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of Social Protection Reforms

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Pensions, Health Care and Long-term Care

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Author: Maciej Żukowski

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GVG

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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**, in 2010 a big debate initiated in 2009 continued, on various changes, including major modifications of the structure introduced by the structural pension reform which started in 1999.

In the end of December 2010 the government proposed a reduction of the contribution rate to the funded pillar (OFE) from 7.3% to 2.3%. The main argument has been to lower the budget subsidies to the pension system and thus to lower the public debt.

A huge public debate has started with clear polarisation of positions. Most economists, including the author, have 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%.

Crucial problems of the pension system in Poland, almost not present in public debates, have remained:

- Equalising the retirement age for women and men and then raising the legal retirement alongside increasing life expectancy;
- Improvement of the minimum security in the general system;
- Reform of the special systems for the armed forces and KRUS;
- Changes in the funded pillar, including introduction of subfunds, increasing investment options, further lowering of the costs;

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 2010 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.

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 (2010 until May 2011)

2.1 Overarching developments

Poland, the only EU member state with a positive economic growth in 2009 (1.7%), experienced a GDP growth of 3.8% in 2010. The **convergence** to the EU has thus even accelerated during the crisis: the GDP per capita in Poland increased from 56% of EU average in 2008 to 61% in 2009 (Eurostat database, access on 14 June 2011).

However, Poland was of course 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 (Eurostat database, access on 14 June 2011).

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 7.9% in 2010. Also the general government debt icreased from 45.0% of GDP in 2007 to 47.1% in 2008, 50.9% in 2008 and 55.0% in 2010 (Eurostat database, access on 14 June 2011).

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 has recently been introduced 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 in 2009 and 2010.

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

2.2 Pensions

2.2.1 The system's characteristics and reforms

The pension system in Poland, introduced by the structural reform which started in 1999, was changed very recently. **The contribution rate to the second funded pillar has been drastically reduced since May 2011**. This was mainly caused by problems with financing the public debt.

In January 2010 the Minister of Labour and Social Policy, Jolanta Fedak, started a political 'action' to reduce the contribution to the funded pillar, called OFE. Her arguments for reducing the contribution focused on low efficiency of managing institutions i.e. PTE. The main objections were: low investment efficiency (low rate of return), extensive share of investments in state securities (*de facto* financing the debt) and high managing costs.

She proposed reducing the hitherto contribution to OFE from 7.3% to 3.0% and the remaining 4.3% should go to ZUS on a special account. This change would reduce the funded part of the system, thus decreasing the necessary subsidies from the state budget to the pension system (to the Social Insurance Institution, ZUS). The proposal has been supported by the Ministry of Finance, Jerzy Rostowski, as it should help to lower the transition costs resulting from the pension reform and thus decrease public debt. For there exists a threat of that the public debt will soon exceed the threshold of 55% of GDP anchored in the Polish constitution. The subsidies to cover the deficit in the pay-as-you-go system resulting from directing a part of the contribution to the pension funds significantly increase the scale of the debt of the consolidated public finances.

In the end of December 2010 the government's proposal has been modified: the contribution rate to OFE should be lowered even more: from 7.3% to 2.3%. Clearly, the main argument has been to lower the budget subsidies to the pension system and thus to lower the public debt.

Figure 1: Structure of the pension system in Poland since 1. May 2011 – two obligatory tiers (pillars)

3.	Additional voluntary old-age provision

2.	Open pension funds *(OFE)* *(Contribution 2.3%)*
1.	Notional Defined Contribution (NDC) *(Contribution 17.22%)*

Source: Author.

A huge public debate has started with clear polarisation of positions. Most economists have 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% (Figure 1).

All the other features of the system have remained unchanged. Only **basic characteristics of the pension system** will be repeated here:

- The general system covers all persons employed outside agriculture. Farmers remain covered by the separate KRUS (*Kasa Rolniczego Ubezpieczenia Społecznego*, Agricultural Social Insurance Fund) scheme. Also, people who serve in military or police are covered by a separate state security scheme. In the following, only the general pension system will be described.

