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on the Socio-Economic Impact
of Social Protection Reforms

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List of abbreviations

DC	Defined Contribution
FUS	Fundusz Ubezpieczeń Społecznych – Social Insurance Fund
IKE	Indywidualne Konta Emerytalne – Individual Retirement Accounts
KRUS	Kasa Rolniczego Ubezpieczenia Społecznego – Agricultural Social Insurance Fund
LTC	Long-Term Care
NDC	Notional Defined Contribution
NFZ	Narodowy Fundusz Zdrowia - National Health Fund
OFE	Otwarte Fundusze Emerytalne – Open Pension Funds
OMC	Open Method of Coordination
PAYG	Pay-as-you-go
PPE	Pracownicze Programy Emerytalne – Occupational Pension Schemes
PSL	Polskie Stronnictwo Ludowe – Polish Peasant Party
PTE	Powszechne Towarzystwa Emerytalne – General Pension Societies
ZOL	Zakład opiekuńczo-leczniczy - Care and treatment facilities
ZPO	Zakład Pielęgnacyjno-Opiekuńczy - Nursing and care facilities
ZUS	Zakład Ubezpieczeń Społecznych – Social Insurance Institution

1 Executive Summary

In the **pension system**, after a large debate, the reduction of the contribution rate to the funded pillar (OFE) from 7.3% to 2.3% was made, starting in May 2011. The main argument has been to lower the budget subsidies to the pension system and thus to lower the public debt.

As a 'compensation' of the reduction of the pension system's funded part, a new form of supplementary voluntary old-age income security has been legislated, starting in 2012 (the PTEs were granted the right to offer it as well). For the first time, the contribution payments for the new savings account should be exempt (to a certain level) from income tax.

After the Parliamentary elections in October 2011, the new government backed by the same Parliamentary coalition and led by the same prime minister announced plans to increase the statutory retirement age. Starting in 2013, the statutory retirement age should be raised by four months every year, reaching 67 years for both sexes, in 2020 for men and in 2040 for women.

At present (February **2012**) a large political resistance to the increase of the statutory retirement age has grown, especially organised by trade unions.

Other problems of the pension system in Poland have also been discussed, however still without clear solutions, including reform of the special systems for the armed forces and KRUS and further changes in the funded pillar, including introduction of subfunds and increasing investment options.

In **health care**, the law on health care activity was passed on 15 April 2011 and came into force on 1 July 2011. The main change is the possibility of voluntary transformation of public hospitals into corporate units (corporatisation).

The law has included incentives for hospitals to take the decision, especially government's support in debt repayment.

The government believes that such institutional change will support micro efficiency of health care providers and thus improve functioning of health care.

On the other hand, the corporatisation of hospitals is criticised both by opposition (from both left and right wings) and many health care experts. The critics argue that the law has opened door to privatisation of hospitals and constitutes a real threat to equal access to health care.

The biggest problem in the Polish health care system remains the discrepancy between growing demand and unsatisfactory supply. The system also lacks coordination between institutions responsible for health care: central administration, local administration and the National Health Fund (NFZ).

In 2011 the financial situation of the health care further deteriorated. Due to the crisis, thus lower contribution and tax revenues, the National Health Fund received less money than in previous periods.

At the turn of 2011 and **2012**, problems with introduction of a new law on medicine reimbursement has caused high political turbulence and critiques of the Ministry of Health and the government.

Health care seems also to be underestimated as a human capital investment in Poland. Health promotion and prevention to improve the health status of the population and reduce sickness burdens, increase labour productivity and allow for prolonged working lives, are not adequately addressed in the government policy.

Long-term care remains a very weak element in the Polish social protection system. In most cases, long-term care needs are covered by family and no formal institutions are used. Plans to introduce a long-term care insurance, discussed since many years, have been postponed because of the financial difficulties due to the crisis.

Recently, an innovative idea of a 'nursing voucher' has been prepared.

It seems unlikely that under the circumstances of crisis such an increase of public expenditure or increasing taxes will be decided. Nevertheless, long-term care will constitute one of the major challenges for the Polish social protection system in the nearest future.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

Poland, the only EU member state with a positive economic growth in 2009 (1.6%), experienced a GDP growth of 3.9% in 2010 and estimated 4.0% in 2011. The **convergence** to the EU has thus even accelerated during the crisis: the GDP per capita in PPS increased in Poland from 56% of EU average in 2008 to 61% in 2009 and 63% in 2010 (Eurostat database, access on 14 February 2012).

However, Poland was also hit by the economic crisis via other countries. Due to the slowdown in economic growth (from 6.8% in 2007 and 5.1% in 2008), the **unemployment** rate started to rise again: from 7.1% in 2008 to 8.2% in 2009 and 9.6% in 2010 and stabilised on the level 9.6% in 2011 (Eurostat database, access on 14 February 2012).

Another negative consequence of the crisis was worsening of the **public finance** situation. The public deficit grew from 1.9% of GDP in 2007 to 3.7% in 2008, 7.3% in 2009 and 7.8% in 2010. Also the general government debt increased from 45.0% of GDP in 2007 to 47.1% in 2008, 50.9% in 2008 and 54.9% in 2010 (Eurostat database, access on 14 February 2012).

The high public deficit has become an issue with the **EU** and postponed the possible introduction of the Euro.

Public finance, especially in the context of the EU, has **impacted the social protection** especially in the area of pensions. A major reduction in the contribution rate to the funded part of the pension system was introduced in 2011 to lower the budget subsidies to the pension system and thus to lower the public debt.

Due to the crisis, also the financial situation of health and long-term care clearly deteriorated between 2009 and 2011.

The **political situation** was stable throughout the period with no Parliamentary/government changes. In 2010 Bronisław Komorowski from the ruling party has been elected the new State President.

In Parliamentary elections on 9 October 2011, for the first time in the Polish post-communist history since 1989, the ruling coalition was re-elected and remained in power. The new government has been formed by the same coalition of *Platforma Obywatelska* (Civic Platform) and *Polskie Stronnictwo Ludowe* (Polish People's Party) and is led by the same prime minister Donald Tusk.

2.2 Pensions

2.2.1 The system's characteristics and reforms

Most people in Poland: employees and self-employed outside agriculture, are covered by the **general obligatory (statutory) pension system** (European Commission 2010). Apart from it, there are **special schemes** for: farmers (social insurance scheme of KRUS - *Kasa Rolniczego Ubezpieczenia Społecznego*, Agricultural Social Insurance Fund, financed mainly from taxes), separate state provision, tax-financed schemes for 'uniformed services' such as military, police and prison service, as well as state provision for judges and prosecutors. Within the general scheme, there are special rules for miners.

After the reform which started in 1999, the new general pension system consists of **two 'pillars'**, both obligatory for all new members (at the start of the reform, those between 30 and 50 could choose whether to participate in both new 'pillars' or to be entirely in the first one, and those above 50 remained in the old system). The **'first pillar'** is an unfunded NDC scheme, administered by the Social Insurance Institution (*Zakład Ubezpieczeń Społecznych, ZUS*). The **'second pillar'** is a fully funded scheme of open pension funds (*otwarte fundusze emerytalne, OFE*), managed by private investment companies – general pension societies (*powszechne towarzystwa emerytalne, PTE*). The 'second pillar' is a privately managed, but heavily supervised by the State, element of the statutory pension insurance in Poland. Thus, Poland has now a mixed system, funded and unfunded, publicly and privately managed, but both elements are defined-contribution schemes (the first one notionally).

The statutory pension system is financed by the **old-age pension contributions** (the contribution rate is equal to 19.52% of gross salary), for employees paid in equal shares by them and their employers. The contribution is collected by ZUS and divided into the contribution for the 'first pillar' (NDC pensions) and for the 'second pillar' (OFE). Since May 2011, the contribution rate for OFE is 2.3% (and thus the pay-as-you-go part 17.22%). The only eligibility condition is the **standard retirement age**, 60 for women and 65 for men, there is no minimum insurance period. Extensive early retirement possibilities were abolished and replaced since 2009 by bridging pensions – a temporary solution for some categories of workers.

Almost **all pensions currently paid come from the old system**, before the reform which started in 1999. One should thus be very careful in assessing the adequacy in the Polish pension system.

Pension payments are **adjusted** annually according to the consumer price index of the households of pensioners (or the general consumer price index, if it is higher than the index for the households of pensioners), increased by at least 20% of real growth of average earnings in the previous year. On 1 March 2012 all current pensions will be increased by a lump-sum of 71 Zloty. This one-off change in the indexation rules has been explained by the government with the objective to strengthen protection of pensioners with lower income.

After reaching the standard retirement age, **accumulation of old-age pension with earnings** from work is allowed without any reductions. However, if the pensioner is below the standard retirement age, his/her pension is reduced when the earnings are between 70% and 130% of average wage and salary and completely suspended when earnings are higher than 130% of the average.

As pensions are financed from contributions before taxes, old-age pensions are subject to personal income **tax**.

Additional sources of income security, among them the 'employee pension programmes' (*pracownicze programy emerytalne*, PPE) - occupational pension schemes or 'individual retirement accounts' (*indywidualne konta emerytalne*, IKE) constitute the voluntary **'third pillar'**. The coverage of the 'third pillar' has remained very low, for example less than 4% of the employees belong to occupational pension schemes.

2.2.2 Debates and political discourse

A **structural pension reform in Poland** was legislated in 1997 and 1998 and started in **1999**. The reform replaced an entirely public pension system administered by ZUS, pay-as-you-go, defined-benefit, and strongly redistributive, by the new mixed system (see chapter 2.2.1). Poland has thus been one of the 'paradigmatic' pension system's reformers in Central and Eastern Europe.

In the 2000s the system remained relatively stable. The reform debates concerned the 'completing' of the reform started in 1999. **Some issues have remained open** till now (Golinowska, Żukowski 2011). The issue of the institutions which will pay the pensions based on the funds accumulated in OFE has remained unsolved (Pacud 2011). Other open issues include: 'lifestyling investment' – to create subfunds, especially those with safer investment policy for people close to retirement age and further decreasing the fees for companies managing OFE.

In **2008** finally the issue of early retirement was solved. Some restricted categories of workers who have worked under special (difficult) conditions have been given a compensation in form of bridging pensions, starting in 2009 (Zieleniecki 2011).

A large debate started in **2010** on a reduction of the contribution to the funded 'second pillar', especially to lower the budget subsidies to the pension system and thus to lower the public debt.

The discussions continued in **2011** with clear polarisation of positions. Most economists criticised the proposal as a step to 'rescue' the present public finances at the costs of further 'generations' or at least governments and 'dismantling' the pension system and pension reform started in 1999, based on a broad consensus. The government was successful in passing the law in Parliament. From 1 May 2011 contribution rate to the 'second pillar' is 2.3%.

As a 'compensation' of the reduction of the pension system's funded part, a new form of supplementary voluntary old-age income security has been legislated, starting in 2012 (the PTEs were granted the right to offer it as well). For the first time, the contribution payments for the new savings account should be exempt (to a certain level) from income tax.

After the Parliamentary elections in October 2011, the new government backed by the same Parliamentary coalition and led by the same prime minister announced **plans to increase the statutory retirement age**. Starting in 2013, the statutory retirement age should be raised by four months every year, reaching 67 years for both ages, in 2020 for men and in 2040 for women.

At present (February **2012**) a large political resistance to the increase of the statutory retirement age has grown, especially organised by trade unions.

There is also still a discussion on and a resistance to plans of changing **special schemes**, especially those for 'uniformed services'.

The crucial issue for the future of the pension system in Poland, which is the necessity to improve minimum income security in pension age to **prevent future pensioners from poverty**

(see section 2.2.5) has started to be discussed in media and in politics. For example, President Komorowski organised a debate on this issue.

Some discussion was also caused by the proposal and finally the decision about lump-sum **indexation** of current pensions in 2012, criticised by many as a populist measure inconsistent with the character of the Polish pension system.

2.2.3 Impact of EU social policies on the national level

Neither the EU Green Paper on pensions nor even the EU 2020 Strategy were discussed in Poland. It is related to a generally low presence of EU social policies in the Polish debates on social problems.

The level of visibility and awareness of the **Social OMC**, both among the key social policy players and society at large, is very low in Poland. Only academics and those directly involved in the preparation of the NSRs know the Social OMC. The issue does not appear in the media.

People involved in the Social OMC think that there has been some impact of the Social OMC on the Polish pension debate. It may be argued that the OMC objective concerning the adequacy of pension provisions initiated or intensified a discussion about (future) replacement rates, both among officials/ministers and in the public debate. Arguably also the issues of balancing the adequacy and financial sustainability of pension systems as well as active ageing have entered the debate thanks to the OMC.

The impact of EU on Polish pension system is also visible in the **two disputes between the European Commission and the Polish government**, concerning two solutions in the Polish pensions system, both related to the second, funded, pillar. In both cases Poland argued that the second pillar of the pension system, although managed by private financial institutions, is a part of the public system.

