovia) region show, that where families care for the elderly, local authorities treat the problem as solved and take no interest in the situation of family carers (Błędowski, 2002).

In cities, where the development of non-governmental organisations is better, local governments put less attention to supporting family carers. It is otherwise in the country where most of care over disabled is provided by the family and where, generally more often than in cities, family which is not cohabiting also takes part in providing care to the cared for.

3 Services for family carers

In Poland there is no formal system of supporting family carers[2]. If it is necessary it is usually another family member who fills in permanently or temporarily the family carer in caring over the elderly. In larger communities one can temporarily use the help of voluntary carers (for example in the form of "granny-sitting"). In rural areas neighbours support family carers.

Because of the low financial capabilities of elderly, using paid services of private carers is infrequent, only in critical situations. In families with high income, it happens that illegal workers from Belarus and other neighbouring countries are hired (full or part time) to help the family.

In case of prolonged sickness nursing care can be granted by the district nurse, but it has a temporary character or consists of instructions on providing care and controlling the quality of care provided by the family (this is provided by the health service not by the social services). There is also a possibility of privately employing a nurse. In recent years nursing agencies have appeared offering nursing services for full payment.

In a way help addressed to disabled elderly, (e.g. a wheelchair or special house appliances) is also helpful for family carers, because they make caring easier. In most larger cities there exist citizen's action groups supporting family carers of people with Alzheimer's disease. Such groups organise also courses for family carers.

[2] The table suggested in the scheme is not fully adequate to the situation of family carers in Poland.

Services for family carers	Availability			Statutory	Public, Non statutory	Voluntary		Private
	Not	Partially	Totally			Public funding	No public funding	
Needs assessment (formal – standardised assessment of the caring situation)		X		X	X			
Counselling and Advice (e.g. in filling in forms for help		X			X	X		X
Self-help support groups		X			X	X	X	
"Granny-sitting"		X					X	X
Practical training in caring, protecting their own physical and mental health, relaxation etc.		X			X		X	
Weekend breaks		X						X
Respite care services		X						X
Monetary transfers	X							
Management of crises		X			X		X	
Integrated planning of care for elderly and families (in hospital or at home)		X				X	X	
Special services for family carers of different ethnic groups	X							
Other	X							

3.1 Examples

3.1.1 Good practices

Article 18 of the act on social care (Dz.U. 98.64.414) states that local authorities decide on the range and place of providing care services. This creates the possibility for both the creation of small family care homes and large care service centres. Their functioning however is dependent on the possibilities of providing transport for people using the care services. The same regulations create the basis for periodical use of help from the community nurse by elderly when their family carers are away. Another way of substituting family carers is to use the help of voluntary workers and local institutions which offer short term use of their services.

3.1.2 Innovative practices

One of the aspects of the use of this regulation is the initiative of creating Centres for Social Services (CSS) on local level. Such centres are supposed to

combine social and medical functions for economically impaired social groups. As a sort of return to the idea of integrated socio-medical care they are supposed to stress the role of the family and informal groups in providing for the needs of and caring for elderly. Self-help groups and non-governmental organizations which are partners in providing care would also find support in CSS. Health care activities would concentrate on rehabilitation and nursing for people chosen by the family physician and community nurse. Social functions go further than just providing necessary financial support and aim at creating conditions under which the elderly can take part in the life of the local community. Rehabilitation equipment would be available in the centre as well as services connected with repairing it. The above possibilities are still a matter of study projects but have no base in any act of law.

Nursing homes which offer their services to the local community create similar possibilities. Such activity should be especially helpful in improving the social evaluation of social care institutions and causing them to be perceived as socially important, offering their services not only to the poorest but to everyone who need professional help.

In regions which use now or used to use in the past financial help and counselling from West European non-profit organizations a practice has developed of creating non-governmental organizations working by the rules of Maltese help, that is substituting or supplementing family members in their care functions. Such organizations can provide transport for disabled elderly and supply basic goods and services as well as instruct family carers.

4 Supporting family carers through health and social services for older people

4.1 Health and Social Care Services

Family carers do not have any special health or social benefits. Neither do they have any privileges in this respect. They are entitled to use medical care and social benefits according to general regulations for all citizens of Poland.

4.1.1 Health services

4.1.1.1 Primary health care

The primary health care over elderly is provided by family doctors. Their outpatient clinics are placed in residential areas near the patients homes. House calls are also made by family doctors and, in case of emergency, by first aid teams. A family doctor's help is free of charge. This applies also to the services of a community nurse cooperating with the family doctor. Patients, regardless of their age, partially cover the cost of medicines at prices fixed by the Ministry of Health. The cost of drugs is a significant expense for the elderly. It is frequent for the elderly to give up a drug because of its cost.

People living in the country can receive treatment in local health centres, located in larger villages, according to the administrative division of the country. Access to the doctor can be difficult for people who live in smaller villages and do not have sufficient communication (bus, train) with the larger village.

Both in cities and in the country there are significant problems with taking diagnostic material at the patients home, rehabilitation and para-nursing treatment (e.g. chiropody) as well as getting house visits by a dentist.

Family carers have contact with the family doctor and nurse, settle visit hours, call the doctor / nurse for house visits etc. The family carer should be present during the doctor's visit.

4.1.1.2 Acute hospital and Tertiary care

Hospital treatment is done, depending on the type of sickness, in the nearest county hospital, or in specialized units at the regional hospital and Medical University clinics. Access to hospital treatment is generally good. Currently, due to reorganization of medical care system, there are some difficulties with covering the cost of expensive treatment in highly specialized services by the National Health Fund.

In some hospitals there are day treatment units for short diagnostics, without the need of full hospitalisation. A new form of geriatric care are the day care geriatric units for the elderly, who need a few hours of institutionalised help

during the day, while the family take care of them in the afternoons and at nights. Such units work on the border of hospital and social care, qualification for them is based mostly on the assessment of social conditions, they are generally financed by the hospital. A very good model of such unit is the day care geriatric unit in the hospital in Gniezno. It has a dozen or so beds, the time of stay in the hospital is restricted to one to three weeks. It has separate nursing staff and a constant supervision of geriatrician, with the possibility of consulting doctors of other specialties.