- The general pension system consists of two tiers, called 'pillars'. The first pillar is pay-as-you-go (PAYG) and administered by the Social Insurance Institution (*Zakład Ubezpieczeń Społecznych*, ZUS) and the second one fully funded and privately managed: the open pension funds (*otwarte fundusze emerytalne*, OFE) are administered by private general pension societies (*powszechne towarzystwa emerytalne*, PTE. 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 third, voluntary pillar.
- Both the first and the second pillars in the general system are based on the same logic of defined contribution (DC), whereas in the first PAYG pillar the capital is 'notional' (Notional Defined Contribution, NDC), the second pillar is fully-funded.
- The risk of old-age has been separated from the risks of invalidity and death of the breadwinner. There are two separate obligatory social insurance branches and contributions: old-age insurance (and contribution) and 'pension' insurance, covering invalidity and survivors. The rate of old-age insurance contribution is 19.52 per cent of the income up to a ceiling on the level of 2.5 times average national wage and salary. For employees it is paid in equal shares by employees and employers.
- The only eligibility condition is the standard retirement age, 60 for women and 65 for men. There is no minimum insurance period.
- The level of pensions is strictly related to the contributions paid. Equivalence has also been increased and redistribution limited compared to the old system through removing the upper level of pension assessment and the introduction of an upper level of contributions – at the level of 250% of average earnings in the national economy.
- The minimum pension will now be financed from the state budget and not from contributions. It will be paid under the condition of fulfilling minimum required insurance period of 20 (women) or 25 (men) years as a toping up of the sum accumulated on both accounts – in the first and in the second pillars. Those who will not fulfil the requirements will only rely on social assistance.
- Pensions 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.
- 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 taxation.

2.2.2 Debates and political discourse

The year 2010 and the first quarter of 2011 was a time of **pension debate**. It started with many issues, concerning the completing of the pension reform and functioning of the open pension funds (OFE).

One of the discussion strands was finalising the pension reform – introducing solutions foreseen in the reform programme, but not realised during ten years since the start of the reform. None of the issues has been finalised.

Again, the issue of the institutions which will pay the pensions based on the funds accumulated in OFE has come back (Pacud 2011).

Similarly, the idea of 'lifestyling investment' - to create subfunds, especially those with safer investment policy for people close to retirement age, originally included in the reform package of 1999, has been discussed. Also, decreasing the fees for companies managing OFE has arrived again or the idea to forbid acquisition to OFE.

Finally, all the issues have been replaced by the major proposal to decrease the contribution rate to the second pillar, in order to lower the public debt (see section 2.2.1). Pension system, probably for the first time in the modern history of Poland, became the main media topic for a longer time. The main newspapers in Poland published statements, articles, interviews, debates about the pension system. Most discussions concentrated on the main controverse about changing the proportions between the first and second pillar and on the transition period financing. However, in the debate also broader issues have necessarily appeared, like functions of a pension system, the role of the state, pay-as-you go versus funding, public versus private management etc.

The issue of increasing retirement age also appeared in the discussion, but there are no official plans of implementation. This issue is treated by politicians as extremely difficult and therefore they avoid even starting the discussion. It is a major failure as raising retirement age is the major solution of both adequacy and sustainability problems of pension systems. For example, during the campaign before presidential elections in 2010, both major candidates declared that there was no necessity in Poland to tackle the issue of increasing retirement age. The issue only appears in scientific publications (see section 2.2.4).

Similarly, another crucial issue for the future of the pension system in Poland, which is the necessity to improve minimum income security in pension age for the future pensioners (see section 2.2.5) is no subject of a national debate.

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 – a few years ago, because the issue was less discussed recently (see above). 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.

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 2.2.1).

Poland also wants to keep the limits for foreign investment of the open pension funds (at present not more than 5% of assets). There has been a legal case against Poland in the European Court of Justice since September 2009.