Poland's position is that money directed from the state budget to cover the deficit in the pension system which emerged from creation of the second pillar should not be counted as increasing public deficit and debt. The European Union however has not agreed to change the rules of public debt calculations. Also this was one of the reasons why Poland decided to cut the contribution rate to the pension funds (see section 2.2.2).

Poland also wanted to keep the **limits for foreign investment of the open pension funds** (at present not more than 5% of assets). There was a legal case against Poland in the European Court of Justice since September 2009 with the ruling of the Court of Justice of 21 December 2011 that these limits were in conflict with the free movement of capital in the EU.

The objectives specified in the **Annual Growth Survey** (European Commission 2011a) are generally at least partly reflected in Poland. There has been progress with regard to restrictions in access to early retirement schemes while supporting longer working lives (see chapter 2.2.4).

The **Council recommendations for Poland** of 12 July 2011 included the recommendation to take action to "raise as planned the statutory retirement age for uniformed services, continue steps to increase the effective retirement age, such as linking it to life expectancy. Establish a timetable to further improve the rules for farmers' contributions to the social security fund (KRUS) to better reflect individual incomes" (European Commission 2011b). As shown earlier, these issues have been tackled, so at least there has been correlation between the pension reforms and recommendations.

2.2.4 Impact assessment

There are various analyses of the functioning of the Polish pension system. On the background of growing critiques of the reform and in the context of proposals to decrease the size of the second pillar (see section 2.2.2), also heavy critiques of the pension reform introduced in 1999 were presented, as breaking with the social insurance traditions – for example Hrynkiewicz 2011, Holko 2011, Kalina-Prasznic 2011.

Labour market participation of the elderly, retirement age

The **standard retirement age** in the pension system in Poland has remained unchanged for decades: 60 for women and 65 for men. The authors of the reform which started in 1999 had planned to introduce a unified minimum retirement age at 62. However, it was not accepted because of the resistance of representatives of women' interest, especially trade unions. As mentioned in section 2.2.2, the 'new old' government finally has taken up the issue and seems committed to raise the statutory retirement age, starting in 2013, by four months every year, reaching 67 years for both ages, in 2020 for men and in 2040 for women.

As mentioned earlier, a success has been reached in the area of **reducing early retirement** possibilities in 2008. Also in 2008 the **Programme "Solidarity of generations**: Activities to increase economic activity of persons 50+", was introduced. Additionally, several public campaigns have been organised to raise the public acceptance of and support for employment of older people. It is important in Poland because of widespread stereotypes.

Even before the restrictions of early retirement and the Programme 50+ came into effect in 2009, the **effective retirement age** had started to rise in Poland, due to very positive development on the labour market. The average age of a 'new' retiree increased from 56.8 years in 2005 to 59.6 years in 2010 (see Table 1).

Table 1: Average age of persons for whom new retirement pensions were granted, 2005-2010

	2005	2006	2007	2008	2009	2010
Total	56.8	56.6	57.1	59.0	59.3	59.6
Men	58.4	57.9	59.7	61.1	61.0	60.2
Women	56.0	56.0	55.8	56.2	57.8	59.0

Source: ZUS 2006, p. 31; ZUS 2007b, p. 33; ZUS 2008, p. 31; ZUS 2009b, p. 29; ZUS 2010, p. 29; ZUS 2011, p. 29.

Employment rate of those aged 55 to 64 increased from 27.2% in 2005 to 34.0% in 2010; still (after Malta) the lowest in the EU (see Table 2). The increase was mainly the result of economic growth, high until 2008 and considerably lower in 2009 (real GDP growth rates were 5.1% in 2008, 1.6% in 2009 and 3.9% in 2010), which led to the overall employment rate growth (from 52.8% in 2005 to 59.3% in 2009 and also 59.3% in 2010) (Eurostat database, access on 14 February 2012).

Table 2: Employment rates of older workers (55-64), 2005-2010, in %

	2005	2006	2007	2008	2009	2010
Total	27.2	28.1	29.7	31.6	32.3	34.0
Men	35.9	38.4	41.4	44.1	44.3	45.3
Women	19.7	19.0	19.4	20.7	21.9	24.2

Source: Eurostat database, retrieved on 14 February 2012.

The main reason of the very low employment rates of older people were the early retirement rules, inherited from the old system. The early retirement possibilities were finally restricted in 2009, with effect from 1 January 2009. The positive impact of the new law may be illustrated

by the number of newly granted old-age pensions which decreased from 341 thousand in 2008 to 243 thousand in 2009 and 92 thousand in 2010 (ZUS 2011, p. 26).

The development of replacement rate, adequacy of pensions

One should be extremely careful while assessing the pension adequacy in Poland. The country experienced a structural pension reform, started in 1999, but all current pensions are still mainly paid from the old, completely different, system. **The current relatively good adequacy in the Polish pension system is a result of the old system, replaced in 1999 by the new which will result in a heavy decrease in adequacy**.

According to the Eurostat statistics for **2010** (Eurostat database, retrieved on 5 February), at present the adequacy of the Polish pensions is above the EU-average for most indicators.

The **at-risk-of-poverty rate** for people aged 65 and more was 14.2% in Poland, compared with 15.9% for the EU-27. For people aged 75 and more it was 12.4% in Poland, compared with 18.0% in EU-27 (Table 3). The rate was much lower in Poland for older people than for people aged 0-64 (18.1%).

Table 3: At-risk-of-poverty rate of older people by gender, Poland and EU-27, 2005-2010, in %

		2005	2006	2007	2008	2009	2010
Poland	total	7.3	7.8	7.8	11.7	14.4	14.2
	males	4.9	5.7	5.6	8.9	10.9	9.9
	females	8.7	9.1	9.2	13.4	16.5	16.8
EU 27	total	18.9	19.0	19.3	18.9	17.8	15.9
	males	15.9	16.1	16.2	15.9	14.9	12.9
	females	21.1	21.1	21.6	21.2	20.1	18.2

Source: Eurostat database, retrieved on 5 February 2012.

The risk of poverty of older people is low in Poland compared to other EU Member States, however it has been growing significantly in recent years. The at-risk-of-poverty rate of older people nearly doubled between 2005 and 2010 and the difference between Poland and the EU average has been reduced substantially (see Table 3). The minimum protection seems insufficient to protect this group from fast deterioration of income position. Especially the situation of former disability pension recipients has deteriorated.

A challenge has been in Poland an **insufficient poverty protection of women in old age** – the difference between pension adequacy for men and women is in Poland even bigger than in the EU 27 (see Table 3).

Due to the redistributive nature of the old system and weaker contribution-benefit link, shorter careers or low income have not led to lower pension adequacy. Due especially to special allowance for those above 75, older old people have been even better protected (the at-risk-of-poverty rate was 15.7% for people 75+ compared with 16.5% for people 65+).

Median relative income of people 65+ as a ratio of income of people 0-64 was in Poland higher than in EU 27: 93% compared with 88%. The same was true for the aggregate replacement ratio: 57% in Poland and 53% in EU 27.

On the other hand, the risk-of poverty or social exclusion (**Europe 2020 indicator**) for people aged 65 and more was in Poland higher than in EU 27 (24.4% compared with 19.8%).

Severe material deprivation of people aged 65 and more was in Poland much higher than in EU 27: 16.5% compared with 6.4%.

Thus, all current relative adequacy indicators for people aged 65 and more indicate that **the old pension system in Poland has been successful in protecting pensioners from poverty and in guaranteeing a relatively high income replacement**. This results from the old system's features: defined-benefit, social lump-sum part of every pension, pensions based on best earnings, redistributive pension formula. As a result, income distribution has been in Poland much more equal for those above 65 than those below (3.5 compared to 5.2). Another reason for a relatively high pension adequacy in Poland at present has been the universal coverage in the past and no breaks in coverage/employment due to full employment and non-existence of open unemployment in the communist period, when most entitlements to current pensions had been earned.

As the income level in Poland is much lower than in the EU, especially in the old Member States, people at risk of poverty in Poland enjoy a much lower standard of living than their counterparts in other countries. This also leads to the conclusion that a relative measure of social exclusion has its limits and as such should be enriched by other indicators, like material deprivation rate. **Material deprivation rate** is much higher in Poland than in the EU 27, but it has decreased substantially between 2005 and 2010 (Table 4). The improvement can be explained by rising income and improvement of living standards. The crisis has slowed down the economic growth, but Poland has avoided recession and the convergence towards EU has continued.

Table 4: Material deprivation rate of older people (65 years+), Poland, 2005-2010 (%)

	2005	2006	2007	2008	2009	2010
Poland	54.3	47.1	40.6	38.6	33.8	32.3
EU 27	18.4	17.1	16.3	15.4	14.3	14.1

Source: Eurostat database, retrieved on 5 February 2012.

Thus, relatively high income of the elderly in Poland does not mean that Polish pensioners enjoy wealth. Not only because of the generally low income level in Poland as compared with the old Member States, but also because of a **worse access to and quality of other goods and services influencing the living standard**, like housing, transport, health care, long-term care etc.

A real challenge related to pension system is the **long-term adequacy of pensions**. Pension replacement rates will decrease substantially, increasing the risk of poverty in old age, rather low at present. **Poland seems to be an extreme case of worsening the current high pension adequacy** (Bukowski, Kula, Morawski 2011).

Adequacy projections for **2050** show that the situation will change substantially and the theoretical replacement rates (TRR) in Poland will almost be halved in that period. In the base case (40 years career and average income earner) the net TRR will decrease from 75.5% in 2010 to 43.3% in 2050.

In the new pension system the link between contributions and pensions is considerable stronger than in the old system. Thus, especially low income, unemployment, or childcare break will have an even stronger negative effect on pension adequacy. For example, between 2010 and 2050 the net TRRs for low income will decrease from 87.1% to 48.2% and for a female worker with 3 years of career break for childcare from 67.7% to 32.4% (the latter also due to the lower retirement age for women).

The substantial decrease in replacement rates in Poland can be explained by the new pension system's solutions:

- the pension entitlement will be based on life-time earnings while it was the best earnings in the old system and

- the new pension system is a DC (NDC) one, thus life expectancy is fully taken into account, putting the longevity risk fully onto the individual.

Financial sustainability of the pension systems

The financial situation of the Social Insurance Fund, and especially of its part related to retirement pensions, has developed negatively since the start of reform (see section 2.2.5).

It has become one of the motivations for the radical reform introduced in 2011 (see section 2.2.1 and 2.2.2).

2.2.5 Critical assessment of reforms, discussions and research carried out

The financial situation of the Social Insurance Fund, and especially of its part related to old-age pensions, has developed negatively since the start of reform in 1999 (see Table 5) for several reasons, and mainly:

- the reform itself, creating a large funded tier out of a part of a previously entirely pay-as-you-go system which created a big deficit for the expenditure on current pensions,
- not completing the reform especially through continuing the costly early retirement,
- due to unfavourable economic development (slower economic growth) in the first years after the reform and in recent years (2009, 2010).

Table 5: Sources of revenues of the Social Insurance Fund 1999-2010, in billion PLN

	1999	2001	2003	2005	2007	2009	2010
Total revenues *= 100 %*	73.7 *(100.0)*	91.6 *(100.0)*	98.6 *(100.0)*	111.0 *(100.0)*	129.6 *(100.0)*	138.4 *(100.0)*	150.1 *(100.0)*
Social insurance contributions *(as % of total revenues)*	63.7 *(86.4)*	69.7 *(76.1)*	69.7 *(70.7)*	77.4 *(69.7)*	88.4 *(68.2)*	86.6 *(62.6)*	89.4 *(59.6)*
Dedicated subsidy for non-insurance benefits *(as % of total revenues)*	3.3 *(4.5)*	3.7 *(4.0)*	3.5 *(3.5)*	3.6 *(3.2)*	23.9 *(18.4)*	30.5 *(22.0)*	38.1 *(25.4)*
Supplementary subsidy covering the deficit of contributions *(as % of total revenues)*	3.9 *(5.3)*	8.8 *(9.6)*	14.9 *(15.1)*	16.5 *(14.9)*			
Subsidy to cover the deficit resulting from directing contributions to pension funds *(as % of total revenues)*	2.3 *(3.1)*	8.7 *(9.5)*	9.9 *(10.0)*	12.6 *(11.4)*	16.2 *(12.5)*	21.1 *(15.2)*	22.3 *(14.9)*
Other revenues *as % of total revenues*	0.5 *(0.7)*	0.8 *(0.9)*	0.6 *(0.6)*	0.9 *(0.8)*	1.1 *(0.8)*	0.2 *(0.1)*	0.3 *(0.2)*

Source: ZUS 2004, p. 13; ZUS 2007a, p. 17; ZUS 2009a, p. 18; ZUS 2010, ZUS 2011, p. 8; authors' estimates.

The crisis which started in 2008 led to a further deterioration of old-age insurance finances: increasing subsidies contributed to a growing deficit of the state budget. This provoked debates on introducing changes to the pension system, including the withdrawal of crucial structural elements of the new system. Finally, a major change in the proportion of contributions transferred to the funded and PAYG (pay-as-you-go) parts of the system has been legislated and started in May 2011: the contribution rate to the funded part has been reduced from 7.3% to 2.3% which will decrease budget subsidies necessary to pay current pensions – as mentioned in

the Polish NRP by 0.6% of GDP in 2011 and by additional 0.5% of GDP in 2012 (Republic of Poland 2011, p. 11).

