Analytical support on social protection reforms and their socio-economic impact

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# Pensions, health and long-term care

## Poland

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# 1 Executive Summary

In the pension system, on 1 January 2013 the gradual increasing of the retirement age for both sexes started, till now at the level of 60 for women and 65 for men. The retirement age will be raised each year by three months, to reach the target age of 67 in 2020 for men and in 2040 for women.

Also on 1 January 2013, the retirement age for the uniformed services (soldiers, policemen etc.) was raised. Now, the pension will be available for persons over 55 years of age with at least 25 years of service (in the old system: after 15 years of service, without any age limit).

In 2013, the debate on the structure of the general pension system in Poland continued and reached its peak in summer. A deep change in the structure of the general pension system in Poland is planned. After a short debate on a government report presented in the end of June, in September 2013 the following government plans were presented:

- Government bonds will be transferred from OFE to ZUS;
- Every participant of the pension system must declare if he/she wants to pay part of his/her pension contribution to OFE (decreased to 2.92%), otherwise his/her whole contribution will be paid to ZUS;
- The management cost will be cut in half for both OFE and ZUS;
- OFE investment policy will be liberalised and benchmark abolished;
- A "safety zipper" will be introduced, i.e. a gradual transfer of OFE assets to a sub-account in ZUS in the period of 10 years before retirement.

The implementation of the present proposals would be a departure from some basic ideas of the structural pension reform, especially of better balancing pay-as-you-go with funding and private with public management of pension systems. The changes will have positive impact on public finances in the short run and a rather negative impact on the pension system in the long run. The implementation of these proposals would lead to the marginalisation of the open pension funds, and later to their disappearance.

In the health care, unlike in previous years, no major reform was introduced. On 1 January 2013 an important innovation started: the electronic verification of beneficiaries' rights *(Elektroniczna Weryfikacja Uprawnień Świadczeniobiorców, short: eWUŚ)*. The system allows an immediate verification whether the person is entitled to benefits financed from public means, on the basis of his/her personal identification number *(PESEL).*

In spring 2013 plans to decentralize the health care system have been announced in media. The central National Health Fund should be dismantled and the regional National Health Funds should be given autonomy. Local self-governments should receive direct influence on functioning of health care in their region. Instead of the central NFZ, a new office should be created – Office of Health Insurance, which should be responsible for valuation of medical services and for the quality assessment of hospitals and health centres. The plans have remained at a very general level and no draft law has been prepared.

No major reforms have been implemented in the long-term care in Poland in recent years. 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 Pensions

## 2.1 System description

### 2.1.1 Major reforms that shaped the current system

In Poland, after several years of discussions on pension reform, the reform concept *„Security through Diversity"* (Office of the Government Plenipotentiary for Social Security Reform 1997) was to a large extent implemented. The new system came on 1 January 1999 in force. Several reasons can be pointed out which enabled such a structural change in the old age security system. The first was the critique of the old system, the second one: the reform concept and, finally, an appropriate organisation of the work on the reform, including political consensus.

The main objectives of the reform were both microeconomic and macroeconomic. The first microeconomic concern was to create a far tighter link between contributions and pensions, thus strengthening the incentive to work and the disincentive to evade. The other microeconomic objective was to lower – in the longer term – social insurance contributions paid by the employer, in order to reduce labour costs and to increase employment. The key macroeconomic aim was to lower the level of public expenditures on pensions, as a proportion of the GDP, to relieve public finance for other aims towards growth. The other aim was to induce people to save more voluntarily.

### 2.1.2 System characteristics

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

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

The statutory pension system is financed by the old-age pension contributions (the contribution rate is equal to 19.52% of gross salary), for employees paid in equal shares by them and their employers. The contribution is collected by ZUS and divided into the contribution for the 'first pillar' (NDC pensions) and for the 'second pillar' (OFE). Since May

2011, the contribution rate for OFE is 2.3% (and thus the pay-as-you-go part 17.22%). The only eligibility condition is the standard retirement age, 60 for women and 65 for men, there is no minimum insurance period. Extensive early retirement possibilities were abolished and replaced since 2009 by bridging pensions – a temporary solution for some categories of workers.

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

Pension payments are adjusted annually according to the consumer price index of the households of pensioners (or the general consumer price index, if it is higher than the index for the households of pensioners), increased by at least 20% of real growth of average earnings in the previous year. On 1 March 2012 all current pensions were increased by a lump-sum of 71 Zloty. This one-off change in the indexation rules was explained by the government with the objective to strengthen protection of pensioners with lower income. For the indexation on 1 March 2013 the indexation rate was 104%.