In both cases Poland argues that the second pillar of the pension system, although managed by private financial institutions, is a part of the public system.

The objectives specified in the Annual Growth Survey are only very generally, without precise objectives, reflected in the Polish National Reform Programme for the Implementation of the "Europe 2020" Strategy (in the following: Polish NRP), adopted by the Polish Council of Ministers on 26th April 2011 (in Polish, 54 pp.).

2.2.4 Impact assessment

There are various analyses of the functioning of the Polish pension system. Also in 2010 some books and articles were published, summing up the 10 years of the pension reform introduced in 1999.

On the background of growing critics of the reform and in the context of proposals to decrease the size of the second pillar (see section 2.1.1), also heavy critics of the pension reform introduced in 1999 were presented, as breaking with the social insurance traditions – for example Hrynkiewicz 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 2.1.2, there are no official plans to increase legal retirement age. Such proposals are however made in scientific publications.

The report "Employment in Poland" published in 2010 (Bukowski 2010) argues for equalising the retirement age and raising it to 67 years for both sexes. Such a reform would to a large extent compensate for the massive withdrawal from the labour markets in the coming years of persons born in the 1950s and the first half of the 1960s. The authors argue for possibly fast increase of retirement age until 2020. Empirical analysis of factors influencing employment of older workers shows that longer working life requires investment in health care, health prevention and working conditions, as well as long-term care.

A success has been reached in the area of **reducing early retirement** possibilities. As described in ANR-PL-10, the issue was solved by the law on bridging pensions of 19. December 2008. For some of the people who have worked under special (difficult) conditions a transitory solution was created: "bridging pensions".

Another important measure taken in 2008 was the **Programme "Solidarity of generations**: Activities to increase economic activity of persons 50+", accepted by the Council of Ministers on 17. October 2008. The programme included measures within labour market policy, as well as measures within social insurance to decrease incentives to withdraw early from the labour market. Also, 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 59.3 years in 2009 (see Table 1).

Table 1: Average age of persons for whom new retirement pensions were granted, 2005-2009

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

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

Employment rate of those aged 55 to 64 increased from 27.2% in 2005 to 32.3% in 2009, 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, 1.7% in 2009 and 3.8% in 2010), which led to the overall employment rate growth (from 52.8% in 2005 to 59.3% in 2009) (Eurostat database, access on 14 April 2011).

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 341,000 in 2008 to 243,000 in 2009 and 92,000 in 2010 (ZUS 2010, p. 26; 2011, p. 26).

Table 2: Employment rates of older workers (55-64), 2005-2009, in %

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

Source: Eurostat database, access on 13 April 2011.

The development of replacement rate, adequacy of pensions

It should be emphasised that all pensions currently paid in Poland are based on entitlements and rules of the old system. But even more, the old system will continue to influence the level of pensions for a longer period.

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 2009 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.

Table 3: At-risk-of-poverty rate of older people by gender, Poland and EU-27, 2005-2009, in %

		2005	2006	2007	2008	2009
Poland	total	7.3	7.8	7.8	11.7	14.4
	males	4.9	5.7	5.6	8.9	10.9
	females	8.7	9.1	9.2	13.4	16.5
EU-27	total	18.9	19.0	19.4	18.9	17.8
	males	15.9	16.1	16.2	15.9	14.9
	females	21.1	21.1	21.8	21.2	20.1

Source: Eurostat database, access on 12 April 2011.

One should always take into account the fact that the income level in Poland is much lower than in the EU, especially in the old Member States. Thus, 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 2009 (Table 4).

Table 4: Material deprivation rate of older people (65 years+), Poland, 2005-2009 (%)

	2005	2006	2007	2008	2009
Poland	54.3	47.1	40.6	38.6	33.8
EU-27	18	17	16.3	15.4	14.3

Source: Eurostat database, access on 13 April 2011.