Nevertheless, I belong to the critics of the present contribution rate reduction to the second pillar from 7.3% to 2.3%, even though before the pension reform in 1999 I was against introduction of a large obligatory funded pillar, proposing instead a reduction of statutory pension system (and contribution) and development of voluntary additional old-age security (Żukowski 1997a, Żukowski 1997b). The criticisms of the present "reform of the reform" rely on several arguments:

- Safety, stability and trust are basic values on which a social protection system is based and they should not be threatened. The major pension reform in Poland in 1999 was based on a broad political consensus;
- The present change is clearly motivated by the current budget situation and is intended to decrease the public debt. Indeed, the change will improve public finance. However, doing this the present government is imposing a higher burden on future "generations", whose conditions for pension system will be even more difficult than at present;
- The change is also reintroducing concentration of risks on labour market/GDP, whereas the idea of the 1999 reform was to balance them with capital market risks;
- In the longer run, pensions from the funded pillar should be higher, and the development so far has proved it; thus decreasing of the contributions for the funded pillar may either lead to lower pensions or higher public spending in future, if the state will be ready to compensate the difference;
- Thanks to the change, the government will achieve "relief" in public finance, which may (but of course does not have to) lower the readiness to introduce necessary reforms.

An alternative strategy to the reduction of the contribution rate to the second pillar could be a series of reforms in the entire old-age security, described below.

Which reforms are necessary?

- **Increasing the retirement age** is the crucial reform measure. It is necessary both for adequacy reasons (especially for women) as well as for sustainability reasons. It is to be hoped that the present government will be successful in implementing the announced plans. The coming weeks will be crucial in this respect.

- **Minimum security** in the general pension system should be improved, to protect future pensioners from poverty in old age. The issue of future 'pension poverty' has become popular in media in recent months. The challenge is how to include an effective poverty protection mechanism into a system based on a strict contribution-benefit link. The Swedish example, with a similar structure of the pension system to Poland, seems to offer a solution.

- The **special schemes** for the armed forces and KRUS should be reformed. In both cases, the directions of the reforms range from at least closer links between income/ service and pensions and, at the extreme, including those groups into the general insurance system. The political support should be built through showing the vast majority of population how inefficient and unjust the privileges for minorities are;

- In the **'second pillar'**, all the changes which have been discussed for years, should be introduced. Subfunds (life-styling) should be introduced, planned during works on the 1999 reform, but postponed several times. It is important to protect pensions especially of older people, close to retirement, in times of financial crises, like the present one.

Other changes should include increasing investment options of OFE and further lowering their costs.

- Development of **'third pillar'**, i.e. voluntary additional income security for old age, is crucial to compensate the declining replacement ratios from the statutory system.
- Broad **pension education** is still necessary.

2.3 Health Care

2.3.1 The system's characteristics and reforms

In the reported period one important change in the health care system was legislated: the possibility to corporatise public hospitals. Before presenting the new law, some **basic characteristics of the health care system in Poland** will be repeated.

The present health care system in Poland results from the reform introduced in January **1999** with the 1997 General Health Insurance Act. With this reform, Poland changed from a National Health Care - type system, financed from the state budget to a social health insurance type, with regional insurance funds financing the direct costs of health services to patients through contracts with service providers. In 2003, regional insurance funds have been replaced by one National Health Fund (*Narodowy Fundusz Zdrowia*, NFZ).

There is in principle **equal access to health care financed from public funds** (Lach 2011). The health care system in Poland is financed mainly by health insurance contributions and partly by taxes - from the state budget and self-government budgets.

The main source of health care financing are insurance contributions. There is a **general health insurance** system, covering all categories of employees, including individual farmers, civil servants and others, beneficiaries of social security benefits, unemployed, students. Also dependant family members are covered. All social groups are practically covered by obligatory health insurance. There is no possibility to opt-out from the system.

A part of health care in Poland is financed by the state budget, for example public health targets, health insurance premiums for specific groups of the population (the unemployed receiving social security benefits, persons receiving social pensions, farmers, war veterans and others), investments in public health care institutions, highly specialised procedures and very expensive drugs.

The management structure of health care has not changed since 2004. The **National Health Fund (NFZ)** is responsible for contracts with health care providers – public or private, they are concluded and accounted for on the level of voivodship branches of the Fund. There are 16 regional offices (branches) of the NFZ that coincide with the administrative division of the country (one branch in every voivodship). The supervision over the National Health Fund is the responsibility of the Minister of Health.

Beneficiaries have the right to obtain **guaranteed health benefits**, with the exception of benefits mentioned in a list of health benefits non-financed from public means (the so called negative basket). The law on health benefits financed from public means defines a wide range of health care benefits under the insurance scheme. It includes health care aiming at maintaining and restoring human health and preventing diseases and injuries; early diagnosis; medical treatment; prevention and alleviation of disabilities. Insured persons are entitled to medical examinations and consultation; diagnostic examinations, preventive care, outpatient health care, medical emergency services, medical rehabilitation, nursing, supply of drugs and medical devices, supply of orthopedic devices and aids, perinatal care during pregnancy,

palliative care and certification of temporary or permanent disability (see Tyszka 2011 for the legal situation in 2011).

Beneficiaries have the right to choose a doctor, a nurse, a midwife of the primary health care, a dentist and specialist benefits' provider within the framework of outpatient health care, as well as the hospital, from among providers who signed contracts with the National Health Fund.

A reform package has been prepared by the government since autumn 2010. It included several changes, but a large debate was almost entirely concentrated on one issue: transformation of hospitals into corporations.

The law on health care activity, often described as the most important legal change in health care for many years, was passed on 15 April 2011 and came into force on 1. July 2011. The main change is the possibility of voluntary **transformation of public hospitals into corporate units (corporatisation)**. The law has included incentives for hospitals to take the decision, especially government's support in debt repayment. Local governments who run hospitals and will not transform hospitals into corporate units, will have to cover their entire debts within three months after the acceptance of the financial report.

The new law regulates that both public and private hospitals which have signed a contract with NFZ, will function according to the same rules. Also public hospitals will now be allowed to offer for fees services outside the contracts with NFZ. Local governments as the owners/founders of hospitals may keep them or are free to sell them, thus privatise. This is the reason why the law is heavily criticised (see section 1.2.2).

Despite heavy critiques of corporatisation of hospitals, there are some positive examples of entities that decided to go through this process on the voluntary basis, which led to improvement of their financial situation.

Another legislated change has been the possibility to employ nurses in hospitals on the base of civic-law contracts. The main nurses' trade union protested against such change assessing it as a weakening of employment security and worsening of working conditions.

On 28 April 2011 three **other health care laws** were passed by the Polish Parliament.

The law on patients' rights has introduced a new administrative system of claiming patient's rights at regional commissions (until now there was only the court's way). The new system started on 1 January 2012.

The law on information system in health care has introduced an individual e-account, on which all data on an insured/patient will be collected. The system should start on 1 August 2014.

The law on the medical profession has changed the system of obligatory yearly internship – it should now take place during the final study year rather than after the graduation from University.

2.3.2 Debates and political discourse

Throughout the reported period there was a **debate on changes proposed by the government**. As described in previous annual national reports, the law on corporatisation of hospitals has a long history. Originally, the law on obligatory transformation was blocked by a veto of President Kaczyński in November 2008. More than two years have passed until the government was able to finalise the plans in a 'softer' version of voluntary corporatisation.

The government believes that such institutional change will support micro efficiency of health care providers and thus improve functioning of health care. The Minister of Health has repeated

many times that through such change not only patient's rights will not be violated, but through higher efficiency and more competition the situation of patients will improve.

On the other hand, the corporatisation of hospitals is criticised both by opposition (from both left and right wings) and many health care experts. The critics argue that the law has opened doors to privatisation of hospitals and constitutes a real threat to equal access to health care. They stress that hospitals should not be profit-oriented and it is the state which is ultimately responsible for the health care for every citizen.

Another issue emerging several times throughout the period were **protests and strikes of medical personnel, mainly nurses**, especially demanding higher earnings. Unlike in previous years, the protests had mainly a local character.

In the end of 2011 and beginning of 2012, the **new drug reimbursement regulations** and changes to the official list of subsidised drugs have become on of the most debated issues in Poland.

Under the reimbursement law adopted by Parliament on 12 May 2011 and introduced 1 January 2012, the Ministry of Health will negotiate the so-called fixed refundable price of a drug with its manufacturer. On the basis of this price, the official profit margin will be calculated. This means that the prices of reimbursed drugs (subsidised from public funds) will be identical in all pharmacies. Previously pharmacies often charged promotional prices for drugs financed by the National Health Fund; some of these drugs could be bought for next to nothing.

The Health Ministry argued the reimbursement law will put an end to a situation in which patients buy drugs even when they do not need them – encouraged by the low prices of subsidised drugs offered by pharmaceutical companies. Being part of the reimbursement system guarantees much greater revenue for pharmaceutical companies than when the drug is distributed on the market outside the state subsidy system.

The new regulations, and especially the revised reimbursement list, from which many drugs were removed, have provoked much controversy. After appeals from various interest groups, including patients and doctors, the list was expanded to include drugs such as those used by patients after transplant surgery, those used in the treatment of bronchial asthma in children, and painkillers for cancer patients, in addition to medical supplies such as blood glucose test strips. The list was first published in the form of a public notice rather than an official regulation as it was done previously. Under the reimbursement law, the list will be updated every two months.

No less controversy was provoked by reimbursement law provisions under which doctors were to be financially responsible for any mistakes made when writing out prescriptions for their patients – they were to meet the costs of any unauthorised reimbursement together with interest. Pharmacists were also made financially responsible for any mistakes made while issuing medication to patients. These new rules led to **protests from doctors and pharmacists**.

2.3.3 Impact of EU social policies on the national level

As with pensions, there is almost no debate on the **OMC** in the field of health care in Poland. The real impact of the OMC on Polish debates and reforms seems to be even lower in health care than in the area of pensions.

The EU 2020 strategy has not yet impacted on health reform debates. The challenge of improvement of access to a high-quality health care and long-term care services has been addressed in the Polish **NRP** 2011 in the objective (Republic of Poland, p. 23) to improve the

society's health state by means of its promotion and adequate prevention measures as well as to increase the accessibility and the quality of health services and also to create safe working conditions.

What has not been mentioned however in the area of health care is the low, especially public expenditure on health care (see section 2.3.4).

Poland has become a popular destination of the '**medical tourism**'. The main reason for this development are lower prices in Poland, due especially to lower remuneration of Polish medical staff, with similar quality. The main services used are dental care, including implants, plastic surgery and orthopedic treatment. Also spa treatment in Poland is popular among foreigners. The biggest national groups using health care in Poland are citizens of Germany, UK and Sweden. The medical tourism to Poland has been already accepted by the Ministry of Economy as one of 15 'export specialisations' which should receive support, especially for promotion abroad.

The crisis caused however some decrease of visits of foreigners in Polish health care institutions by 10-20%. The estimated number of foreign patients decreased from 330 thousand in 2009 to 250 thousand in 2010. The year 2011 witnessed a growth again, also due to weaker Polish currency, reaching about 300 thousand.

2.3.4 Impact assessment

Financial development, financial sustainability, impact of crisis

The expenditure, especially public expenditure **on health care is low in Poland** (see Table 6), much below the EU average.

Table 6: Expenditure on health care, % of GDP, 2005-2009

	2005	2006	2007	2008	2009
Public expenditure	4.3	4.3	4.5	5.1	5.3
Private expenditure	1.9	1.9	1.9	1.9	1.9
Total expenditure	6.2	6.2	6.4	7.0	7.4

Source: OECD 2011a.

Whereas the expenditure on pensions are high and thus decreasing expenditure in the long run was the priority of the pension reform in 1999, health care is rather underfinanced in Poland. Health care clearly needs more public financing, in order to improve access and quality. This of course does not mean that there is no problem of sustainability of health care in Poland, especially in the longer perspective.

An analysis of private expenditure on health care in Poland suggests that unlike public expenditure on health care, private expenditures are not properly estimated. Their estimation on the basis of household surveys leads to an underestimation of private and thus total health care expenditure. Some authors argue for using national accounts for this purpose (Suchecka 2011).

Due to the crisis, in Polish circumstances meaning not a recession but a decreasing economic growth, the **financial situation of health care clearly deteriorated between 2009 and 2012**, compared to the positive developments in 2007 and 2008 (see Table 6). It was also caused by the resignation from the earlier government plans to increase the contribution rate for health insurance from 9 to 10%.

In the years 2009, 2010 and 2011 the National Health Fund received less money than in previous periods. The problems in 2009 could be mitigated by reserves from previous years. However, in 2010 the situation further deteriorated – the budget for 2010 was lower compared

to 2009 by about 2.71%. Thus the limits of funding set by the National Health Fund were very low in 2009 and in 2010.