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

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

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

### 2.1.3 Details on recent reforms

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

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

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

The discussions continued in 2011 with clear polarisation of positions. Most economists criticised the proposal as a step to 'rescue' the present public finances at the costs of further 'generations' or at least governments and 'dismantling' the pension system and pension

reform started in 1999, based on a broad consensus. The government was successful in passing the law in Parliament. From 1 May 2011 contribution rate to the 'second pillar' is 2.3% instead of 7.3% and the contribution rate to the 'first pillar' is 17.22% instead of 17.22%.

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

After the Parliamentary elections in October 2011, the new government backed by the same Parliamentary coalition and led by the same prime minister announced plans to increase the statutory retirement age. Starting in 2013, the statutory retirement age should be raised by four months every year, reaching 67 years for both ages, in 2020 for men and in 2040 for women. Despite the large political resistance, especially organised by trade unions, the government has been successful to pass the act through Sejm (on 11 May 2012) and Senate (on 24 May 2012). On 1 June 2012 the President signed the law and the process of gradual increase of the retirement age started on 1 January 2013.

Some progress was also made at the same time in raising the retirement age for the uniformed services (soldiers, policemen etc.). Now, the pension will be available for persons over 55 years of age with at least 25 years of service (in the old system: after 15 years of service, without any age limit). This change should be described as extremely modest, only slightly restricting the privileges of those groups.

## 2.2 Assessment of strengths and weaknesses

### 2.2.1 Adequacy

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

According to the Eurostat statistics for 2011 (Eurostat database, retrieved on 14 October), at present the adequacy of the Polish pensions is above the EU-average for most indicators.

The at-risk-of-poverty rate for people aged 65 and more was 14.7% in Poland, compared with 15.9% for the EU-27 (Table 1). For people aged 75 and more it was 11.8% in Poland, compared with 17.9% in EU-27. The rate was much lower in Poland for older people than for people aged 0-64 (18.1%).

Table 1: At-risk-of-poverty rate of older people by gender, Poland and EU-27, 2006-2011, in %

| | | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|
| Poland | total | 7.8 | 7.8 | 11.7 | 14.4 | 14.2 | 14.7 |
| | males | 5.7 | 5.6 | 8.9 | 10.9 | 9.9 | 10.2 |
| | females | 9.1 | 9.2 | 13.4 | 16.5 | 16.8 | 17.4 |
| EU-27 | total | 19.0 | 18.4 | 19.0 | 18.0 | 16.0 | 15.9 |
| | males | 16.1 | 15.3 | 15.7 | 15.0 | 12.9 | 13.2 |
| | females | 21.1 | 20.7 | 21.4 | 20.3 | 18.3 | 18.0 |

Source: Eurostat database, retrieved on 14 October 2013.

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 2006 and 2011 and the difference between Poland and the EU average has been reduced substantially (see Table 1). The minimum protection seems insufficient to protect this group from fast deterioration of income position. Especially the situation of former disability pension recipients has deteriorated.

A challenge has been in Poland an insufficient poverty protection of women in old age – the difference between pension adequacy for men and women is in Poland even bigger than in the EU-27 (see Table 1).

Due to the redistributive nature of the old system and weaker contribution-benefit link, shorter careers or low income have not led to lower pension adequacy. Due especially to special allowance for those above 75, older old people have been even better protected (the at-risk-of-poverty rate was 11.8% for people 75+ compared with 14.7% for people 65+).

Median relative income of people 65+ as a ratio of income of people 0-64 was in Poland higher than in EU-27: 94% compared with 89%. The same was true for the aggregate replacement ratio, i.e. the ratio of the median individual gross pensions of 65-74 age category relative to median individual gross earnings of 50-59 age category: 55% in Poland and 54% in EU-27.

Thus, all current relative adequacy indicators for people aged 65 and more indicate that the old pension system in Poland has been successful in protecting pensioners from poverty and in guaranteeing a relatively high income replacement. This results from the old system's features: defined-benefit, social lump-sum part of every pension, pensions based on best earnings, redistributive pension formula. As a result, income distribution has been in Poland much more equal for those above 65 than for the whole population (3.5 compared to 5.0). Another reason for a relatively high pension adequacy in Poland at present has been the universal coverage in the past and no breaks in coverage/employment due to full employment and non-existence of open unemployment in the communist period, when most entitlements to current pensions had been earned.

As the income level in Poland is much lower than in the EU, especially in the old Member States, people at risk of poverty in Poland enjoy a much lower standard of living than their counterparts in other countries. This also leads to the conclusion that a relative measure of social exclusion has its limits and as such should be enriched by other indicators, like material deprivation rate.