Both developments: increasing of the at-risk-of-poverty rate of older people and decreasing material deprivation rate can be described as a convergence of Poland with the EU. The same is true for the median relative income of elderly people which is higher in Poland than in EU 27 but has decreased substantially between 2005 and 2009 (see Table 5).

Table 5: Median relative income of elderly people (65+), Poland, 2005-2009

	2005	2006	2007	2008	2009
Poland	1.09	1.07	1.04	0.97	0.92
EU-27	0.86	0.85	0.84	0.85	0.86

Source: Eurostat database, access on 14 April 2011.

The relatively good, albeit worsening, income position of the retirees, compared to other groups in Poland, is also illustrated by the recently published reports on incomes and living conditions of the population in Poland, based on the EU-SILC surveys of 2007, 2008 and 2009 (see Table 6).

Table 6: Average yearly per capita net disposable income in households by socio economic groups, 2007-2009, in PLN

Year	Total	Households of					
		emp-loyees	farmers	self-employed	retirees	pensioners	living on unearned sources
2007	10576	11360	6255	11132	10989	8375	5834
Total =100	*100.0*	*107.4*	*59.1*	*105.3*	*103.9*	*79.2*	*55.2*
2008	12164	13068	8008	13386	11804	9544	6269
Total =100	*100.0*	*107.4*	*65.8*	*110.0*	*97.0*	*78.5*	*51.5*
2009	13681	14569	8134	16819	13062	10293	7248
Total =100	*100.0*	*106.5*	*59.5*	*122.9*	*95.5*	*75.2*	*53.0*

Source: GUS 2009b, p. 77, 123; GUS 2011b, p. 90, authors' estimates.

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 major challenge related to pension system is the **long-term adequacy of pensions**. Pension replacement rates will decrease substantially (see Table 7), increasing the risk of poverty in old age, rather low at present.

Table 7: Theoretical pension replacement rates, base case, 2006 and 2046

	2006	2046
Total gross replacement rate	63.2	47.5
Total net replacement rate	77.7	58.7

Source: ISG 2009, p. 79.

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).

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 8) 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 8: 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	30.5	38.1
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)*	*(18.4)*	*(22.0)*	*(25.4)*
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. 7; 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 NSR by 0.6% of GDP in 2011 and by 1.1% of GDP in 2012 (Polish NSR 2011, p. 12).

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 critics of the present "reform of the reform" relies 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 changes are necessary?

- Increasing the retirement age for women and equalising it with the retirement age for men, an issue which had been included in the original reform concept and had emerged several times since the reform, should be approached again with the arguments of improving future adequacy of womens' pensions and improving financial sustainability of the pension system. After that step the legal retirement age should be raised to 67, alongside increasing life expectancy;
- Minimum security in the general system should be improved, to protect future pensioners from poverty in old age;
- The special systems 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 privilegies for minorities are;
- In the second pillar, all the changes which have been discussed for years, should be introduced, including introduction of subfunds, increasing investment options, further lowering the costs;
- 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).

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).

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 will start 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.

Another legal act is still in the legislation process: the law on subsidised medicines (by the NFZ) which should introduce regulated prices: in every pharmacy there will be the same price for the same medicine.

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 personels, mainly nurses**, especially demanding higher earnings. Unlike in previous years, the protests had mainly alocal character.

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 (p. 24) 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 of this development are lower prices in Poland, due especially to lower remuneration of Polish medical staff, with similiar 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 crisis caused however some decrease of visits of foreigners in Polish health care institutions by 10-20%. 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 as an 'export specialisation'.

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 9), much below the EU average.

Table 9: Expenditure on health care, % of GDP, 2006-2008

	2006	2007	2008
Public expenditure	4.33	4.55	5.07
Private expenditure	1.86	1.87	1.94
Total expenditure	6.20	6.43	7.01

Source: GUS 2009a, p.185, GUS 2011, p.192.