Access to health care, quality, health outcomes, inequalities

The World Bank (2010) analysis presents a quite **positive assessment of the Polish health care system** than generally accepted. "The Polish health system is widely, characterised as achieving poor health outcomes, suffering from an overload of hospitals and hospital beds, low public spending, inequitable and impoverishing because of high out-of-pocket spending, corrupt because of side payments for care, providing unsatisfactory services, and – consequently – characterised by low patient satisfaction. The conventional wisdom may still be accurate to an extent, but this review of the health system suggests that the Polish authorities have had considerable success in addressing every one of these problems. The criticisms to some degree describe a system that no longer exists. Through persistent tinkering and efforts to fix these problems, the health care system and the financing of it have been transformed. The new challenges resemble to some degree the old ones, but it is time to recognise that some things have been fixed, and future challenges are more pressing than the old battles" (World Bank 2010, vol. II, p. 55).

The results of a survey made by the Central Statistical Office in 2010 on use of health care (GUS 2011) also show that **access to health care** in Poland is better than often assumed. 12% of people reported that their (subjectively assessed) needs to visit a doctor were not satisfied. However, the main reason for that (of one third of the group) was just waiting that problems would disappear. 23% reported long waiting times as the reason and 9% of the group pointed to lack of money. This would imply that some 3% of all needs are not covered due to long waiting times and about 1% for financial reasons.

The first assessment shows some improvement in **patients' rights** enforcement after the introduction of the law on patients' rights and the Patients Ombudsman in April 2009 (Serwach 2011).

A survey carried out on a group of Polish hospitals accredited by the National Centre for **Quality** Assessment in Health Care shows that hospitals have problems with implementation of standards in the fields of information management, hospital infection monitoring, anesthesiology and assessment of patient condition. The main reason of the problems was that the medical staff doesn't accept changes in hospital operation appearing during the implementation of Hospital Accreditation Programme (Stawowy, Kautsch 2011).

There are however concerns that the new law on corporatisation of hospitals will **increase inequalities in access to health care**.

In April 2011, in an article in the major Polish daily Golinowska (2011) discusses the government's assumptions of the recent corporatisation reform: increase of efficiency, privatisation, and competition. She argues that the expected increase in efficiency of hospitals (balancing revenues and costs) does not necessarily mean a better and more efficient treatment (social/health efficiency). There is no evidence that private hospitals are better in terms of quality of treatment. Hospitals should not be risk-oriented. Equally, competition may have only limited positive effects in an area like health care, where market mechanism and prices are restricted.

Watson (2011) discusses the social and political processes of health care transformation in post-communist Europe which has involved in practice. He begins by suggesting a theoretical framework for the study of post-communist welfare. Focusing on Poland, he examines what lies behind the frictions which have become an integral feature of health care change, which most recently has centred on the privatisation of hospitals. An empirically detailed interpretive

analysis of the Polish nurses' protests is put forward, drawing on interviews, protest bulletins, as well as official and media reports. The paper concludes that the liberalisation and privatisation currently in train can be seen as a contested 'revolution from above' in and through health care, and that the democratic potential offered by protests has been subverted insofar as health care policy-making has itself become privatised.

2.3.5 Critical assessment of reforms, discussions and research carried out

Not only can the assessment about the deficiencies of the health care system in Poland from the previous annual national report be almost entirely repeated, also changes introduced recently (see section 2.3.1) desire critiques.

Access to health care, formally equal for all, is a problem for many people especially because of the financial barrier. Private financing is relatively high in Polish health care, both in form of official payments as well as under-the-table payments. According to the OECD health data 2011, out-of-pocket payments amounted to 22.2% of total expenditure on health in Poland in 2009 (positive was their decrease from 28.1% in 2004), compared e.g. to 13.1% in Germany or 14.4% in Czech Republic (OECD 2011a). Unlike for pensions, **public expenditure for health care is low** in Poland in terms of GDP share. Health care clearly needs more public financing. Decreasing economic growth, as a result of the financial crisis clearly worsened the financial situation of the health care system.

Health care needs are growing, due to many factors, including ageing of the population, increasing living standards or medical technology development. Thus, the biggest problem in the Polish health care system is the **discrepancy between growing demand and unsatisfactory supply**. Additionally, there is a growing problem of medical staff shortage (especially of nurses), due to insufficient expenditure on health staff education and emigration especially after the EU accession. It has been estimated that about 5 thousand physicians have left Poland after 1 May 2004 (to compare: there were more than 80 thousand physicians in Poland in 2008). Emigration of physicians from Poland may be analysed as a rational choice to maximise their human capital (Murdoch 2011).

The new law passed in April 2011, enabling corporatisation of hospitals, is yet another example of weakness of general health policy as well as trust in market solutions which cannot function properly in this area due to well-known market failures in health care.

Which reforms are necessary?

- **Increasing public expenditure** on health care, especially through raising the contribution rate to the general health insurance is crucial;
- Raising **expenditure on medical staff** (doctors, nurses) **education** is necessary;
- **Salaries** of doctors and especially nurses in public health care should be raised;
- The health care still needs a **better coordination**. The system needs better mechanisms of effective allocation of resources: human, capital and material;
- Like education, health care should be recognised as a **human capital investment** in Poland. Health promotion and prevention to improve the health status of the population and reduce sickness burdens, increase labour productivity and allow for prolonged working lifes, should be more adequately addressed in the government policy.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

Long-term care is not a separate social protection part; there is no separate long-term insurance or protection in Poland. Even the term 'long-term-care' *(opieka długoterminowa)* is only used by experts, especially in the health sector.

An **informal care** plays the major role: In most cases, long-term care in Poland is provided by family members at home. There are several explanations for that:

- traditionally strong family relations, including high share of elderly residing with their children (high 'co-residence index'),
- traditional role division: women retire early (lower retirement age for women has been functional in this respect), also to care for their parents/parents-in-law (high 'non-working-women aged 55-64 index') (Golinowska 2010, p. 5),
- insufficient institutional offer of publicly financed care,
- lack of affordable private care establishments.

The institutionalised long-term care in Poland operates within **both the health and social assistance sectors** – see Table 7.

Table 7: Providers of long-term care in Poland

Type of care	Social assistance	Health care	Informal care/Private sector
Home care	Nursing services Specialist nursing services Cash benefits	Nursing services, family doctors	Family care, informal groups (family, neighbours, friends), care paid by the person or his/her family, home care
Semi-resi-dential care	Day centres Support centres		
Institutional (residential) care	Social assistance centres (homes) (6 types)	Care and treatment facilities (*Zakład opiekuńczo-leczniczy*, ZOL), Nursing and care facilities (*Zakład pielęgnoacyjno-opiekuńczy*, ZPO) Geriatric hospitals/units; palliative facilities	Private care centres

Source: Błędowski, Wilmowska-Pietruszyńska 2009, p. 12.

The six types of social assistance centres are those for:

- elderly people,
- chronically somatically ill people,
- chronically mentally ill people,
- mentally disabled adult people,
- mentally disabled children and young people,
- physically disabled people.

Responsibility for the development, organisation, financing and management of LTC in Poland is divided between four groups of actors/stakeholders: the central government, the governmental health agency (health sector), governmental labour and social agency (social sector) and territorial self-government (Golinowska 2010, p. 13) – see Table 8.

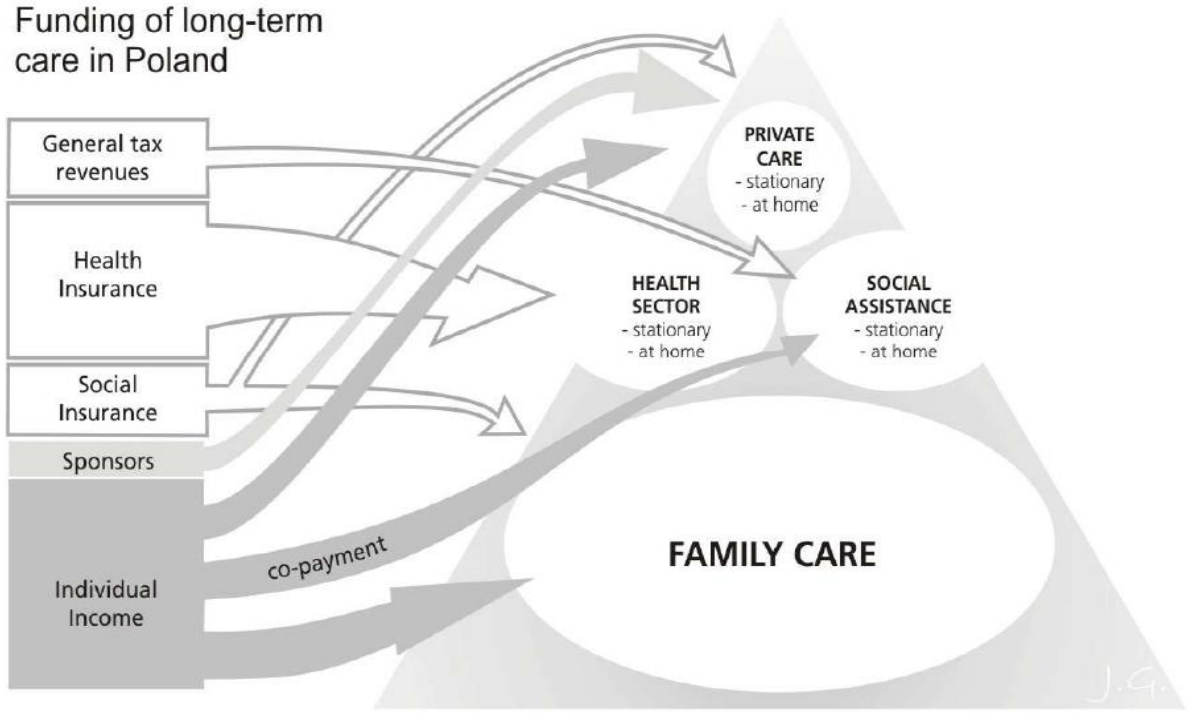
Table 8: Actors and responsibilities in organising and providing of long-term care in Poland

Actors	Responsibility	Type of responsibility
Central government	General	General regulations: strategy, standards, education of professionals, regulation of payments, means for territorial self-governments
Health care sector	Residential LTC - home based nursing	Regulation of access and funding (health insurance)
Social assistance sector	Residential social and health assistance support for home care	Regulation of access and co-funding of services
Territorial self-government	Both sectors	Assessment of needs, participation in the management of LTC facilities, responsibility for development of LTC infrastructure and financing or co-financing home care
NGOs	Social initiatives promoted by the appropriate level of territorial self-government if they are unique and respond to the uncovered services by public institutions	Development of good standards, response to specific needs

Source: Golinowska 2010, p. 13.

Long-term care in Poland is **funded** on the public-private basis. Within the public sector, there are two sources: health insurance (LTC services in the health sector) and general taxation (social assistance homes) – see Figure 1.

Figure 1: Long-term care funding in Poland



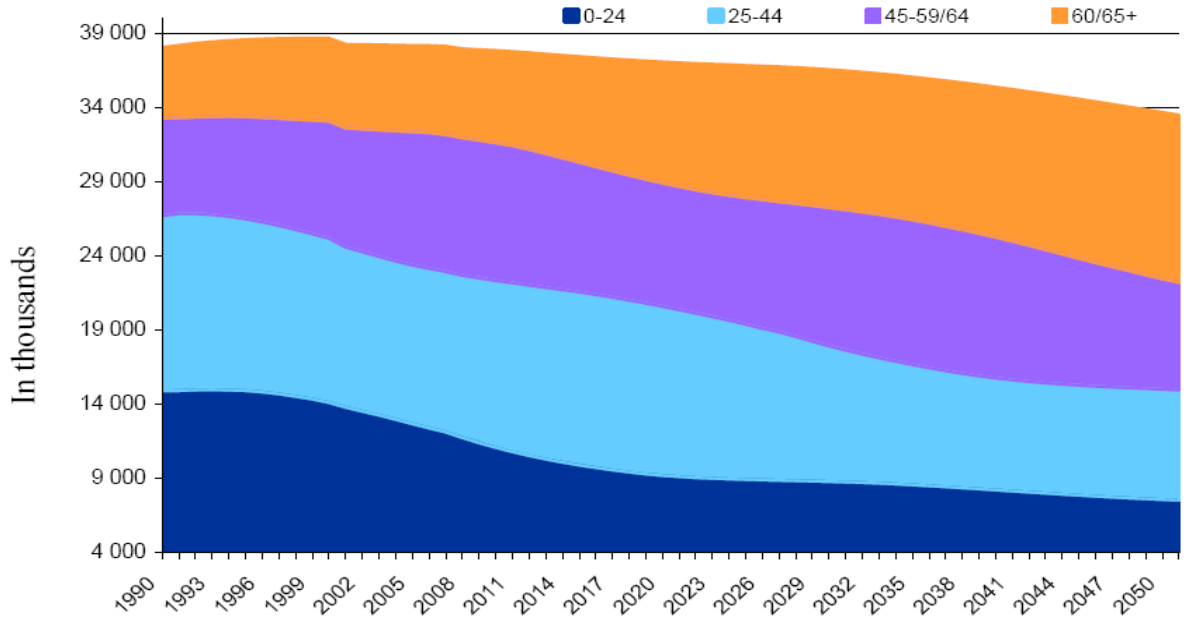
Source: Golinowska 2010, p. 20.