Geriatric out-patient clinics are organized in some larger cities, but are not incorporated into national health care system. Their structure and range of services depend on the local authorities and conditions.

Geriatric hospital units are organized very rarely (only a few in the whole country). In Katowice, a large industrial centre, there is the only specialised geriatric hospital, organized by the city authorities and financed by the National Health Fund. In some Medical Universities there are geriatric clinics, providing specialized treatment of elderly patients, and training for medical students and nurses, as well as specialisation of physicians in geriatrics. So far there are no private geriatric clinics; the elderly, whose only source of income is their pension, are usually quite poor and could not pay for private hospital treatment.

4.1.1.3 Are there long-term health care facilities (includes public and private clinics)?

The Polish equivalent of the long term hospitals are the Nursing Care Homes, independent of hospital administration, which are supposed to provide long term rehabilitation or nursing for people who need long rehabilitation or who are chronically ill, beyond the possibilities of hospital treatment (Dz.U. 91.91.408).

The units for chronically ill in general hospitals are originally aimed for patients who have finished hospital treatment and wait for a place in institutions. The units are financed by the health insurance system, have lower standard and limited staff.

4.1.1.4 Are there hospice / palliative / terminal care facilities?

Terminal care units are generally designed for patients with cancers, in the terminal stage of their life. They are often run by charities. There are also home-hospices**,** offering care over terminally ill at home. Terminal care is a well developed branch of health care. Currently the need of creating similar units for extremely old or non-cancer terminally ill patients is discussed. A new form of terminal palliative care at home for the elderly in advanced old age, termed “Domestic Hospice”, has been introduced in the city Poznań.

4.1.1.5 Are family carers expected to play an active role in any form of in-patient health care?

In Poland there is no custom of families or informal carers helping patients in hospitals or institutions. The help of family members is often a source of conflicts between the nurses and them as well as unfounded claims as to the form and quality of care. There is of course the possibility for family members to stay with the patient, but without them taking part in providing care. However in hospices trained volunteers play an important role.

4.1.2 Social services

Benefits granted to the elderly in the place where they live include financial and material help, advice and services. The system of financial help is best developed. Benefits include regular temporary or single payments, as well as family benefits for elderly, who do not have their own source of income. Other forms of material help include providing clothing or fuel, while services consider mostly help around the household and caring over a disabled person. Advising applies to whatever problems an elderly person may have. Institutional help takes the form of a permanent stay in a social assistance home (organised by the public administration, NGO or the private sector).

The number of people using social assistance services is increasing, but at the same time the number of the elderly receiving help becomes proportionally smaller as there is an increase in the number of younger unemployed citizens.

4.1.2.1 Residential care (long-time, respite)

Residential care in Poland is realized mostly in social care homes. They are financed by the local government and managed by them. There are usually specialised institutions for somatically disabled, mentally disabled, elderly disabled and not disabled elderly. Their standards are very varied; in recent years it has systematically improved. The introduction of standards of life and work in social care homes which are provided for in the act on social care are to be the way to further improvements (Dz.U. 97.44.277).

The relatively largest number of places is offered by institutions managed by the Ministry of Economy, Employment and Social Policy. The number of these institutions in 2002 was 811 and its growing (MGPiPS, 2003). Although only one type of houses is aimed for elderly (there were 162 of them), but also in homes for chronically ill, mentally disabled and chronically mentally ill most of the inhabitants are elderly. In these houses there was a total of 79,308 places. Around 75 % of social care homes are managed by local authorities. Other institutions are managed by church and non-governmental organizations. Over 130 private care homes have a total of 2,300 places (GUS, 2002). Altogether in all institutions there are over 81.6 thousand places, that is 21.1 places per 10 thousand people. This has increased by 3.3 places since 1990. The num-

ber of places in institutions for elderly has in this time increased from 18.6 to 23.9 per 10 thousand people post-production age.

The deployment of institutions for elderly in various regions of Poland is very uneven. In the regions in which the percentage of elderly is the highest, the number of institutions is also the highest. This does not however mean, that in demographically younger regions the number of places in institutions is sufficient.

The activities of social care homes often reaches behind their walls. They offer not only the possibility of getting a warm meal or daily services for elderly who live outside the institution, but also taking part in therapeutic activities (Szarota, 1998). This form of activity can be transformed into an activity similar to the day care centres (vide 4.1.2.2.6).

4.1.2.1.1 Basic data on % of > 65s in residential care by age group and type of residential care (sheltered housing, residential homes)

By the end of 2002 a total of 78,935 people were institutionalised, including 10,114 bedridden. Among the inhabitants 23.6 % (18.6 thousand) were people aged 61-74 and 29.8 % (23.5 thousand) – people aged 75 and more (MGPiPS, 2003). Altogether over half of the inhabitants were 60 or more. Despite the increase in the number of places in institutions in 2002 the number of people admitted into the institutions was lower than the number of those awaiting to be admitted (3.3 and 3.8 thousand). The percentage of institutionalised elderly aged 61-74 in comparison to their overall numbers in society was 0.4 % and elderly aged 75 or more was 1.3 % (MGPiPS, 2003).

In Poland there are no institutions which would allow a slow transition from partial to full institutionalisation. In new residential areas sheltered housing is infrequent. There are no complexes of institutions in which there would be the possibility – as the structure of the household and the level of fitness of inhabitants changes – of transiting form an individual to a collective household.

4.1.2.1.2 Criteria for admission (degree of dependency, income etc.)

The decision whether to admit a person into a care home is taken by the local authorities on the basis of an environmental enquiry and the opinion of a physician. One of the criteria of admittance is loss of fitness (need for nursing care in a specialized institution) or a detriment in social conditions (loneliness, lack of family, lack of ability to manage the household, very low income etc.)

4.1.2.1.3 Public / private / NGO status

The institutions of social care are mostly administered and financed through state budget. This concerns institutions for the elderly, for disabled children and the mentally disordered. In recent years institutions for the care over elderly managed privately or by religious congregations or charities have appeared. From 1991 the number of social assistance homes administered by

private institutions or NGOs has been constantly growing. The number of homes organised by local governments (public administration) in 2002 was 610, and of non-public ones (private or NGO) – 190. Privately owned homes for the aged are not under supervision of social policy officers (there are documented cases of extreme neglect in the privately owned homes). Care institutions organised by NGOs are usually supervised by local social centres.