Material deprivation rate is much higher in Poland than in the EU-27, but it has decreased substantially between 2006 and 2011 (Table 2). The improvement can be explained by rising income and improvement of living standards. The crisis has slowed down the economic growth, but Poland has avoided recession and the convergence towards EU has continued.

Table 2: Material deprivation rate of older people (65 years+), Poland and EU-27, 2006-2011 (%)

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|
| Poland | 47.1 | 40.6 | 38.6 | 33.8 | 32.3 | 30.1 |
| EU-27 | 17.1 | 16.3 | 15.4 | 14.3 | 14.1 | 15.1 |

Source: Eurostat database, retrieved on 14 October 2013.

Thus, relatively high income of the elderly in Poland does not mean that Polish pensioners enjoy wealth. Not only because of the generally low income level in Poland as compared with

the old Member States, but also because of a worse access to and quality of other goods and services influencing the living standard, like housing, transport, health care, long-term care etc.

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

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

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

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

- the pension entitlement will be based on life-time earnings while it was the best earnings in the old system;
- the new pension system is a DC (NDC) one, thus life expectancy is fully taken into account, putting the longevity risk fully onto the individual.

The increase of statutory retirement age to 67 will have a positive impact on future replacement rates, especially for women.

Labour market participation changes have resulted clearly from economic growth. It was high until 2008, in 2010 and 2011 and considerably lower in 2009 and 2012 (real GDP growth rates were 6.8% in 2007, 5.1% in 2008, 1.6% in 2009, 3.9% in 2010, 4.5% in 2011 and 1.9% in 2012). The overall employment rate (20-64) increased during the high growth period, from 60.1% in 2006 to 65.0% in 2008, but decreased slightly as a result of slower growth to 64.7% in 2012 (Eurostat database, access on 14 October 2013).

The average employment (mainly contributory) period of persons who were granted retirement pensions decreased from 35.1 years in 2007 to 33.7 years in 2012. This resulted from a substantial decrease of the average employment period of men and a slight increase of the average employment period of women (Table 3). This is a result of a transition from a full employment period of the former system of the centrally planned economy to the market economy with unemployment and flexibility of employment careers. Decreasing contributory periods, especially in a DC system like the Polish one, will lead to lower pensions.

Table 3: Average employment period of persons who were granted retirement pensions, 2007-2012

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|
| Total | 35.1 | 37.4 | 36.6 | 35.3 | 34.3 | 33.7 |
| Men | 38.7 | 40.6 | 38.9 | 35.5 | 34.2 | 33.4 |
| Women | 33.3 | 32.9 | 34.8 | 34.9 | 34.8 | 34.7 |

Source: ZUS 2008, p. 34; ZUS 2009b, p. 32; ZUS 2010, p. 32; ZUS 2011, p. 32; ZUS 2012b, p. 33; ZUS 2013a, p. 33.

### 2.2.2. Sustainability

Poland still has at present a relatively young population – old age dependency ratio (20-64) in Poland was 20.90% in 2010, the second lowest in the EU after Slovakia and much lower than the EU-27 average of 28.35% (Annex, table 3). This has two reasons from the past: high fertility and low life expectancy. In 1983, the peak of the second post-war baby boom, 723.6 thousand children were born and the total fertility rate was clearly above 2 (GUS 2012a, p. 28, 279). The second reason was low life expectancy, stagnant in Poland until the end of communism, since 1960s for men and since 1970s for women – one of important indicators of the communist system's failure.

But ageing of population is underway in Poland due to decreased fertility and growing life expectancy. In 2003 only 351.1 thousand children were born, only a half of the level 30 years earlier, and the total fertility rate dropped from 2.276 in 1980 to 1.297 in 2011 (GUS 2012a, p. 30, 279). Life expectancy started to grow again after 1990: life expectancy at birth grew for men from 66.23 years in 1990 to 72.44 years in 2011, and for women from 75.24 years in 1990 to 80.9 years in 2011. Also life expectancy at 65 grew clearly, reaching in 2010 14.8 years for men and 19.1 years for women (GUS 2012a, p. 404).

Demographic projections show that the age composition of the population in Poland will change dramatically and Poland is going to have one of the oldest populations in Europe in 2060. Projected life expectancy at birth in 2060 should be in Poland much closer to the EU average than at present, at 82.4 years for men and 87.9 years for women. Projected life expectancy at 65 should grow to 21.2 years for men and 24.8 years for women in 2060 (Annex, table 5). Growing life expectancy and low fertility rate will lead to a higher old-age dependency ratio, projected (for 20-64) at 70.5 in 2060, the highest in EU-27 (Annex, table 3).