No changes in the financing/organisation of long-term care have been introduced recently.

2.4.2 Debates and political discourse

There is a growing **awareness of growing needs for long-term** care. Demography alone is a huge challenge (see Figure 2).

Figure 2: Population of Poland by age, 1990-2050



Comment: 1990-2007 – real data, from 2008 – prediction by Eurostat.
Source: MoLaSP 2008, p. 116.

As mentioned in previous annual reports, in recent years several plans to introduce obligatory **long-term care insurance** were prepared. They were mainly based on German experience. The Senate, the upper chamber of the Polish parliament, presented in 2009 a proposal of a long-term care insurance, with contribution between 1 and 1.5% of income. The new insurance would cover all those currently insured by the health care insurance. A new fund would be created, managed by the National Health Fund. This proposal provoked critics, especially pointing out the fact that this new contribution would mean 'rising taxes'. The economic and financial crisis and the public finance problems in Poland have stopped these plans. A new diagnosis and proposal have been suggested by the ruling party in a green paper in 2010 (Augustyn 2010).

The present state of LTC in Poland has been assessed as not satisfactory due to fragmentation and lack of coordination, underfinancing, inefficiency of public spending, low offer of services, and low incentives for development of market elements. The green paper calls for a radical change, necessary in the context of fast growing numbers of persons in need of long-term care.

In April 2011 the work of the Senate on a new law on '**nursing vouchers**' was announced. Such a voucher could finance care either delivered by a private care person at home, at a day (semi-residential) centre or at a residential care home (centre). It was announced that the value of such a voucher, financed from the state budget, would be between 800 and 1,200 zloty, depending on the level of long-term care needs. The new system should have started in 2012, although its full implementation would be of a longer duration.

Two main arguments for the introduction of this new solution were presented. Firstly, the needs for long-term care will grow due to the rapid ageing of the population (see Figure 2). According to estimates of GUS (Central Statistical Office), the number of older persons in need

of permanent care will grow from about 1 million at present to 2.5 million in 2035. Secondly, whereas families now provide care for their elderly, it will change dramatically due to decrease of the number of young persons, longer working lives and also because of higher retirement age. The 'nursing vouchers' would be a very valuable strengthening of long-term care in Poland. The proposed solution is based on freedom of choice between care at home and semi-residential or residential care as well as between public and private establishments.

On 13 February **2012** a conference on "Long-term care in Poland – in need of changes" was organised by the Committee of Family and Social Policy of the Senate and there a new version of the proposal of a long-term care system was presented. The proposal includes introduction of a nursing voucher and financing of social insurance contributions of those caring for their family members from state budget. This is based on the fact that some 80% of long-term care in Poland is provided by family members. The project assumes a gradual introduction of the new system, starting in 2013 with those mostly dependent.

2.4.3 Impact of EU social policies on the national level

On one hand, as with pensions and health care, there is almost **no discussion on the OMC** in the field of long-term care in Poland.
On the other hand, it seems that the **idea of long-term care** included in the Social OMC indirectly contributed to the initiation of discussion about this issue. It may be argued that the Social OMC had an impact on the concept of integrated long-term care.
The EU 2020 strategy has not yet impacted on long-term care reform debates. The challenge of developing a long-term care, in the context of ageing of population, is mentioned in the Polish NRP 2011 (p. 24).

2.4.4 Impact assessment

Golinowska (2010, p. 7) argues that LTC **needs** are not adequately assessed in the planning/programming documents at the governmental level (either by the Ministry of Labour and Social Affairs or the Ministry of Health). However regional governments (voivodships) provide planning documents (according to regulations concerning territorial self-government obligations) with an assessment of social and health needs and *inter alia* with LTC needs in a given territory.

Only some 0.9% of the Polish population over the age of 65 received long-term care in an institution setting in 2008, well below the OECD average of 4.2% (OECD 2011b).

Estimations of long-term care **funding** show that public expenditure on residential LTC constitutes only about 0.25% of GDP in Poland – see Table 12. Cash benefits for the elderly with the function to finance nursing and care needs at home constitute another 0.5% of GDP (Golinowska 2010, p. 20). Thus together, long-term care benefits, in cash and in kind, amount to 0.75% of GDP.

Table 9: Public funding of long-term care functions in the health care and social assistance sectors, in PLN (billion), 2006 and 2008

Payer for long-term care	2006	2008
Health insurance; NFZ hospitals Long-term care	0.800 0.599	0.700 0.970
General taxation: social assistance with LTC services	1.200	1.280
Total – without hospitals Total – with hospitals	1.799 2.599	2.250 2.950
% of GDP – without hospitals – with hospitals	0.17 0.25	0.18 0.23

Source: Golinowska 2010, p. 16.

The **quality** of residential care as an element of long-term care in Poland is differentiated, although a general improvement can be observed. Standardisation of facilities can only partly solve this problem. There is a need of continued action in this field. Some arguments are raised for more private solutions in residential care, supported by state (inter alia fiscal) incentives, more competition, better information and more involvement of non-governmental organisations in monitoring the quality (Jurek 2011).

2.4.5 Critical assessment of reforms, discussions and research carried out

Long-term care is a very weak element in the Polish social protection system. In most cases, long-term care needs are covered by family and no formal institutions are used. An absolute majority of non-professionals taking care of family members at home are women.

For these reasons, spending on institutionalised long-term care is low at present. It should grow substantially, in order to cover growing needs, especially in face of rapid ageing of the population.

Access to long-term care is often a problem. Many people in need wait for admission to insufficient number of social welfare homes or are unable to pay for private care.

In Poland the main concept how to solve the problem of growing long-term care needs is the introduction of social long-term care insurance. Recently, an innovative idea of a 'nursing voucher' has been prepared.

It seems unlikely that under the circumstances of crisis such an increase of public expenditure or increasing taxes will be decided. Nevertheless, long-term care will constitute one of the major challenges for the Polish social protection system in the nearest future.

Which reforms are necessary?

- In the long-run, introducing a **statutory long-term care insurance** would be probably the best institutional solution in Polish circumstances;
- As in health care, gradual **increase of public spending** on long-term care is necessary, to close the gap between growing needs and insufficient supply;
- Better (especially fiscal) **incentives to develop private care establishments** should be introduced;
- **Supervision and monitoring of care quality** should be strengthened.

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

Polish social protection has traditionally not promoted employment of the elderly. One can even say that the social protection has been directed clearly to deactivation of people and that Poland traditionally has had a very ‚passive' social protection. The result has been a very low employment rate of those aged 55 to 64: 34.0% in 2010, (after Malta) the lowest in the EU (see chapter 2.2.4).

The new pension system does reward longer careers through a very strong contribution-benefit link: both mandatory pillars are defined contribution, in the first it is notional (NDC), in the second it is fully funded DC. The authors of the reform which started in 1999 believed that this alone would lead to prolonging working life: People would choose to stay longer in employment to earn higher pensions. This was a reason that keeping low retirement age and failure to implement the planned changes (the original reform plan was to equalise the retirement age at 62 both men and women) was not seen as a big problem by some of the reformers.

The **effective retirement age** did start to rise in Poland, especially due to a very positive development on the labour market. The average age of a 'new' retiree increased from 56.8 years in 2005 to 59.6 years in 2010 (see chapter 2.2.4).

The plans to raise the **standard retirement age**, unchanged for decades: 60 for women and 65 for men, were not introduced due to public resistance. As already mentioned, the present government seems committed to raise the statutory retirement age, starting in 2013, by four months every year, reaching 67 years for both ages, in 2020 for men and in 2040 for women.

Higher retirement ages should be accompanied by other measures of **active ageing** – longer working times, improving attitudes towards older people in the workplace, removing barriers to continuing work. The culture of early exit from the labour force, strong in Poland among employees and employers, has to be transformed. One could argue that this has started already. The Eurobarometer on active ageing (European Commission 2012, p. 11) shows that the age citizens consider to be "old" is relatively high in Poland (62.8) compared for example with Germany (60.1), Czech Republic (59.5) or Slovakia (57.7). Also, more people in Poland (37%) than in EU 27 (33%) would like to continue working after they reach the age they are entitled to a pension (European Commission 2012, p. 75)

Reaching retirement age alone has been ruled by the Supreme Court in Poland as not sufficient for terminating an employment contract (**retirement)** as this could be treated as discrimination on the grounds of age. Thus, if an employee is going to continue his/her employment, the employer cannot prevent him/her from doing so only pointing to reaching the retirement age.

2.5.2 Participation in society

Social protection in Poland does not promote volunteer work/unpaid work. Periods of unpaid/volunteer work are not considered as contributory periods.

Participation in voluntary work is much lower in Poland than in EU 27, according to the recent Eurobarometer on active ageing. Only 13% in Poland, compared with 26% in EU 27 and 55% in Sweden participate in voluntary work (European Commission 2012, p. 89).

Generally, the contribution of older persons to society is in Poland less appreciated (seen) than in most other EU countries (see Table 10).

Table 10: "There are many different ways in which people can contribute to society. To what extent do you think people in (OUR COUNTRY) aged 55 and over contribute in the following areas?"

	Workers	Consu-mers	Volun-teers	Financial support for families	Carers for sick/disabled family	Taking care of grand-children	Average
EU 27	65	72	58	74	71	82	70
Poland	53	59	31	65	64	83	59

Source: European Commission 2012, p. 30.

There is only one exception: taking care of grandchildren. Traditionally, lower retirement age for women was explained in Poland by the women's role in caring for their grandchildren or/and parents. 69% of people in Poland, compared to 48% in EU 27, think the retirement age should be lower for women than for men to allow women to take care for their grandchildren or dependant relatives (European Commission 2012, p. 64)

Hence increasing the retirement age for women has to be accompanied by **development of institutional childcare and long-term care**, necessary also for many other reasons.

2.5.3 Healthy and autonomous living

The social protection in Poland guarantees relative high income, compared to other groups of society and relatively high replacement rates. However, this does not necessarily mean **autonomous living of the elderly**, due to low general income level in Poland as compared with the old Member States, but also due to a worse access to and quality of other goods and services influencing the living standard, both within social protection (health care, long-term care) and outside of it (housing, transport, etc.) (see chapter 2.2.4).

Till now, there is a relatively weak **help at home** included in the health care (home based nursing) and long-term care (home carers) benefit basket (see chapter 2.4.1).

Poland provides tax relief on expenses involved in the care of a dependent relative. Polish workers can also take time off work with compensation, up to 14 days per year. A nursing allowance of PLN 520 (EUR 132) is available for carers who have given up jobs to care for family members with certified significant disability (OECD 2011b).

Within the present plans of development of a long-term care system, there is a political priority to provide support for home care as opposed to institutional care. The present plans for a new long-term care system include financing of social insurance contributions of those caring for their family members from state budget (see chapter 2.4.2).

Also, only to a very limited extent, the health/long-term care system in Poland is focusing on prevention to avoid or delay the dependency of care.

References

AUGUSTYN, Mieczysław (ed.) (2010), Opieka długoterminowa w Polsce. Opis, diagnoza, rekomendacje *(Long-term care in Poland. Description, diagnosis, recommendations)*, Grupa robocza ds. przygotowania ustawy o ubezpieczeniu od ryzyka niesamodzielności przy Klubie Senatorów Platformy Obywatelskiej, Klub Parlamentarny Platformy Obywatelskiej RP, Warszawa.

BŁĘDOWSKI, Piotr, WILMOWSKA-PIETRUSZYŃSKA, Anna (2009). Organizacja opieki długoterminowej w Polsce – Problemy i propozycje rozwiązań *(Organising long-term care in Poland – Main problems and possible solutions)*, Polityka Społeczna 7/2009, pp. 9-13.

BUKOWSKA, Grażyna, KULA, Grzegorz, MORAWSKI, Leszek (2011), Ryzyko ubóstwa osób starszych (*Poverty risk of older persons*), CeDeWu.pl, Warszawa.

EUROPEAN COMMISSION (2010), Joint report on pensions. Progress and key challenges in the delivery of adequate and sustainable pensions in Europe. Country profiles, European Commission, EPC Secretariat, SPS Secretariat, retrieved on 30 January 2012 at http://ec.europa.eu/economy_finance/publications/occasional_paper/2010/pdf/ocp71_country_profiles_en.pdf.

EUROPEAN COMMISSION (2011a), Annual Growth Survey 2012, European Commission, Brussels, 23.11.2011, retrieved on 15 January 2012 at http://ec.europa.eu/europe2020/pdf/ags2012_en.pdf.

EUROPEAN COMMISSION (2011b), Council Recommendation of 12 July 2011 on the National Reform Programme of 2011 of Poland and delivering a Council opinion on the updated Convergence Programme of Poland, 2011-2014, Official Journal of the European Union, 23.07.2011, retrieved on [10 January 2012] at http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2011:217:0005:0008:EN:PDF.