The cost of stay in an institution may be covered by the inhabitant's own pension (usually around three quarters of the pension), by their families or, if neither source is available, by social care funds.

Considering the low pensions in Poland it is easy to say that their payment for institutionalisation is not enough to cover the costs, therefore the difference must be paid from the local government's budget. The cost of stay of only 1 % of inhabitants is covered by the family, and it does not always cover all costs. Around 3 % of the overall number of inhabitants pays all the costs of their stay by themselves (MGPiPS, 2003). In practice this means that the stay of almost every inhabitant is partially financed from the social care funds.

In recent years institutions for the care over elderly managed privately or by religious congregations or charities have appeared. The costs of stay in such institutions are usually larger then in public ones, they are partially covered from pensions (usually around 75 % of its amount) and from payments by the families. Their standard is also varied, adequately to the costs.

4.1.2.1.4 Does residential care involve the participation of carers or work with carers?

In Poland there is no tradition in residential care to involve non-formal or family carers in the caring process. Co-operation with the family carers is usually restricted to contacts with social workers in the period of preparation of the elderly person to be transferred to a home.

4.1.2.2 Community care services (statutory coverage and whether aimed primarily at older people living alone or including support to family carers)

Social care is realized on three levels: borough, county, region. On the borough level a community assistance is organized, that is assistance granted in the place of residence of the beneficiary and half-institutional assistance (day care homes). Community assistance includes financial assistance (mainly permanent, temporary and intentional benefits) and services – (e.g. home nursing services, laundry services). On the county level some specialized services and social care homes are organized. One of the objectives of county institutions is designing strategies for solving social problems, in which problems connected with old age and disability should find their place.

Social care granted in place of residence is on the basis of the act on social care addressed to the whole family, not only to one of its members (in conse-

quence granting a benefit is dependent on the income and estimated needs of all the members of the household). All the benefits and services are coordinated by the social care centre subordinate to the borough or city authorities. Social care centres realize services by their own means or charge non-governmental organizations with providing the services; in special cases private institutions can also be hired. However in Poland there is yet no social services market, which would allow social care centres to buy services for elderly and disabled from non-governmental organizations or private companies.

Granting social benefits is dependent not only on household's income, but also on an environmental inquiry conducted in the family's place of residence

In 2002 the number of pensioners receiving benefits was 418.3 thousand (173.5 thousand in the country). Altogether there were 1,043 thousand people living in these families. There were 160.7 thousand one-person households and 92 thousand two-person households. Almost three quarters of this group of beneficiaries lived in cities. Implicitly it points to the fact that elderly living in the country receive help rather from the family and informal groups.

Providing care services is one of the responsibilities of boroughs. In 2002 these services were used by 81.2 thousand people. They are usually performed at least once a day. It can be therefore imagined that the such services are not performed frequently enough.

4.1.2.2.1 Home-help

People are entitled to help in managing the household due to prolonged sickness or inability to handle care and educational problems, especially in incomplete and numerous families. In this case benefits include help in managing the household (doing shopping, keeping the house clean, help with preparing meals etc.), help in maintaining personal hygiene (washing, bathing) and help in leading as independent a life as possible under the circumstances by taking part in caring over a chronically ill person and organizing the local community, neighbours and informal groups to support a disabled person. These services can be performed by either a social workers or by the agency of non-governmental organizations. Time devoted to performing these services is usually no more than 2 hours, services are performed suitably to needs, but usually 2-3 times a week. Because of the limited technical and organizational possibilities such help is directed first of all to those who have no possibility of receiving similar help from their families, and their disability level makes them unable to perform the mentioned actions themselves.

The access to help in managing the household is vary varied. It is generally easier to get it in cities, where there is a well developed network of non governmental organizations and Social Welfare Centres hire special staff. In the country the access to such services is worse. There is however a partially formalized structure of neighbourhood help – neighbours who care for an elderly make an agreement with the local Social Welfare Centre, according to which

they receive a small payment for helping the elderly with the household. However this form is quite limited.

4.1.2.2.2 Personal care

Personal services (washing, bathing, keeping personal hygiene) are closely connected with the household management services. These services are rather performed by health care workers (community nurses etc.).

4.1.2.2.3 Meals services

Services connected with providing a meal are provided either in canteens or in the disabled person's home. Dinners are distributed by the Polish Red Cross, Polish Committee of Social Welfare or non-governmental organizations. In recent years the number of dinners served (brought to the cared for people's homes) from canteens in care homes and schools has grown. In Poland the service of providing dinners by specialized companies which are hired by social welfare institutions is practically unknown. Meals are provided first of all for children and teenagers. From over 1,050 thousand people receiving this service in the year 2002 only around 80 thousand was above 35. As observations in chosen boroughs show the team from Warsaw School of Economics (Kurzynowski, 2002), adults receiving this service are usually disabled elderly.

4.1.2.2.4 Other home care services (transport, laundry, shopping etc.)

Other services connected with managing a household and preventing social exclusion (creating conditions allowing social integration) include repairing household appliances, laundry and transport. (shopping was discussed in point 4.1.2.2.1).

Organizing transport applies both to getting to health and social care centres and to the elderly's family. Cars adjusted to disabled people's needs are usually bought from the sources of the National Disabled Rehabilitation Fund. In some places where various initiatives for are active (e.g. Disabled People's Priesthood), informal groups are organized which include members of disabled people's families and other inhabitants who help and organize social contacts of people with reduced mobility (Kurzynowski, 2002).

4.1.2.2.5 Community care centres

Community Care Centres are public institutions, which organize and provide community services (i.e. realised in the place of residence) and benefits. People and families in need can apply to the centre, but its employees are responsible for searching the local community for economically weak families. The centre organizes the help service system (enters agreements with non-governmental organizations, private companies and public institutions, such as school) and supervises its realization. In some centres services are performed

by social workers themselves. Besides centres make their space available for non-governmental organizations and self-help groups.

4.1.2.2.6 Day care ("protective" care)

Day care homes offer mostly services for elderly. They are usually available for a few (4-8) hours a day. Elderly get there a warm meal, take part in rehabilitation exercises, are cared for by a nurse and have access to various other forms of organized activity. The elderly using the services of day care homes are usually quite fit because most of the homes have no way of providing transport.