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. The author argues 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 in 2009 and 2010**, compared to the positive developments in 2007 and 2008 (see Table 9). It was also caused by the resignation from the earlier government plans to increase the contribution rate for health insurance from 9 to 10 per cent.

Both in 2009 and 2010 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.

Despite heavy critics 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.

Access to health care, quality, health outcomes, inequalities

The World Bank (2010) analysis presents a much more **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).

Results of the analysis presented in the article of Sowa (2010) show that important changes in **utilisation of medical services** took place in Poland. Firstly, despite cost-control health policy utilisation of primary, secondary and hospital services has been growing between 1996 and 2004, with the soundest increase in utilisation of the dentistry. This is a result of growing importance of health in a society with increasing educational and economic aspirations. Secondly, the results show that primary and hospital care are easily accessible to poorer educated, while dentistry is distributed highly unequally and these inequalities are growing. Thus, despite growing utilisation, highly privatised dentistry seems to be less accessible to poorer groups of the society. It could be an evidence of a trend that the higher privatisation level of medical services, the higher is the risk of exclusion of the poorer groups of the society from its utilisation.

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 a recent article of the major Polish daily Golinowska (2011) discusses the government's assumptions of the recent corporatisation reform: increase of efficiency, privatisation, 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 health care transformation in postcommunist Europe wich has involved in practice. He begins by suggesting a theoretical framework for the study of postcommunist 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 critics.

Access to health care, formally equal for all, is a problem for many people expecially 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 2010, out-of-pocket payments amounted to 22.4% of total expenditure on health in Poland in 2008 (positive was their decrease from 28.1% in 2004), compared eg. to 13.0% in Germany or 15.7% in Czech Republic (OECD Health Data 2010). Unlike for pensions, **public expenditure for health care is very 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.

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 changes 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 lives, 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 10.

Table 10: 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 for care
Semi-residential 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 11.

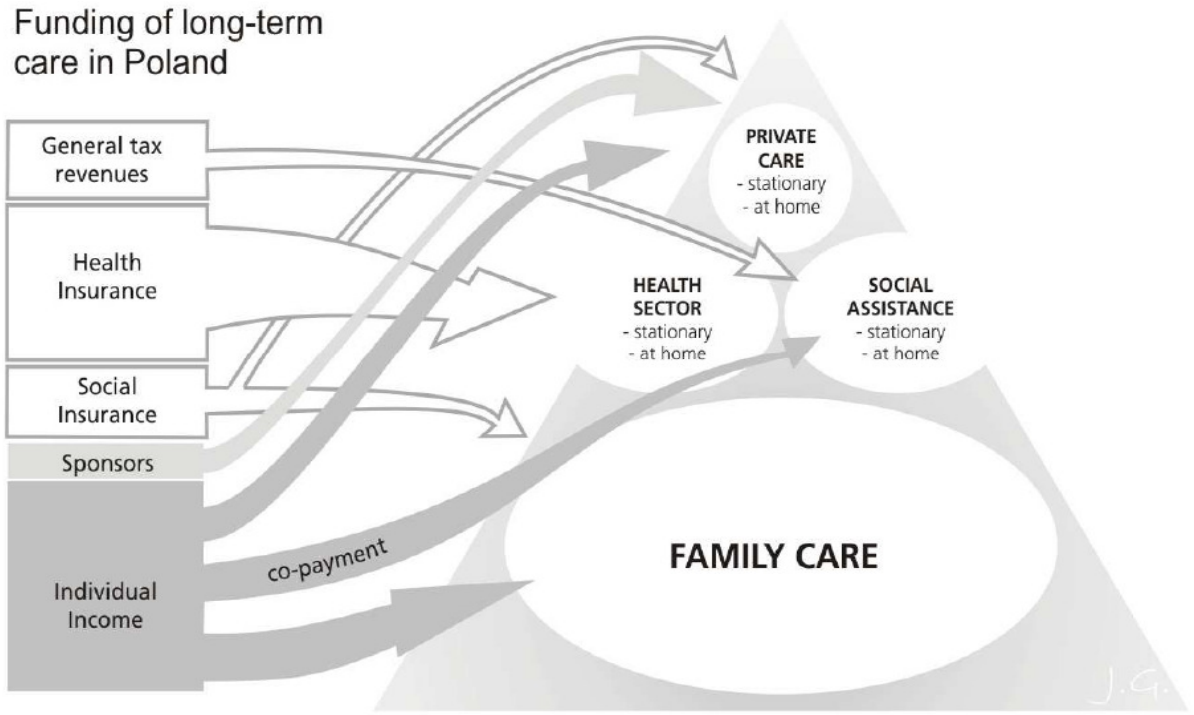
Table 11: Actors and responsibilities in organising and providing of long-term care in Poland