EUROPEAN COMMISSION (2012), Active Ageing Report, Special Eurobarometer 378, European Commission, January 2012.

GOLINOWSKA, Stanisława (2010), The system of long-term care in Poland, CASE Network Studies & Analyses No. 416/2010.

GOLINOWSKA, Stanisława (2011), Zdrowie to nie tylko zdrowie *(Health is not only health)*, Gazeta Wyborcza, 16-17 April 2011, pp. 21-22.

GOLINOWSKA, Stanisława, ŻUKOWSKI, Maciej (2011), The impact of the economic and financial crisis on the Polish pension system, Zeitschrift für Sozialreform, Journal of Social Policy Research, vol. 57, 3/2011, pp. 267-285.

GUS (2011), Ochrona zdrowia w gospodarstwach domowych w 2010 r. *(Health care in households in 2010)*, Central Statistical Office), Warsaw, retrieved on 10 February 2012 at http://www.stat.gov.pl/cps/rde/xbcr/gus/PUBL_zo_ochrona_zdrowia_w_gospodarstwach_domowych_2010.pdf

HOLKO, Maciej (2011), Emerytura – ubezpieczenie, oszczędność czy dywidenda? – artykuł dyskusyjny (*Retirement pension - insurance, saving or dividend? - discussion paper*), Polityka Społeczna 11-12/2011, pp. 12-17.

HRYNKIEWICZ, Józefina (ed.) (2011), Ubezpieczenie społeczne w Polsce. 10 lat reformowania *(Social insurance in Poland. 10 years of reforming)*, Instytut Stosowanych Nauk Społecznych Uniwersytetu Warszawskiego, Warszawa 2011, 364 pp.

JUREK, Łukasz (2011), O jakości usług świadczonych w domach pomocy społecznej *(About quality of services in residential care facilities)*, Polityka Społeczna 3/2011, pp. 23-27.

KALINA-PRASZNIC, Urszula (2011), Ochrona ryzyka starości a odrzucone paradygmaty społecznego ubezpieczenia emerytalnego *(Retirement risks and neglected patterns of social protection)*, Polityka Społeczna 4/2011, pp. 7-11.

LACH, Daniel, Eryk (2011), Zasada równego dostępu do świadczeń opieki zdrowotnej *(The principle of equal access to health care)*, Wolters Kluwer Polska, Warszawa.

MoLaSP (2008), National Strategy Report on Social Protection and Social Inclusion 2008-2010, Ministry of Labour and Social Policy, Warsaw, December 2008.

MURDOCH, Anna (2011), Emigracja lekarzy z Polski (*Emigration of physicians from Poland)*, Oficyna Wydawnicza – Szkoła Główna Handlowa, Warszawa.

OECD (2011a), OECD Health Data 2011 – Frequently Requested Data, Paris, OECD, Paris, retrieved on 12 February 2012 at http://www.oecd.org/document/16/0,3746,en_2649_37407_2085200_1_1_1_37407,00.html.

OECD (2011b), Poland – Long-term care, in Help Wanted? Providing and Paying for Long-term Care, OECD, Paris, retrieved on 8 February 2012 at http://www.oecd.org/dataoecd/61/23/47877986.pdf.

PACUD, Radosław (2011), Wypłaty emerytur dożywotnich – stan obecny i perspektywy *(Payment of life-long funded old-age pensions – the present situation and perspectives)*, Praca i Zabezpieczenie Społeczne 2/2011, pp. 2-9.

REPUBLIC OF POLAND (2011), National Reform Programme Europe 2020, Warsaw, April 2011.

SERWACH, Małgorzata (2011), Prawa pacjenta do świadczeń zdrowotnych i ich kontekst *(Patients' rights on health care services and their context)*, Polityka Społeczna 1/2011, pp. 19-23.

STAWOWY, Magdalena, KAUTSCH, Marcin (2011), Jakość świadczeń medycznych w akredytacji szpitala *(Quality of medical services and hospital accreditation)*, Polityka Społeczna 2/2011, pp. 21-25.

SUCHECKA, Jadwiga (ed.) (2011), Finansowanie ochrony zdrowia. Wybrane zagadnienia *(Health care financing. Selected issues)*, Wolters Kluwer Polska, Warszawa.

TYSZKA, Norbert (ed.) (2011). Świadczenia opieki zdrowotnej finansowane ze środków publicznych – Vademecum 2011 *(Health care benefits financed from public sources – Vademecum 2011)*, Warszawa: Narodowy Fundusz Zdrowia, retrieved on 14 February 2012 at http://www.nfz.gov.pl/new/art/4379/vademecum_2011_10_20.pdf.

WATSON, Peggy (2011), Fighting for life: Health care and democracy in capitalist Poland, Critical Social Policy 1/2011, pp. 53-76.

WORLD BANK (2010), Poland: Public expenditure review, Volume I: Analysis of social sectors and public wages, Volume II: Background papers, Poverty Reduction and Economic Management Unit, Europe and Central Asia Region, Report No. 52536-PL, March 8, 2010.

ZIELENIECKI, Marcin (2011), Emerytura pomostowa w nowym systemie emerytalnym (*Bridging pension in the new pension system)*, Fundacja Rozwoju Uniwersytetu Gdańskiego, Gdańsk.

ZUS (2004), Rocznik Statystyczny Ubezpieczeń Społecznych: System pozarolniczy 1999-2002 *(Statistical Yearbook of Social Insurance: Non-agricultural system 1999-2002)*, Warszawa, Zakład Ubezpieczeń Społecznych.

ZUS (2006), Ważniejsze informacje z zakresu ubezpieczeń społecznych 2005 r. *(Essential information on social insurance in 2005)*, Warsaw: Zakład Ubezpieczeń Społecznych *(Social Insurance Institution)*, Departament Statystyki *(Statistical Department)*, May 2006, retrieved on 10 January 2012 at http://www.zus.pl/files/dane2005.pdf.

ZUS (2007a), Rocznik Statystyczny Ubezpieczeń Społecznych: System pozarolniczy 2003-2005, *(Statistical Yearbook of Social Insurance: Non-agricultural system 2003-2005)*Warszawa, Zakład Ubezpieczeń Społecznych.

ZUS (2007b), Ważniejsze informacje z zakresu ubezpieczeń społecznych 2006 r. *(Essential information on social insurance in 2006)*, Warsaw: Zakład Ubezpieczeń Społecznych *(Social Insurance Institution)*, Departament Statystyki *(Statistical Department)*, May 2007, retrieved on 10 January 2012 at http://www.zus.pl/files/dane2006.pdf.

ZUS (2008), Ważniejsze informacje z zakresu ubezpieczeń społecznych 2007 r. *(Essential information on social insurance in 2007)*, Warsaw: Zakład Ubezpieczeń Społecznych *(Social Insurance Institution)*, Departament Statystyki *(Statistical Department)*, May 2008, retrieved on 10 January 2012 at http://www.zus.pl/files/dane2007.pdf.

ZUS (2009a), Rocznik Statystyczny Ubezpieczeń Społecznych 2006-2008, *(Statistical Yearbook of Social Insurance 2006-2008)*Warszawa, Zakład Ubezpieczeń Społecznych.

ZUS (2009b), Ważniejsze informacje z zakresu ubezpieczeń społecznych 2008 r. *(Essential information on social insurance in 2008)*, Zakład Ubezpieczeń Społecznych, Departament Statystyki, maj 2009, retrieved on 8 May 2011 at http://www.zus.pl/files/dane2008.pdf.

ZUS (2010), Ważniejsze informacje z zakresu ubezpieczeń społecznych 2009 r. *(Essential information on social insurance in 2009)*, Zakład Ubezpieczeń Społecznych, Departament Statystyki, Warszawa, maj 2010, retrieved on 8 May 2011 at http://www.zus.pl/files/Ważniejsze%202009.pdf.

ZUS (2011), Ważniejsze informacje z zakresu ubezpieczeń społecznych 2010 r. *(Essential information on social insurance in 2010)*, Zakład Ubezpieczeń Społecznych, Departament Statystyki, Warszawa, czerwiec 2011, retrieved on 10 January 2012 at http://www.zus.pl/files/Ważniejsze%202010.pdf.

ŻUKOWSKI, Maciej (1997a), Wielostopniowe systemy zabezpieczenia emerytalnego w Unii Europejskiej i w Polsce. Między państwem a rynkiem *(Multipillar old-age security systems in the European Union and Poland. Between state and market)*, zeszyty naukowe seria II, zeszyt 151, Akademia Ekonomiczna w Poznaniu, Poznań.

ŻUKOWSKI, Maciej (1997b), Koncepcja emerytury bazowej *(The concept of basic old-age pension)*, in: S. Golinowska (ed.), Reforma systemu emerytalno-rentowego *(Pension system reform)*, Centrum Analiz Społeczno-Ekonomicznych CASE, Raporty CASE nr 6, Warszawa, kwiecień 1997, pp. 57-72.

3 Abstracts of Relevant Publications on Social Protection 2001 until February 2012

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R5] BUKOWSKA, Grażyna, KULA, Grzegorz, MORAWSKI, Leszek, Ryzyko ubóstwa osób starszych, CeDeWu.pl, Warszawa 2011, 168 pp.

"Poverty risk of older persons"

The book presents results of an empirical analysis of the risk of poverty among older persons in Poland, both at present and in the future.

At present, the risk of poverty among older persons is relatively low, due to the old pension system. Especially people with low income from work enjoy a very high pension replacement rate, which is the main reason of their low economic activity. Higher social participation of present pensioners should be encouraged, to increase their life satisfaction.

The situation of future pensioners, receiving pensions from the new system, will be radically different. Many people will face a risk of poverty. Increasing retirement age is the crucial solution. However, the institutional uncertainty experienced by many people in Poland may cause irrational behavior, for example to use the first retirement possibility even if this is not optimal.

Future health care and long-term care needs will grow substantially.

[R2] DOMAŃSKI, Czesław (ed.), Nieklasyczne metody oceny efektywności i ryzyka. Otwarte fundusze emerytalne, Polskie Wydawnictwo Ekonomiczne, Warszawa 2011, 301 pp.

"Non-classical methods of efficiency and risk assessment. Open pension funds"

Open pension funds participate in the financial and capital markets, and their main objective is to accumulate and increase the financial means for future pensions. Thus, the interest in their results is quite obvious. The authors have assessed the methods of efficiency and risk assessment used so far and proposed their own solutions in this respect. New methods of extended efficiency assessment which have been proposed in the literature after 2000 have been called 'non-classical'.

In the last chapter, the proposed methods have been applied to the efficiency and risk assessment of the open pension funds between 2000 and 2010.

[R1-R5] GOLINOWSKA, Stanisława, ŻUKOWSKI, Maciej, 2011, The Impact of the Economic and Financial Crisis on the Polish Pension System,

Zeitschrift für Sozialreform, Journal of Social Policy Research, vol. 3, pp. 267-285.

The article starts with the description of the pension reform in Poland introduced in 1999. That reform rested on replacing a portion of the pay-as-you-go scheme with a fully-funded capital scheme, and on withdrawing from a defined-benefit pension formula in favour of equivalent solutions via introducing a defined-contribution pension formula. When, in 2008, the global financial crisis disrupted financial markets, the rate of returns on investments from pension funds dropped dramatically. Moreover, the difficult state of public finances started to encumber further financing of the reform's transitional period. This arose a discussion on "reforming the reform" in Poland and led to a reduction of the contribution rate to the funded pillar from 7.3% to 2.3% beginning in May 2011. The recent debate has highlighted and addressed a range of issues which had not been aired to date.

[R1-R5] HRYNKIEWICZ, Józefina (ed.), Ubezpieczenie społeczne w Polsce. 10 lat reformowania, Instytut Stosowanych Nauk Społecznych Uniwersytetu Warszawskiego, Warszawa 2011, 364 pp.

"Social insurance in Poland. 10 years of reforming"

In the book, four perspectives on the pension reform which started in Poland in 1999 have been covered: demographic, economic, legal, social. Most authors are scientists representing various disciplines, from various academic centres in Poland.

Most articles are critical about the reform. In the final chapter, the editor points both to the high transition costs of the reform, which have been the reason for the drastic reduction of the contribution rate to the funded pillar in May 2011, as well as to the social costs, especially "the dismantling of the social security system, based on the principle of social solidarity"(p. 352). In the final section she argues: "The project of changes realised since 1999 has increased the distance between Poland and social security standards of the European Union. It has led to lower level of social security, lower benefits, bigger differences between income from work and income from benefits" (p. 355).

[R2] HOLKO, Maciej, Emerytura – ubezpieczenie, oszczędność czy dywidenda? – artykuł dyskusyjny, Polityka Społeczna 11-12/2011, pp. 12-17.

"Retirement pension - insurance, saving or dividend? - discussion paper"

The issue of pension system is discussed in the article. The leading thesis is as follows: "Social insurance is not savings or investments or tax; (intergenerational) pension insurance contract should not be converted into a loan agreement or contract of capital transfer having the characteristics of gambling, which unfortunately happened in Poland".