The number of day care homes organised by local authorities is small and its gradually getting even smaller. Even in the year 200 there were 236 of them while in 2002 it has decreased to 214. This means that they are not even present in all counties, while they are needed in many boroughs.

4.1.2.3 Other social care services

Psychological assistance and counselling is one example of such service. It is usually done by the employees of Social Welfare Centres and County Family Help Centres or non-governmental organisations. Counselling usually concerns legal problems (e.g. the right to benefits, alimentation and inheritance questions etc.) Adjusting houses or flats to the needs of a disabled person is hardly ever done. Expenditures on this aim are constitute an insignificant percentage.

It is infrequent to find training programs for family carers in the reports from Social Welfare Centres, even though the range of their activity is, as it seems, on the whole quite typical. Equally infrequent is it for self help groups of family carers or elderly to appear. Especially the latter should be supported by local social welfare institutions, as "modern gerontology stresses the great importance of such self help activities, because on one hand they supplement the state's welfare services and on the other hand they are educational and activating for elderly." (Halicka, Pędich, 1997)

Other forms of help for the elderly and their family carers are practically unknown. Only some jobs (in a very narrow range) are financed from state or local social budget (e.g. renovating a flat or adapting it to the needs of a disabled person).

4.2 Quality of formal care services and its impact on family caregivers: systems of evaluation and supervision, implementation and modelling of both home and other support care services

The idea of integrating social and medical aid is rarely mentioned in Poland. Experiences of the period of from before the political transformation, when so-

cial assistance and health care were managed by one Ministry of Health and Social Affaires showed that social workers were treated as less essential than medical staff. The social assistance reform of 1990 has divided the social and health care departments in all levels of administration, which contributed to the treatment of social care as an equal partner of health care. Attempts are made at integrate again local health and social care agencies into “Socio-Medical Service Centres” (Kurzynowski, 2002). Such centres would organise medical help, take part in the rehabilitation process, provide services at home and support the social integration of the elderly and disabled. The main obstacle to this project now is a problem of appropriate laws and regulations in the public administration.

4.2.1 Who manages and supervises home care services?

Social care institutions, which are administered by the local authorities and financed from the state budget, have their own staff employed full time in the given institution. Care and administrative activities are controlled and evaluated by a social welfare department on the appropriate level of administrative liability (borough, county, region or central government).

4.2.2 Is there a regular quality control of these services and a legal basis for this quality control? Who is authorized to run these quality control?

Appropriate acts of law regulate the rules of control, its frequency and criteria. The primary organ of control is the ministry of economy, labour and social policy. The state administration controls the upholding of the law and finances on the country and regional level. Control and consultations are performed by social work specialists. Control over the economy of social care institutions is based on annual (or quarterly) activity reports. The control over non-governmental organizations is limited to the range decided by contracts for the realisation of certain services by the NGO and the financial support which can be granted by the ministry. Most of this control is restricted to the financial aspects and legal basis of the NGO’s activity.

4.2.3 Is there any professional certification for professional (home and residential) care workers? Average length of training?

Social workers are educated in colleges of further education. Furthermore, according to the act on social care, social workers, to be promoted above the lowest post, have to complete courses in their particular speciality (work with unemployed, homeless, chronically ill, elderly). The carers themselves should be professionals, after 3 years of education. Managerial staff must have university education.

4.2.4 Is training compulsory?

Training of qualified staff is obligatory and regulated by special rules, but it is not always realised and not everywhere. This applies to governmental institutions. There are no legal regulations for the supervision of private institutions.

Private care homes are organised on the basis of the act on private enterprise. According to this act, anyone who wants to receive permission to open a business has to have appropriate qualifications, or employ professional staff. The activities of private care homes is not supervised by health and social welfare institutions. Regulations on professional qualifications and supervision do not apply to family carers.

4.2.5 Are there problems in the recruitment and retention in care workers?

Because of high unemployment in Poland, hiring enough social workers and carers is not a problem, as well as keeping them. However there are obstacles in the form of low earnings, which can have a negative effect on choosing the best and most professional employees, and limited financial capabilities of institutions, as a result of which the number of employees is not always equal to the actual needs.

In coming years the number of nurses and carers, who find employment in EU countries, may prove to be an obstacle. This may cause a detriment in the employment market situation and difficulties in hiring and keeping qualified health and social care employees.

4.3 Case management and integrated care (integration of health and social care at both the sectoral and professional levels)

Case management is used very rarely, usually in health and social care institutions co-operating with scientific institutions, which come up with new solutions. Such situations are purely experimental and have not yet found a wider use.

4.3.1 Are family carers' opinions actively sought by health and social care professionals usually?

Quite often there are problems in communication between family carers (and the sick person's family) and professional carers (medical and social) because both sides are convinced that they know better. Professional carers do not usually take the suggestions of family carers into account.

5 The Cost – Benefits of Caring

The GDP for the country? (Will be obtained from OECD and others centrally)

5.1 What percentage of public spending is given to pensions, social welfare and health?

The share of public spending in GDP is growing. In 2001 it was 38.9 %. This growth is caused by unfavourable changes in demographic structure (more elderly) and in the country's economic situation (more people who are unemployed or using social welfare benefits). Old age pensions make up 11.8 % of GDP, social welfare – 0.8 % (MPiPS, 2002), and health care – 4.7 % (GUS, 2002). In recent years the level of spending on social welfare remains unchanged.

Research on household budgets shows that in spite of there being unpaid health care in Poland, the expenses on health care are growing (GUS, 2002). It is estimated that the overall expenses on health care in households reach an average of 4.5 %, but in the households of old age pensioners – 7.7 % of the overall expenses per person in a household.

Expenses on social benefits in 2001 (in million PLN)

Old age benefits	87,099.5
Accident benefits	4,807.6
Health benefits*	27,916.8
On which for long-term care	446.1
Non-institutional social assistance services	32,96.6
Institutional services of social assistance	1,238.4

* Founded by National Health Fund in 2003; current 1 EURO is the equivalent of approximately 4.8 PLN

5.2 How much – private and public – is spent on long term care (LTC)?

In 2001 spending on long-term care by National Health Fund (NFZ) amounted to 446.1 mln PLN. This sum was spent directly on granting of long-term care. This amount was spent for financing of geriatric hospitals and hospices. This took only 1.6 % of all spending for health protection by NFZ. The private spending for LTC may reach even 3 thousand PLN for family with old disabled person.