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 cofunding 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 selfgovernment 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 2.

Figure 2: Long-term care funding in Poland



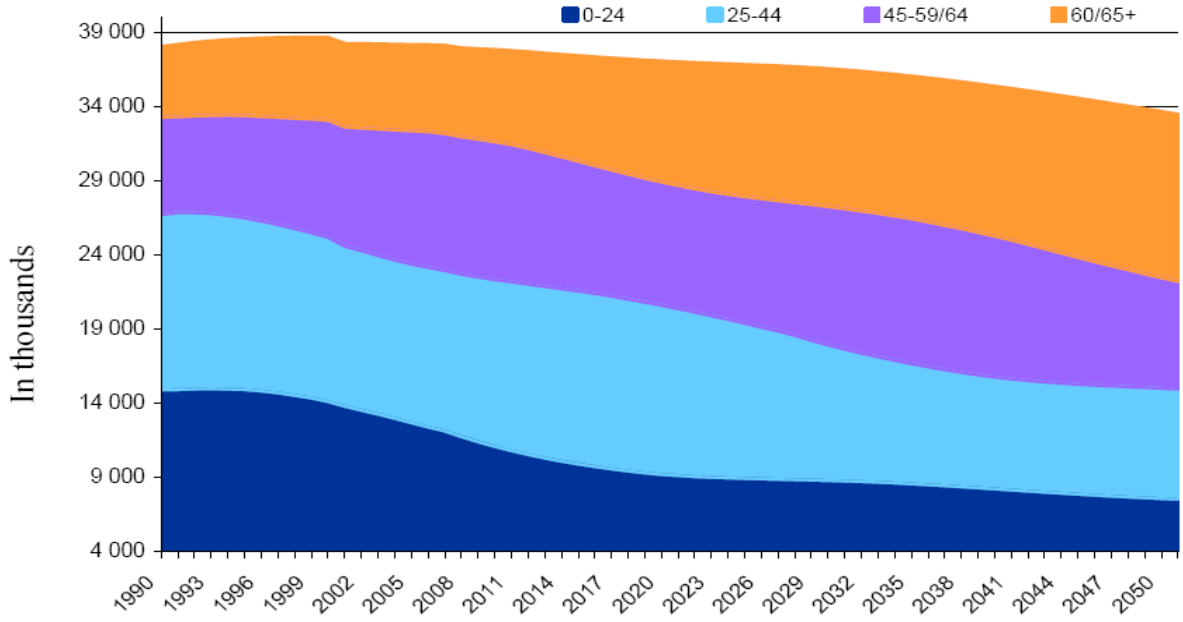
Source: Golinowska 2010, p. 20.

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 3).

Figure 3: 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 desagregation 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**' has been announced (Gazeta Wyborcza, 28.04.2011). 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 start in 2012, although its full implementation would beo of a longer duration.

Two main arguments for the introduction of this new solution have been presented. Firstly, the needs for long-term care will grow due to the rapid ageing of the population (see Figure 3). 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. In the context of public finance problems, however, the implementation of the new solution seems unrealistic.

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.

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 12: 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 	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 changes are necessary?