The author is extremely critical of a capital pillar in any pension system and of the Polish pension reform. He argues for a complete closure of the funded pillar in the Polish pension system and thus a "return to the nature of social insurance".

[R2] KALINA-PRASZNIC, Urszula, Ochrona ryzyka starości a odrzucone paradygmaty społecznego ubezpieczenia emerytalnego, Polityka Społeczna 4/2011, pp. 7-11.

"Retirement risks and neglected patterns of social protection"

The author argues that the new pension system introduced in Poland in 1999 has largely limited the constitutional right of individuals to social security after retirement as it lacks primary features (paradigms) of social insurance. In the first NDC pillar new elements such as individual accounts or defined contribution payments have reduced the retirement risk

protection creating compulsory saving scheme. The second pillar is by definition not a typical social insurance. It is based on the system of compulsory individual investments where both individual and general risks are imposed on its members and social solidarity effects are eliminated.

[R2] PACUD, Radosław, Wypłaty emerytur dożywotnich – stan obecny i perspektywy, Praca i Zabezpieczenie Społeczne 2/2011, pp. 2-9.

"Payment of life-long funded old-age pensions – the present situation and perspectives"

The author analyses the legal situation after the non-acceptance by the President of Poland of the law on funds of life-long funded old-age pensions of 19 November 2009. The issue who will pay the pensions based on the funds accumulated in OFE has not been solved yet, and in the article various proposals are analysed.

[R3] ZIELENIECKI, Marcin, Emerytura pomostowa w nowym systemie emerytalnym, Fundacja Rozwoju Uniwersytetu Gdańskiego, Gdańsk 2011, 313 pp.

"Bridging pension in the new pension system"

A scientific monograph of bridging pension – the new institution in the Polish pension law, introduced in 2008 to replace extensive earlier retirement possibilities. The author, doctor of law at the University of Gdańsk, has analysed the issue on a broader background of differentiation of the pension law in Poland until the structural pension reform which started in 1999. In the second chapter the process of gradual abolition of the earlier retirement possibilities has been analysed. The third chapter presents the origin and the constitutional foundations of the bridging pensions. The next two chapters analyse the conditions to and organisation and financing of bridging pensions.

[R2] ZIELIŃSKI, Paweł, System ze zdefiniowaną składką – czy na pewno zawsze lepszy?, Polityka Społeczna 11-12/2011, pp. 9-12.

"Defined contribution system - Is it always better?"

In the study the author compares the two types of pension systems: defined benefit system and defined contribution system. While describing advantages and disadvantages of both of them, he pays attention to the features that are often being left out (or ignored) by other authors. As a result, the defined contribution system is usually presented as relatively better than system with defined benefit. In conclusion the author proposes using the hybrid systems that take advantage of strengths of both systems.

[R1-R5] ZUS, 2011, System emerytalny – problemy na przyszłość. Materiały z seminariów ZUS, Zakład Ubezpieczeń Społecznych, Warszawa, 191 pp.

"Pension system – future problems. Materials from ZUS seminars"

The publication collects materials from seminars organised by the Social Insurance Institution (ZUS) for representatives of public institutions between October 2010 and June 2011. The main objective of the seminars was to present determinants of the long-term forecasts prepared by ZUS. The papers are presented in the following sections: Problems of long-term forecasting; Role of life expectancy tables in a pension system; Rules of payments from the second pillar; Problem of raising the retirement age; Differentiation of pension systems in Poland; Directions of changes in disability pension systems in Poland and other countries.

[H] Health Care

[H4, H5] DETYNA, Beata, DETYNA, Jerzy, Jakość usług medycznych. Ocena statystyczna. Podstawy metodyczne, Difin, Warszawa 2011, 350 pp.

"Quality of medical services. Statistical assessment. Methodic principles"

The objective of the authors is to propose methods of quality assessment of processes in medical services in health care units. The methods used so far are analysed. Potential barriers and conditions for successful implementation of the proposed methods are presented. The authors stress that in quality assessment of health services such methods should be used which enable a quantification of assessment results. The final chapter is a case study of implementation of new methods of quality assessment of processes in medical services. After some modifications, the proposed method could be used in all entities, not only in health care.

[H3] LACH, Daniel, Eryk, Zasada równego dostępu do świadczeń opieki zdrowotnej, Wolters Kluwer Polska, Warszawa 2011, 397 pp.

"The principle of equal access to health care"

A scientific monograph of realisation in the Polish legal system of statutory health insurance of the principle of equal access to health care benefits. The author, doctor of law at the Adam Mickiewicz University in Poznań, has started his analysis with the contents of the constitutional principle of equal access to publicly financed health care. The following chapters analyse the realisation of this principle in several aspects: institutional, personal and financial.

[H1, H4] MURDOCH, Anna, Emigracja lekarzy z Polski, Oficyna Wydawnicza – Szkoła Główna Handlowa, Warszawa 2011, 384 pp.

"Emigration of physicians from Poland"

An economic analysis of the emigration of physicians from Poland written by an economist from the Warsaw School of Economics as a habilitation. The book starts with migration at large, emigration of highly qualified specialists and facts about emigration of physicians from Poland. It has been estimated that about 5 thousand physicians have left Poland after 1 May 2004 (to compare: there were more than 80 thousand physicians in Poland in 2008).

In the second part, determinants of the human capital migration have been analysed.

In the third part, emigration of physicians from Poland has been analysed as a rational choice to maximise their human capital.

[H1-H7] NOJSZEWSKA, Ewelina (ed.), System ochrony zdrowia. Problemy i możliwości ich rozwiązań, Wolters Kluwer Polska, Warszawa 2011, 659 pp.

"Health care system. Problems and possible solutions"

The book presents articles prepared for a large conference organised in Warsaw in November 2010 on problems faced by Polish health care system and their possible solutions. This is a wide presentation of various aspects of functioning of the Polish health care system, presented by specialists from various disciplines, mainly economics and management, and distinguished practitioners.

36 articles are divided into six sections: Health care expenditures in Poland; Private financing of health care – private health insurance and copayment; Functioning of the health care system in Poland; Assessment of the health care system functioning in Poland; Management in health care system; Legal aspects of the health care system functioning.

[H4, H5] OPOLSKI, Krzysztof, DYKOWSKA, Bożena, MOŻDŻONEK, Monika, Zarządzanie przez jakość w usługach zdrowotnych, CeDeWu, Warszawa 2011, 244 pp.

"Quality management in health services"

The book starts with the analysis of importance of quality in health service. Chapter two describes fundaments of quality management. Chapter three is devoted to various systems of quality management: accreditation, ISO norm, Total quality management and other. In chapter four methods and instruments used in quality management are described. Chapter five deals with costs of quality management.

[H4] SERWACH, Małgorzata, Prawa pacjenta do świadczeń zdrowotnych i ich kontekst, Polityka Społeczna 1/2011, pp. 19-23.

"Patients' rights on health care services and their context"

The law on patients' rights and laws and the Patients Ombudsman from 6.11.2008 includes index of rights of persons receiving health care services. The articles deals with primary patient laws to health care services and medical procedures financed from public sources. These rights are parallel, this is why it is necessary to analyse each law. The issues were background of many judgments of Polish courts.

[H4, H5] STAWOWY, Magdalena, KAUTSCH, Marcin, Jakość świadczeń medycznych w akredytacji szpitala, Polityka Społeczna 2/2011, pp. 21-25.

"Quality of medical services and hospital accreditation"

The article describes outcomes of the survey carried out on a group of Polish hospitals accredited by the National Centre for Quality Assessment in Health Care. The aim of the survey was to identify the groups of standards and individual standards that were difficult to implement, standards that weren't implemented and the causes of problems with implementation. Hospitals have problems with implementation of standards in the field of information management, hospital infection monitoring, anesthesiology and assessment of patient condition. The standards that weren't implemented belong to groups called information management, anesthesiology and patient rights. The main reason of the problems was that the medical staff don't accept changes in hospital operation appearing during the implementation of Hospital Accreditation Programme.

[H1, H4, H5] SUCHECKA, Jadwiga (ed.), Finansowanie ochrony zdrowia. Wybrane zagadnienia, Wolters Kluwer Polska, Warszawa 2011, 426 pp.

"Health care financing. Chosen issues"

The scope of the book is broader than the title suggests. There are chapters on transformation of health care systems in several countries (including Poland), public expenditure on health care and their determinants, private expenditure on health care in Poland, willingness to pay for health care, public-private partnership in health care, outsourcing as a method to get internal financial sources, guaranteed services in health care, diagnosis related groups in some EU member states, earnings in health care institutions.

The chapter on private expenditure on health care in Poland suggests that unlike public expenditure on health care, private expenditure are not properly estimated in Poland. Their estimation on the basis of households surveys leads to underestimation of private and thus total health care expenditure in Poland. The author argues for using national accounts for this purpose.

[H2] ZADWORNA-CIEŚLAK, Magdalena, OGIŃSKA-BULIK, Nina, Zachowania zdrowotne młodzieży – uwarunkowania podmiotowe i rodzinne, Difin, Warszawa 2011.

"Health behaviour of youth – individual and family determinants"

One of few publications in Polish literature on determinants of health behaviour of young people. Both individual and family determinants have been included in the analysis.

The book starts with a survey of recent literature on concepts explaining health behaviour of young people and of their determinants. The book presents also the results of empirical research conducted among 600 persons – young persons and their parents. The research concentrated on chosen, both individual and family, factors.

On this basis, a general preventive programme of shaping health behaviour is presented, addressed both to young people and their parents.

[L] Long-term care

[L] JUREK, Łukasz, O jakości usług świadczonych w domach pomocy społecznej, Polityka Społeczna 3/2011, pp. 23-27.

"About quality of services in residential care facilities"

The article deals with quality of residential care as an element of long-term care in Poland. The author points to a differentiation of quality, although a general improvement can be observed. Standardisation of facilities can only partly solve this problem. There is a need of continued action in this field. The author argues for more private solutions in residential care, supported by state (inter alia fiscal) incentives, more competition, better information and more involvement of non-governmental organisations in monitoring the quality.

[L] RACŁAW, Mariola (ed.), Publiczna troska, prywatna opieka. Społeczności lokalne wobec osób starszych, Instytut Spraw Publicznych, Warszawa 2011, 322 pp.

"Public concern, private care. Local communities towards older persons"

In the first part, some structural aspects of the development of local social policy on older persons (macro level) have been analysed. Among others, possibilities and restrictions in marketisation of long-term care for older persons have been analysed by Jolanta Peresk-Białas.

In the second part, examples of local activities towards older persons have been presented. The activities include various forms of activisation, not only care, by formal (city, commune) and informal carers.

[L] STYPUŁA, Anna, BRZYSKA, Monika, TOBIASZ-ADAMCZYK, Beata, Postrzeganie usług kierowanych do osób starszych w Polsce przez świadczeniobiorców i świadczeniodawców, Polityka Społeczna 9/2011, pp. 12-17.

"Perception of services for older people in Poland by service users and service providers"

The advancing ageing of Polish society along with transformations in the contemporary model of family cause the rise of demand for services supporting functioning of elderly people in their home environment. As part of the project "Improving Access to Community-Based Services for Older People Living at Home" there were organised two focus groups in order to examine the perception of health and social services directed to older persons by senior citizens and service-providers. The main reasons for using community-based services, the most common sources of information on services as well as the barriers and factors facilitating the using of the community-based services were identified.

4 List of Important Institutions

Important scientific and other institutions which influence the scientific and political debate on social protection reforms - if not mentioned otherwise, all the following institutions are public.

Instytut Gospodarstwa Społecznego, Szkoła Główna Handlowa – Institute of National Economy, Warsaw School of Economics

Contact person:	Professor Piotr Błędowski
Address:	ul. Wiśniowa 41, 02-520 Warszawa
Phone:	+48 22 5649112
Webpage:	http://www.sgh.waw.pl/instytuty/igs-kes

The Institute was created in 1920 and it was led until 1941 by the famous Polish sociologist Ludwik Krzywicki. Reestablished in 1957, now led by Professor Piotr Błędowski, concentrates on research concerning, inter alia: situation of older persons, unemployment and poverty, meeting social and medical needs in local societies, social policy on regional, national and international level.

Instytut Polityki Społecznej, Wydział Dziennikarstwa i Nauk Politycznych, Uniwersytet Warszawski – Institute of Social Policy, Faculty of Journalism and Political Science, Warsaw University

Contact person:	Professor Cezary Żołędowski
Address:	ul. Nowy Świat 67, 00-927 Warszawa
Phone:	+48 22 8266652, 0048 22 5520286
Webpage:	http://www.ips.uw.edu.pl

Institute of Social Policy at the Warsaw University is one of the leading research and teaching institutions in the area of social policy in Poland. It offers study of social policy at all levels. The Institute, now led by Professor Cezary Żołędowski, employs many leading scholars in this area. Research carried out at the Institute concerns such areas like theory of social policy, social problems, labour market and unemployment, social security, local social policy, social economy, European social policy, migrations and migration policy, comparative social policy.