5.3 Are there additional costs to users associated with using any public health and social services?

The National Health Fund is financed from an 8.25 % (of earnings or benefit) insurance premium. This premium is rising since 1999 from 7.5 % to 8.25 % in 2004. When buying prescribed medicine, people who are insured pay part of its cost. In recent years this has become a significant burden for households, which leads to many elderly being forced to give up their treatment (Golinowska, 1997). Furthermore, patients forced to wait too long for a visit at a specialist or specialised diagnostic procedures often go to private clinics. This means extra expenses. It is estimated that every Pole pays an average of 2,000 PLN yearly - more than 400 EUR - into the health care system (e.g. medicine, paid services) (Holly, 2001). This situation is particularly difficult for elderly, who are more frequent to fall ill and need easy access to specialised doctors. In this situation not only elderly, but also their family carers have extra expenses.

Formally all health services are free of charge. Basic health care is covered by the National Health Fund. However, due to long waiting periods for some of the services, such as diagnostic tests or specialized consultations, patients decide to pay for private medical care. For people with lower income this may create a serious financial burden. Social services are free of charge and financed from the central or local budget. Support for the poorest is also provided by charity organizations such as Caritas.

5.4 What is the estimated public / private mix in health and social care?

It is difficult to estimate the proportion between the frequency of using free care in public health care sector and privately obtained treatment. Health services are significantly more frequently obtained from public system**.** It can be assumed that in cities the percentage of people using private institutions is greater, but often caused by long waiting time in public health care institutions and, especially in case of highly specialised consultations or clinics.

Due to financial limitations in the state budget it may be expected that in the nearest future partial payment may be introduced for some more expensive forms of treatment, particularly specialized surgery. The suggestion of obligatory contribution of all patients to payment for all health services is being discussed. Using private social help institutions is much less frequent.

5.5 What are the minimum, maximum and average costs of using residential care, in relation to overage wages?

In the year 2000 the average old age pension, disability pension and family benefit were equal to 52.8 %, 37.8 % and 45.4 % of the average earnings. The

cost of stay in an institution can be up to 70 % of an old age pension or other benefit. However, because the inhabitants of care homes usually have very low income, they only cover the minimal costs of stay. The cost is not dependant on the kind of care home, or the range of services used by the inhabitant.

5.6 To what extent is the funding of care for older people undertaken by the public sector (state, local authorities)? Is it funded through taxation or / and social contributions?

Most of the assistance for elderly and disabled (except for pensions) is financed by the public sector, usually local government. From this source – on the borough level – community services are financed. From county sources the costs of institutionalisation are paid, as well as specialised care services The central government finances investments and specialist or professional training. The health insurance premium is used only to finance health care services. Investments in the social welfare (residential care homes) and health care (hospitals, out-patient clinics, sanatoriums, rehabilitation centres) are for the most part financed by the central government.

5.7 Founding of family carers

5.7.1 Are family carers given any benefits (cash, pension credits / rights, allowances etc.) for their care? Are these means tested?

	Attendance allowance	Carers´ allowance	Care leave
Restrictions	yes*	no	no
Who is paid?	Persons over 75	-	-
Taxable	no	-	-
Who pays?	State budget	-	-
Pension credits			
Levels of payment / month	142 PLN	-	-
Number of recipients in 2002	1,841,400	-	-

* All people over 75 receive an attendance allowance.

5.7.2 Is there any information on the take up of benefits or services?

Family carers generally receive no financial gratification for their care. There are however the aforementioned possibilities of receiving financial support or other forms of assistance. There are no laws or regulations giving family carers the right to receive gratification or other benefits for the services they perform. There are no additions to pensions for this.

5.7.3 Are there tax benefits and allowances for family carers?

Basically there is no tax relief, and as far there was no right to use social insurance (e.g. against accidents) by family carers.

5.7.4 Does inheritance or transfer of property play a role in caregiving situation? If yes, how?

There is the possibility of inheriting a house (flat etc.) in exchange for a jointure (providing a place to live and costs of living to the former owner of the house) – this is regulated by the family and care code.

5.7.5 Carers' or Users' contribution to elderly care costs

a. Medical, nursing and rehabilitation services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
General practitioner	X					
Specialist doctor	X		X			X
Psychologist	X		X			
Acute Hospital	X					
Long-term medical residential care (for terminal patients, rehabilitation, RSA, etc.)		X				X
Day hospital	X					
Home care for terminal patients		X	X			
Rehabilitation at home	X		X			
Nursing care at home (Day / Night)	X	X	X			X
Laboratory tests or other diagnostic tests at home		X	X			
Telemedicine for monitoring		X				X
Other, specify: “home care”						

b. Social-care services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reim-bursed	wholly reim-bursed	Based on severity
Permanent admission into residential care / old people's home		X			X	
Temporary admission into residential care / old people's home in order to relieve the family carer		X			X	X
Protected accommodation / sheltered housing (house-hotel, apartments with common facilities, etc.)		X			X	
Laundry service		X			X	
Special transport services		X			X	
Hairdresser at home		X			X	
Meals at home		X			X	
Chiropodist / Podologist						
Telerescue / Tele-alarm (connection with the central first-aid station)						X
Care aids	X					
Home modifications		X			X	X
Company for the elderly			X			
Social worker	X					
Day care (public or private) in community center or old people's home	X			X		
Night care (public or private) at home or old people's home	X			X		X
Private cohabitant assistant ("paid carer")			X			
Daily private home care for hygiene and personal care			X			
Social home care for help and cleaning services / "Home help"		X			X	
Social home care for hygiene and personal care						
Telephone service offered by associations for the elderly (friend-phone, etc.)						
Counselling and advice services for the elderly	X					
Social recreational centre		X			X	
Other, specify						

c. Special services for family carers	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Training courses on caring						
Telephone service offered by associations for family members		X				X
Internet Services						
Support or self-help groups for family members		X				
Counselling services for family carers						
Regular relief home service (supervision of the elderly for a few hours a day during the week)						
Temporary relief home service (substitution of the family carer for brief periods of time, for example, a week)						
Assessment of the needs	X					
Monetary transfers						
Management of crises						
Integrated planning of care for the elderly and families at home or in hospital	X					
Services for family carers of different ethnic groups						
Other, specify						

6 Current trends and future perspectives

6.1 What are the major policy and practice issues debated on family care of the elderly in your country from the carers' point of view? Are older people and / or carer abuse among these issues?