- In the long-run, introducing a general 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.

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ZUS (2007a), Rocznik Statystyczny Ubezpieczeń Społecznych: System pozarolniczy 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, http://www.zus.pl/files/dane2006.pdf (accessed on 8 May 2011)

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ZUS (2009a), Rocznik Statystyczny Ubezpieczeń Społecznych 2006-2008, Warszawa, Zakład Ubezpieczeń Społecznych.

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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

[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

[R3-R4] BUKOWSKI, Maciej (ed.), Zatrudnienie w Polsce 2008. Praca w cyklu życia, Centrum Rozwoju Zasobów Ludzkich, Warszawa 2010, 206 pp.

"Employment in Poland 2008. Work in the life cycle"

The fourth edition of "Employment in Poland" report, initiated by the Ministry of Labour and Social Policy and prepared by a consortium led by the Centre for Human Resources Development. This issue deals with the problem of employment in the life cycle, which is crucial taking into account demographic changes and ageing of the society. Especially various aspects of employment of older workers are analysed.

Inter alia, positive consequences of equalising the retirement age and raising it to 67 years for both sexes are analysed. Such a reform would compensate to a large extent for the massive withdrawal from the labour markets in the coming years of persons born in the 1950s and the first half of the 1960s. The authors argue for possibly fast increase of retirement age, until 2020. The Empirical analysis of factors influencing employment of older workers shows that longer working life requires investment in health care, health prevention and working conditions, as well as long-term care.

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

"Retirement risks and neglected pattarens 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.

[R2] SZCZEPAŃSKI, Marek, Stymulatory i bariery rozwoju zakładowych systemów emerytalnych na przykładzie Polski, Politechnika Poznańska, Rozprawy nr 447, Wydawnictwo Politechniki Poznańskiej, Poznań 2010, 474 pp.

"Occupational pension scheme development-barriers and drivers. The example of Poland"

The study identifies factors influencing the development of occupational pension schemes in general, with the application to Poland. The analysis shows that the key development barriers for employee pension schemes in Poland involve institutional in nature exogenous factors, non-institutional in nature exogenous factors (primarily macroeconomic determinants) and endogenous factors attributable to the employer. Due to low interest in employee pension schemes among employees, the endogenous factors connected with employees played a lesser role in practice and can be regarded as secondary factors influencing the researched process. Based on the research results, the author argues that popularisation of employee pension schemes requires systemic changes, support of individual employee prudence and both economic and non-economic incentives on the side of employers coming from consistent state policy promoting this form of collective savings for old age.

[H] HealthCare

[H5] KLIMEK, Dariusz, Kontraktowa forma świadczenia pracy w ochronie zdrowia – szansa czy zagrożenie?, Polityka Społeczna 7/2010, pp. 10-15.

"Contract employment in health service - a chance or a danger?"

The number of medical personnel performing contractual work in Poland is steadily growing regardless of the organisational form of health service institutions. The dissemination of this form of work provides both a number of opportunities and threats resulting from the changes

in the fields of: civil liability of a person employed on the basis of the contract, level of remuneration, working hours and legal relationship between the parties. It results from the short balance of opportunities and threats presented in the paper that in the short-term the positive results of the switch from work contract to contracts outweigh the negative ones. In the long-term the predominance of advantages is not so obvious.

[H1, H3] KOLASA, Katarzyna, Zasada równości i sprawiedliwości społecznej a współpłacenie. Analiza porównawcza między Polską a Szwecją, Polityka Społeczna 10/2010, pp. 17-24.

"Principle of equality and equity and out-of-pocket health care payments. A comparative study between Poland and Sweden"

To assess compliance with equity principles with regard to out-of-pocket health care payments (OOP), a comparative study between Poland and Sweden was performed. The patient's perspective was adopted. The study aimed to verify whether the burden of OOP was more equally distributed across households in Sweden than in Poland and whether the financial catastrophe resulting from over-high co-payments in relation to households' budgets affected to greater extend Polish families.