Instytut Pracy i Spraw Socjalnych – Institute of Labour and Social Studies

Contact person:	Ewa Gimalska
Address:	ul. Bellottiego 3B, 01-022 Warszawa
Phone:	+48 22 53 67511
Webpage:	http://www.ipiss.com.pl

The Institute of Labour and Social Studies, now led by Professor Bożena Balcerzak-Paradowska is a leading research institute in this area in Poland. The Institute has been operating for forty years serving not only government administration and policy makers, but also taking active part in academic research works, tutoring and supervising series of publications. The research covers such topics as: labour market policy, migration, human resource management, labour law, collective labour relations, social security, family policy, social exclusion, etc.
The publishing house of the Institute prepares numerous publications (for Polish and international markets) that are useful in the teaching process. The Institute publishes the monthly scientific journal "Social Policy".
The Institute also organises seminars and conferences. It takes part in numerous EU funded research activities.

Instytut Spraw Publicznych (ISP) – Institute of Public Affairs (IPA)

Contact person: Katarzyna Renaud
Address: ul. Szpitalna 5, 00-031 Warszawa
Phone: +48 22 5564260
Webpage: http://www.isp.org.pl

The Institute of Public Affairs, led by Dr Jacek Kucharczyk, is an independent, non-partisan public policy think tank. The IPA was established in 1995 to support modernisation reforms and to provide a forum for informed debate on social and political issues. It conducts research as well as societal analysis and presents policy recommendations.
The IPA has prepared reform proposals for the key areas in society and politics. The Institute has a network of associates, which consists of scholars from different academic institutions as well as numerous social and political actors. The IPA publishes the results of its activities in the form of books and policy papers. It also organises seminars, conferences and lectures.
One of the IPA's programmes is The Social Policy Programme which monitors social consequences of the systemic transformation in Poland and other East and Central European countries. The projects which are implemented within the programme's framework concern:

- *strategies for preventing unemployment and social marginalisation,*
- *health care and social security reforms,*
- *the status and needs of particular social groups,*
- *trade unions and social dialogue,*
- *the role of non-governmental organisations in social policy.*

Instytut Zdrowia Publicznego, Wydział Nauk o Zdrowiu, Uniwersytet Jagielloński – Institute of Public Health, Faculty of Health Care, Jagiellonian University

Contact person: Elżbieta Brzezicka
Adress: ul. Grzegórzecka 20, 31-531 Kraków
Phone: +48 12 4241360
Webpage: http://www.izp.cm-uj.krakow.pl

The Institute of Public Health in the Faculty of Health Care at the Jagiellonian University Medical College is the former Cracow School of Public Health, established in 1990 as the first school of public health in Poland.
The Institute conducts research and development activities as well as training within the broadly understood field of public health: health organisation and health economics, social aspects of health care systems, administration and management, epidemiology, health promotion, issues of community health, managing pharmaceuticals and medical materials, computerisation and issues relating to the dissemination of information within health care.
The Institute was led by Professors Cezary Włodarczyk (1997-2002), Stanisława Golinowska (2002-2007) and now is led by Professor Andrzej Pająk.

Izba Gospodarcza Towarzystw Emerytalnych (IGTE) – Polish Chamber of Pension Funds

Contact person: Ewa Lewicka
Address: Al. Jana Pawła II 34 lok. 7, 00-141 Warszawa
Phone: +48 22 6206768; 0048 22 6206738
Webpage: http://www.igte.com.pl

Established in 1999 as an organisation of economic self-government of general pension societies, the Polish Chamber of Pension Funds is managing the open pension funds, the funded obligatory tier of the universal pension system in Poland. It is now an association of 12 out of 14 open pension funds operating in Poland. The Chamber represents the interests of these pension funds. It enables them to prepare common opinions about issues vital for them.

Katedra Polityki Społecznej i Gospodarczej, Wydział Ekonomii, Uniwersytet Ekonomiczny w Katowicach – Department of Social and Economic Policy, Faculty of Economics, University of Economics in Katowice

Contact person: Andrzej Rączaszek
Address: ul. Bogucicka, 14 40-287 Katowice
Phone: +48 32 2577565
Webpage: http://www.ue.katowice.pl/?contentid=874

The Department of Social and Economic Policy at the University of Economics in Katowice was led by Professor Lucyna Frąckiewicz, and since her retirement it is led by Professor Andrzej Rączaszek. It is researching and teaching, among others, on social security, including retirement and disability pensions and long-term care. It is organising yearly big conferences on social policy, integrating various research centres in this area.

Katedra Pracy i Polityki Społecznej, Wydział Ekonomii, Uniwersytet Ekonomiczny w Poznaniu – Department of Labour and Social Policy, Faculty of Economics, Poznań University of Economics

Contact person: Piotr Michoń
Address: Al. Niepodległości 10, 61-875 Poznań
Phone: +48 61 8543883
Webpage: http://www.kpips.ue.poznan.pl

The Department of Labour and Social Policy at the Poznań University of Economics was led until 2010 by Professor Józef Orczyk and now it is led by Professor Jan Szambelańczyk. It is researching and teaching, among others, on social security, including retirement pensions in Poland and in the EU, family policy, education, human resource management. It is known for integrating research on labour and on social policy.

Katedra Prawa Ubezpieczeń Społecznych i Polityki Społecznej, Wydział Prawa i Administracji, Uniwersytet Łódzki – Department of Social Insurance and Social Policy Law, Faculty of Law and Administration, University of Łódź

Contact person: Wiesława Rychter
Address: ul. Kopcińskiego 8/12, 90-232 Łódź
Phone: +48 42 6354604
Webpage:
http://www.wpia.uni.lodz.pl/struktura/index.php?go=katedry/katedra_info.php&kat=5190000

The Department of Social Insurance and Social Policy Law at the University of Łódź, led by Professor Teresa Bińczycka-Majewska, is doing research of various problems of labour and social law. The Department is best known from law expertise on social security law, including social security coordination in the EU and the health care law and systems.

Katedra Socjologii i Polityki Społecznej, Wydział Nauk Ekonomicznych, Uniwersytet Ekonomiczny we Wrocławiu – Department of Sociology and Social Policy, Faculty of economic Sciences, Wrocław University of Economics

Contact person: Anna Dolińska
Address: ul. Komandorska 118/120, 53-345 Wrocław
Phone: +48 71 3680192
Webpage: http://www.ksips.ue.wroc.pl

The Department of Sociology and Social Policy at the Wrocław University of Economics, led by Professor Zdzisław Pisz, is conducting research on various areas of social policy, including social protection on national and local level. The specialisations are, among others, education, labour market, health care, social inclusion, disability insurance, civil society.

Katedra Ubezpieczenia Społecznego, Szkoła Główna Handlowa – Department of Social Insurance at the Warsaw School of Economics

Contact person: Dariusz Stańko
Address: ul. Wiśniowa 41 p. 35 02-520 Warsaw
Phone: +48 22 5648603
Webpage: http://www.sgh.waw.pl/katedry/kus

The Department of Social Insurance at the main Polish university of economics: Warsaw School of Economics was created in 1995, i.e. when interests in insurance issues had been increasing considerably due to development of insurance market and the reform of social security system.
The Department does teaching and scientific activities in the field of comprehensively defined insurance with particular focus on social aspects of insurance theory and insurance practice.
The Department is led by Professor Tadeusz Szumlicz, one of the best experts in insurance, especially social insurance, in Poland.

Komisja Nadzoru Finansowego (KNF) – Polish Financial Supervision Authority (PFSA)

Contact person: Marzena Borowiec
Address: Plac Powstańców Warszawy 1, 00-950 Warszawa
Phone: +48 22 2625888
Webpage: http://www.knf.gov.pl

Since 2006 the Polish Financial Supervision Authority (PFSA) is the governmental supervisory body over all financial institutions in Poland: banks, insurance companies, capital market institutions, electronic money institutions and pension funds and schemes. The aim of financial market supervision is to ensure regular operation of this market, its stability, security and transparency, confidence in the financial market, as well as to ensure that the interests of market actors are protected.
The Authority, dealing generally with financial market, is connected to the social protection - the funded tier of the pension system (open pension funds), it also supervises voluntary employee pension programmes.

Komitet Nauk o Pracy i Polityce Społecznej Polskiej Akademii Nauk – Committee on Labour and Social Policy Sciences, Polish Academy of Sciences

Contact person: Lucyna Machol-Zajda
Address: Bellotiego 3b, 01-022 Warszawa
Phone: +48 22 5367521
Webpage: http://www.knopips.pan.pl

A scientific committee of the Polish Academy of Sciences, constituting an independent body, cooperating with the Academy's division; nation-wide representation of disciplines dealing with labour and social policy. Members are chosen by all professors in those disciplines nationwide. The chairman is now Professor Józef Orczyk. The Committee organises conferences and seminars, awards prizes for outstanding research results and also is the editor of the journal "Problems of social policy".

Ministerstwo Pracy i Polityki Społecznej – Ministry of Labour and Social Policy

Contact person: Bożena Diaby
Address: ul. Nowogrodzka 1/3/5, 00-513 Warszawa
Phone: +48 22 6611000
Webpage: http://www.mpips.gov.pl

The Ministry of Labour and Social Policy is subdivided in various departments to deal with their tasks in the fields of Economic Analyses and Forecasts, Social Dialogue and Partnership, Funds, Social Assistance and Integration, Public Gain, Labour Law, Labour Market, Family Benefits, Social Insurance, Implementing the European Social Fund, International Cooperation, Office of the Government Plenipotentiary for Disabled People.

Ministerstwo Zdrowia – Ministry of Health

Contact person:	Krzysztof Suszek
Address:	ul. Miodowa 15, 00-952 Warsaw
Phone:	+48 22 6349600
Webpage:	http://www.mz.gov.pl

Since 1989 the Ministry of Health experienced profound changes, but still remains the main responsible public entity for legislation and provision of all health-related topics. It is responsible for the national health policy including the approval of National Health Plans, major capital investments and medical science and education, with administrative responsibility for those health care institutions that it directly finances. Medical universities, university hospitals and research institutes are semi-autonomous but ultimately accountable to the Ministry of Health.

Narodowy Fundusz Zdrowia (NFZ) – National Health Fund

Contact person:	Robert Zawadzki
Address:	ul. Grójecka 186, 02-390 Warsaw
Phone:	+48 22 5726000
Webpage:	http://www.nfz.gov.pl

The National Health Fund finances the health services provided to insured persons from social contributions through its regional branches. Furthermore, the NHF contracts service providers for the supply of health services. It publishes periodical and occasional information bulletins and relevant statistical data.

Polska Izba Ubezpieczeń (PIU) – Polish Chamber of Insurance

Contact person:	Marcin Tarczyński
Address:	ul. Wspólna 47/49, 00-684 Warszawa
Phone:	+48 22 4205105
Webpage:	http://www.piu.org.pl

Established in 1990, the PIU was a voluntary association of insurers. Under the Insurance Law of 8 June 1995, the Chamber was transformed into an organisation of insurance economic self-government with the obligatory membership.
The Chamber associates all the insurers active in the Polish market, representing the insurance sector. It enables to prepare common opinions about issues vital for insurers as well as policyholders. It integrates the insurance sector and lays the foundations for establishing an active and efficient insurance lobby.
As the Polish social security system has been based on social insurance principles, and there are close links to private insurance (e.g. in the 'second pillar' of the pensions system), the Chamber also deals with issues of social security, especially lobbying for more market (insurance) solutions.
It publishes the bimonthly magazine "Wiadomości Ubezpieczeniowe" ("Insurance Issues").

Polskie Stowarzyszenie Ubezpieczenia Społecznego (PSUS) – Polish Association of Social Insurance

Contact person:	Antoni Malaka
Address:	Zarząd Główny PSUS ul. Reymonta 4/6 pok. 402, 50-225 Wrocław
Phone:	+48 71 3606251
Webpage:	http://www.psus.pl

The Association is a forum of cooperation of lawyers, doctors, economists, sociologists and representatives of other disciplines, dealing with social insurance either as their research theme or as practitioners in social insurance administration. Many employees of ZUS are members of the Association.
The main objectives are:

- *developing and popularising the social insurance ideas,*
- *improving the social insurance system through supporting research and contacts between researchers and practitioners,*
- *raising the importance of social insurance in research and teaching,*
- *popularising knowledge in the area of social insurance.*

The main activities are conferences, organised yearly. The papers prepared for the conference are published in a book. The Association is organising also lectures and training.

Polskie Towarzystwo Polityki Społecznej (PTPS) – Polish Society for Social Policy

Contact person:	Justyna Godlewska
Address:	Zarząd Główny PTPS, ul. Pandy 13, 02-202 Warszawa
Phone:	+48 22 8236623
Webpage:	http://www.ptps.org.pl

An association of people researching and interested in social policy matters. It is following the traditions of the pre-war association. The association is now chaired by Professor Julian Auleytner. The main aims are: promoting the ideas of social policy, promoting and supporting research in this area, integrating the society of people dealing with this area. It is organising conferences, supporting research, disseminating information on social policy.

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en