“In Poland, because of the traditional family ties, there still are chances to keep and strengthen the function of family in caring, but only under the condition that the state takes steps towards an active policy of helping families to realise this function. Families, without the much needed help, (…) will be forced to give up caring over their dependent members.” (Hrynkiewicz, 2001) Even though the situation of elderly in Poland is subject to many researches and publications, there is no policy debate on the subject. In consequence the government, not only on the central level, but also local, is not aware of the importance of family carers. They are treated rather as a permanent element of this care, doing most of the activities for the elderly. Local authorities do not seem to take into consideration the growing tendency of young people to migrate and change (permanently or temporarily) their place of residence, because of the bad situation on the employment market. That is why there is not enough activity aimed at making families interested in prolonging the period of caring over an elderly. This is caused not only by treating the family as a permanent, unchangeable element of social situation of elderly, but also being unaware of the costs of care within the community and in an institution. And after all supporting and preparing the family to provide care is the cheapest and in the same time the most socially desirable way of satisfying the needs of elderly.

Within the last two years a social debate has been going on, on the problem of social exclusion. It can be expected that continuing this discussion will lead to it spreading to the problem of social exclusion of elderly and than the role of family carers will be exposed, as an important factor in preventing it.

6.2 Do you expect there to be any changing trends in services to support family carers, e.g. more state or more family support, more services or more cash?

“An assumption should be made, that there is no way of optimally helping an elderly living in a family, without helping the family in its care functions.” (Kawczyńska-Butrym, 2001b) It is necessary to increase the interest of policy makers in the problems of elderly, first of all by the development of a system of health and social services and supporting family carers and granting them appropriate benefits (e.g. health, accident and social insurance on the basis of the care they provide) and rights (e.g. free public transport form the place of

residence to the place of caring). In the long term social policy greater stress should be put to preparing to old age not only people in the pre-pensionary age but also members of their families. The subject “preparation to living in a family”, which is taught at schools, should include the problems of old age, sickness and dependency. It is also crucial to support social initiatives and self-help groups and broadening the range of social services (e.g. lending equipment for disabled and rehabilitation, free training for family carers, organising self-help groups).

6.3 What is the role played by carer groups / organisations, "pressure groups"?

Family carers do not organise themselves into self-help groups and so far have no influence on law regulations and their practice. Activities aiming at supporting family carers have no organised or institutional character and are dependent on local initiatives. Only family care over people with Alzheimer’s disease gets help from NGO – Association for Help to People with Alzheimer’s Disease and Polish Alzheimer Foundation. Information centres and training for carers as well as clubs for carers of people with the Alzheimer’s disease are organised. These organisations also popularise these problems in the press, TV and local governments, influence the public opinion and form a sort of a pressure group.

6.4 Are there any tensions between carers' interests and those of older people?

No information provided.

6.5 State of research and future research needs (neglected issues and innovations)

“Social policy towards elderly may yet for a long time be restricted to satisfying their basic needs. Because of the same reason it is hard to expect any initiatives realising the aims of social policy towards old age to be started in the nearest future.” (Szatur-Jaworska, 2000) Our research concerning family carers, their role and needs may be of crucial importance, both as a source of information (analysing the situation and needs) and as a way of giving our opinions to decision makers and opinion forming groups.

6.6 New technologies – are there developments which can help in the care of older people and support family carers?

No relevant data recorded.

6.7 Comments and recommendations from the authors

“Elderly as a whole are not a subject of social policy in Poland.” (Szatur-Jaworska, 1991) The demographic situation in Poland shows clearly that including the needs of family carers is necessary. Social policy towards elderly should have the following qualities:

- Its subjects should be – the elderly as a person, elderly as a social group and the ageing society as a demographical fact.
- The problem should be analysed from the elderly’s point of view and their needs should be included.
- Creating the possibility of elderly actively being part of their generation should be one of the elements of policy towards elderly. One has to remember that around 75 % of elderly do not need permanent care; social policy should therefore include also the needs of the healthy elderly.
- Activity is also needed which would integrate the society across generations and create a society in which elderly play an important and active role, also as family carers (Pędich, 1998).

Taking the Polish reality into consideration it seems that the above postulates will not be a priority among the tasks of social policy.

7 Appendix to the National Background Report for Poland

7.1 Socio-demographic data

Polish society has a growing number of elderly. The percentage of people aged 80 or more is growing at an increasing rate, which leads to an increase of tasks connected with caring over elderly. In the same times families are becoming smaller, leaving fewer people to share the caring tasks and making them relatively more difficult. The natural growth index is around 0, and sometimes even below.

7.1.1 Profile of the elderly population-past trends and future projections

Similarly to most European countries, in Poland there is a significant increase in the number of elderly. The percentage of people in the post-productive age (60 or more for women and 65 or more for men) has in the second half of the 20th century (1950-2000) increased from 6.2 to 14.7. In the same period the percentage of people aged 80 or more has grown even more - from 0.7 to 2.0 %.

By the year 2030 the number of people in retirement age will increase about 3,200 thousand people and the percentage of people in this age group will reach 24 %. The growth dynamics in the oldest age group will still be even faster, and the percentage of these people will double. The overall number of people in Poland will drop by 600 thousand, the number of children and adults in the productive age will also diminish. The average life expectancy for people aged 75 in Poland for women will have increased from 7.8 in 1950-1959 to 12.2 in 2040-2049, and for men from 6.9 to 11.3 (Seniorzy w polskim spoleczeństwie, 1999).

7.1.1.1 Life expectancy at birth (male / female) and at age 65 years

The life expectancy of men and women in Poland is systematically getting longer. The life expectancy in rural and urban areas as well as in various regions differs slightly.