Household Budget Surveys 2003 from Swedish Statistical Office and Polish Statistical Office were utilised. Besides calculation of basic descriptive statistics, Fairness of Financial Contribution and Kakwani index were computed. The catastrophic payment headcount ratio was measured as well.

Although principles of equity and justice are well established in both countries, Sweden adheres to them more thoroughly than Poland with respect to OOPs. In contrast to Sweden, the biggest share of OOP in Poland is spent on pharmaceuticals and medical devices. Conclusions: In Poland, the introduction of OOP for the public health care services is abandoned because of equity principle. The study indicates that the rapid development of modern private market of health care services, where private provides regulate OOP, and constant deterioration of the public system in Poland lead to excessive consumption of drugs and private services.

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

"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.

[H3] SOWA, Agnieszka, O nierównościach w korzystaniu z usług ochrony zdrowia ze względu na wykształcenie, Polityka Społeczna 9/2010, pp. 33-36.

"On educational inequalities in medical services utilisation"

Results of the analysis presented in the article show that important changes in utilisation of medical services took place in Poland. Firstly, despite cost-control health policy utilisation of primary, secondary and hospital services has been growing between 1996 and 2004, with the most sound increase in utilisation of the dentistry. This is a result of growing importance of health in a society with increasing educational and economic aspirations. Secondly, the results show that primary and hospital care are easily accessible to poorer educated, while dentistry is distributed highly unequally and these inequalities are growing. Thus, despite growing utilisation, highly privatised dentistry seems to be less accessible to poorer groups of the society. It could be an evidence of a trend that the higher privatisation level of medical services, the higher is a risk of exclusion of the poorer groups of the society from its utilisation.

[H4] 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 a 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.

[L] Long-term care

[L] AUGUSTYN, Mieczysław (ed.), Opieka długoterminowa w Polsce. Opis, diagnoza, rekomendacje, Grupa robocza ds. przygotowania ustawy o ubezpieczeniu od ryzyka niesamodzielności przy Klubie Senatorów Platformy Obywatelskiej, Klub Parlamentarny Platformy Obywatelskiej RP, Warszawa 2010, 191 pp.

"Long-term care in Poland. Description, diagnosis, recommendations"

A green paper, written by a team of experts, prepared within Parliamentary works on a new law on long-term care insurance by the ruling party in Poland – Civic Platform, edited by the member of Senate (the upper chamber of Polish parliament) Mieczysław Augustyn.

The is the most comprehensive recent analysis of the current situation and challenges of the long-term care. On this background, a proposal is made to introduce in longer term a long-term care insurance in Poland.

[L] BIELAK, Marta, Badania jakościowe nad środowiskiem zamieszkania w domach opieki społecznej dla ludzi starszych. Wybrane przykłady, Wydawnictwo Politechniki Śląskiej, Gliwice 2010.

"Quality assessment of living environment in social housing for the elderly people. Selected examples".

The scope of the study, of an architect, was to address the question: "How should the housing environment for the elderly be created to ensure, as well as possible, the satisfaction of their individual needs?" The main part of the study contains a report of the author's own studies conducted on some selected currently functioning nursing facilities in Poland and in the USA. The conclusions may constitute an important component useful in the creation of a good functional and spatial programme for such type of facilities.

[L] GOLINOWSKA, Stanisława, The system of long-term care in Poland, CASE Network Studies & Analyses No. 416/2010, 37 pp.

The study describes the present system of long-term care in Poland, family-based, highly unregulated and disintegrated between social assistance and health care services. It is the health sector that concentrates policy debate with a proposal of an introduction of nursing insurance. Provision of public services is insufficient and a market of private services, paid out-of-pocket rapidly develops. It seems that the main problems of the long-term development in the future will be raising demand against insufficient resources and diversified priorities of the health care system.

[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.

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 fourty 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 – Ministy 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.

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(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