Table 1: Life expectancy in Poland in years 1990 - 2001

Specification	Life expectancy at age specified											
	Males						Females					
AGE	0	1	15	30	45	60	0	1	15	30	45	60
1990	66.5	66.7	53.1	39.1	26.0	15.3	75.5	75.5	61.8	47.2	33.0	20.0
1995	67.6	67.6	53.9	39.8	26.7	15.8	76.4	76.3	62.6	47.9	33.6	20.5
2000	69.7	69.4	55.6	41.4	27.9	16.7	78.0	77.6	63.8	49.0	34.7	21.5
2001	70.2	69.8	56.0	41.8	28.3	17.0	78.4	77.9	64.1	49.4	35.0	21.8
Urban areas	70.4	70.0	56.2	41.9	28.4	17.1	78.2	77.8	63.9	49.2	34.8	21.7
Rural areas	69.9	69.5	55.7	41.6	28.1	17.0	78.7	78.3	64.5	49.7	35.3	22.0

Source: GUS, 2003, Rocznik Statystyczny 2002

Table 2: Average life expectancy of people aged 60 and 75 in Poland (prognosis)

Years	Age: 60		Age: 75	
	Men	Women	Men	Women
2000 – 2009	16.7	20.9	8.5	10.1
2010 – 2019	18.0	21.6	9.5	10.7
2020 – 2029	19.0	22.3	10.2	11.2
2030 – 2039	19.6	23.0	10.7	11.8
2040 – 2049	20.3	23.8	11.3	12.2

Source: Seniorzy w polskim spoleczeństwie, GUS, Warszawa 1999, s. 26.

7.1.1.2 % of > 65 year-olds in total population by 5 or 10 year age groups

Table 3: The percentage of elderly in five-year age groups according to place of residence

Age groups	All			Urban			Rural		
	All	Men	Wo-men	All	Men	Wo-men	All	Men	Wo-men
In per-cents	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
65-69	4.2	3.7	4.6	4.2	3.7	4.6	4.1	3.6	4.6
70-74	3.7	3.1	4.3	3.6	3.0	4.1	4.0	3.2	4.7
75-79	2.7	1.9	3.4	2.5	1.7	3.1	2.9	2.1	3.8
80-84	1.3	0.8	1.7	1.2	0.7	1.5	1.5	1.0	2.0
85-89	0.6	0.3	0.8	0.6	0.3	0.8	0.7	0.4	0.9
90-94	0.2	0.1	0.4	0.2	0.1	0.3	0.3	0.1	0.4
95-99	0.0	0.0	0.1	0.0	0.0	0.1	0.0	0.0	0.1
100 or more	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Altogether 65 and older									
	12.7	9.9	15.3	12.3	9.5	14.5	13.5	10.4	16.5
Altogether 65 and older, in thousands									
	38230.1	18516.4	19713.7	23610.4	11234.2	12376.2	14619.7	7282.2	7337.5

Source: National census 2002 results, available on the website www.stat.gov.pl

7.1.1.3 Marital status of > 65 year-olds (by gender and age group)

Table 4: People aged 65 or more according to gender and marital status

Marital status	Altogether	Men	Women
Single	4.4	3.3	5.1
Married	50.5	77.3	34.2
Widowed	41.8	16.4	57.3
Divorced	2.7	2.5	2.9
Separated	0.0	0.1	0.0
Altogether	**100.0**	**100.0**	**100.0**

Source: counted on the basis of the national census 2002 results, available on the website www.stat.gov.pl

7.1.1.4 Living alone and co-residence of > 65 year-olds by gender and 5-year age groups

Table 5: People above 65 living in one-person households or with others

The number of people in a household	Percentage of household		
	Altogether	Outside of farming	In farming
1	30.2	32.4	20.7
2	42.9	44.0	38.2
3	11.5	10.6	15.4
4	6.0	5.5	8.6
5	5.2	4.5	8.6
6 and more	4.2	3.0	8.5
Altogether	100.0	100.0	100.0

Source: The results of the research of the life situation of elderly in Poland, Synak B. editor. 2001, Polska starość, Gdańsk, Wydawnictwo Uniwersytetu Gdańskiego

Table 6: Elderly living with other according to family bonds (in %)

People in household	Living with others		Altogether
	With children	With no children	
Spouse, partner	30.3	25.0	61.3
Daughter(s)	51.0	-	25.7
Son(s)	56.1	-	28.2
Daughter(s)-in-law	21.4	1.7	10.9
Son(s)-in-law	22.3	4.2	11.5
Grandchildren	52.4	57.5	31.5
Siblings	0.6	11.7	1.3
Other relatives	1.9	26.7	3.4
Unrelated people	0.6	5.8	0.8

Source: Results of a research on the life situation of elderly in Poland, Synak B, editor. 2001, Polska starość, Gdańsk, Wydawnictwo Uniwersytetu Gdańskiego

7.1.1.5 Urban / rural distribution by age (if available and / or relevant)

The migration of population to the cities, which took place mostly in the 1950's and 1960's have caused demographic ageing in urban areas to be more severe. In 2000 59.6 % of elderly lived in cities. This percentage is constantly growing (it is faster among women). Overall, 10 % of the Polish society consists of women aged 60 or more, and almost 3 / 4 of them live in cities. The percentage of elderly in rural areas is also growing, though not as fast.

In the 1990's the percentage of elderly living in cities has grown from 11.6 to 14.2 while among the inhabitants of rural areas it has grown from 15.0 to 15.6.

It means that although the ageing process rural areas is more advanced, the age structure in cities changes in the same way.

7.1.1.6 Disability rates amongst > 65 year-olds. Estimates of dependency and needs for care

Table 7: The percentage of disabled among people aged 65 or more, 65-74 and 75 or more*

	65 and more	65-74	75 and more
Disabled altogether	42.2	38.5	48.4
Complete disabled	8.3	6.3	11.6
Serious disabled	25.7	23.1	29.9
Does not feel a handicap	8.2	9.1	6.8

The percentage of disabled to the whole population of people in an age group
Source: Results of a research on the life situation of elderly in Poland, Synak B, editor. 2001, Polska starość, Gdańsk, Wydawnictwo Uniwersytetu Gdańskiego

Estimating the extent of dependency and need for assistance for disabled elderly is very difficult due to a lack of sufficient data their disability levels. If we assume that every person who states her disability level as complete (according to the national census these are the people who cannot leave home on their own) and 50 % of those stating their disability level as serious, it can be assumed that a total of 1,027.6 thousand people need help (371.7 thousand men and 655.9 thousand women).

Although because of the general decrease in the number of people living in rural areas in all regions of Poland the percentage of disabled living in these areas is higher than in urban populations, but 59 % of all disabled live in cities. Taking this into account, it can be estimated that the number of people needing help in urban communities is 606.3 thousand, while in rural communities it is 421.3 thousand.

Indicators of disability (by Polish Central Statistical Office)

Next table shows the disability indicator (GUS, 1997) including subgroups of age, gender and place of residence. According to the criteria set out by the Central Statistical Office the percentage of disabled among people aged 60 or more is about 40 %, rises in following age groups, and is a little higher among men and people living in the country in early old age and people living in the city in late old age.

Table 8: Disability indicator (in %)

Disability level	Altogether, regardless of age	Age groups		
		60 – 69	70 – 79	80+
Altogether (men + women)				
Fit	81.0	59.9	58.4	52.9
Disabled	17.5	38.8	40.6	46.5
Men				
Fit	80.9	56.4	59.5	50.6
Disabled	17.2	41.9	39.9	48.5
Women				
Fit	81.1	62.7	57.8	53.9
Disabled	17.7	36.4	41.0	45.6
Urban				
Fit	82.5	63.6	57.8	50.9
Disabled	15.9	34.9	41.2	48.9
Rural				
Fit	78.5	54.4	59.2	55.2
Disabled	20.1	44.6	39.9	43.8

According to the data of the Central Statistical Office (GUS): The heath state of people in Poland in 1996 – (for people aged 60 or more; quoted after L. Frąckiewicz)

Next table shows mobility indicator, the second indicator used by the Central Statistical Office (Witkowski, 2000). Around 25 % of inhabitants of Poland aged 65 and more experience some degree of impairment of mobility, while only 7 % do not leave house or are bedridden. The loss of mobility increases with age, applying to from 15 % of people aged 60-64 to 44 % of people aged over 75.

Table 9: Mobility indicator (in %)

	Age 60-64	Age 65-69	Age 70-74	Age 75+
Full mobility	84.5	78.6	74.1	55.0
Impaired mobility	14.9	20.3	25.5	43.8
Bedridden	0.7	1.5	1.0	6.0
Mobility at home only	2.8	4.6	5.6	11.4
Mobility near the home only	11.3	14.3	18.9	26.4

Source: Results of a research on the life situation of elderly in Poland, Synak B, editor. 2001, Polska starość, Gdańsk, Wydawnictwo Uniwersytetu Gdańskiego

7.1.1.7 Income distribution for top and bottom deciles i.e. % aged > 65 years in top 20 % of income, or % > 65s in top 20 %, and the same for poorest 20 % income groups

There is no data on the decyle distribution of income in households, nor on the income of people aged 65 or more. It is, however, possible to assess the income of their households. The income per capita in these households is a little higher than in an average household. Because elderly live in many households in rural areas, it can be assumed that their income is very low.

Table 10: Incomes of the households in Poland in PLN (2001)

Specification	Grand total	Of which households			
		of retirees	of employees	of farmers	of the self-employed
Per household	2,005.77	1,629.02	2,366.38	2,072.01	2,966.50
Per capita in household	644.48	673.89	683.07	497.54	808.22
Of which disposable income	620.47	639.89	662.58	481.38	773.83
Related to the average income per capita in all households	100.0	104.6	106.0	77.2	125.4

Source: GUS. 2002. Rocznik Statystyczny 2002, Warszawa

7.1.1.8 % > 65 year-olds in different ethnic groups

Poland is mostly a homogeneous country. Nationality (German, Lithuanian, Byelorussia, Ukrainian) or ethnic (Kashubian, Silesian) groups are small and their situation is not significantly different from that of Poles. According to the national census 2002, 97.0 % people have declared themselves Polish.

7.1.1.9 % Home ownership (urban / rural areas) by age group

Elderly in Poland usually live in their own houses or a housing association flat. Houses are usually owned by people in rural areas and flats by people in cities. The largest group (34 %) lives in their own house and 4 / 5 of those people live in the country. The second largest group are people living in housing association owner-occupied flats (31 %). 14 % of elderly live in council flats. Most elderly in rural areas live in their own houses. There are 71 % of them, while in large cities only 5 %. Furthermore 2 / 3 of elderly in cities live in housing association flats - more often owner occupied than rented.

7.1.1.10 Housing standards / conditions if available by age group e.g. % without indoor plumbing, electricity, TV, telephone, lift (if above ground floor), etc.

Table 11: Plumbing and other installations in elderly's homes

	Altogether	Place of residence		
		Large cities	Towns	Country
No running water	5.5	0.5	1.7	11.7
Running water only	14.1	2.7	8.8	25.4
Running water, toilet Out of these:	80.4	96.8	89.5	62.9
Water, toilet, bathroom	77.4	95.5	86.9	58.4
Water, toilet, bathroom, gas	71.0	91.0	81.9	49.8
Water, toilet, bathroom, gas, central heating	64.4	86.4	75.3	42.0

Source: Research on the life situation of elderly in Poland, 2001, Synak B, editor. Polska starość, Gdańsk: Wydawnictwo Uniwersytetu Gdańskiego

Table 12: Household equipment and place of residence of elderly (in %)

Equipment	Altogether	Large cities	Towns	Country
Telephone	71.7	86.6	76.2	58.9
Refrigerator	96.3	97.3	98.0	94.4
Freezer	27.6	19.5	23.8	35.7
Dishwasher	2.2	2.0	2.2	2.3
Automatic washing machine	57.9	73.2	66.1	41.8
Vacuum cleaner	87.2	94.8	94.3	76.6
Radio	90.4	96.4	89.8	87.4
Colour TV	89.8	94.6	93.9	83.6
Video	22.4	25.4	25.7	17.7

Source: Research on the life situation of elderly in Poland, 2001, Synak B, editor. Polska starość, Gdańsk: Wydawnictwo Uniwersytetu Gdańskiego

7.2 Examples of good or innovative practices in support services

No data.

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