Thus, the demographic development in Poland will create a heavy challenge for the financial sustainability of the pension system. This was one of the reasons of the structural pension reform which started in 1999. However, the reform itself contributed to the financial problems.

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 (Table 4) 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, 2012).

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 decreased the subsidy to cover the deficit resulting from directing contributions to open pension funds (Table 4).

Table 4: Sources of revenues of the Social Insurance Fund 1999-2012, in billion PLN

| | 1999 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|
| Total revenues<br>*= 100 %* | 73.7<br>*(100.0)* | 129.6<br>*(100.0)* | 136.1<br>*(100.0)* | 138.4<br>*(100.0)* | 150.1<br>*(100.0)* | 155.8<br>*(100.0)* | 172.0<br>*(100.0)* |
| Social insurance contributions<br>*(as % of total revenues)* | 63.7<br>*(86.5)* | 88.4<br>*(68.2)* | 81.6<br>*(60.0)* | 85.3<br>*(61.7)* | 89.0<br>*(59.3)* | 101.5<br>*(65.2)* | 121.1<br>*(70.4)* |
| State budget subsidies not related to pension funds<br>*(as % of total revenues)* | 7.2<br>*(9.8)* | 23.9<br>*(18.4)* | 33.2<br>*(24.4)* | 30.5<br>*(22.0)* | 38.1<br>*(25.4)* | 37.5<br>*(24.1)* | 39.5<br>*(23.0)* |
| Subsidy to cover the deficit resulting from directing contributions to pension funds<br>*(as % of total revenues)* | 2.3<br>*(3.1)* | 16.2<br>*(12.5)* | 19.9<br>*(14.6)* | 21.1<br>*(15.2)* | 22.3<br>*(14.9)* | 15.4<br>*(9.9)* | 8.2<br>*(4.8)* |
| Other revenues<br>*as % of total revenues* | 0.5<br>*(0.7)* | 1.1<br>*(0.9)* | 1.3<br>*(1.0)* | 1.5<br>*(1.1)* | 0.7<br>*(0.5)* | 1.3<br>*(0.9)* | 3.2<br>*(1.9)* |

Source: ZUS 2004, p. 13; ZUS 2009a, p. 18; ZUS 2012a, p. 21; ZUS 2013a, p. 8; authors' estimates.

Despite the decrease of subsidies related to the 'second pillar" in 2011, the forecast done by the Social Insurance Institution (ZUS) in 2013 shows that the pension system will remain in deficit until 2060 and the deficit will grow (ZUS 2013b). Further changes concerning the open pension funds have been proposed (see section 2.3).
Labour market participation of the elderly had been traditionally very low in Poland, due to low retirement age and many early retirement possibilities, but it has increased recently.

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 earlier, the 'new old' government finally has taken up the issue and seems committed to raise the statutory retirement age, starting in 2013, by four months every year, reaching 67 years for both ages, in 2020 for men and in 2040 for women.

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

Even before the restrictions of early retirement and the Programme 50+ came into effect in 2009, the effective retirement age had started to rise in Poland, due to very positive development on the labour market. The average age of a 'new' retiree increased from 57.1 years in 2007 to 59.9 years in 2012 (Table 5).

Table 5: Average age of persons who were granted retirement pensions, 2007-2012

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|
| Total | 57.1 | 59.0 | 59.3 | 59.6 | 59.8 | 59.9 |
| Men | 59.7 | 61.1 | 61.0 | 60.2 | 60.1 | 60.2 |
| Women | 55.8 | 56.2 | 57.8 | 59.0 | 59.5 | 59.5 |

Source: ZUS 2009a, p. 43; ZUS 2012a, p. 46; ZUS 2013a, p. 30.

Employment rate of those aged 55 to 64 increased from 29.7% in 2007 to 38.7% in 2012 (Table 6), still one of the lowest in the EU. The increase was mainly the result of economic growth. Employment rate of older workers rose recently even though for the entire population it decreased slightly due to slower growth (see section 2.2.1). This is because the crisis hits younger people on the labour market and older workers are relatively protected.

Table 6: Employment rates of older workers (55-64), 2007-2012, in %

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|
| Total | 29.7 | 31.6 | 32.3 | 34.1 | 36.9 | 38.7 |
| Men | 41.4 | 44.1 | 44.3 | 45.2 | 47.8 | 49.3 |
| Women | 19.4 | 20.7 | 21.9 | 24.2 | 27.2 | 29.2 |

Source: Eurostat database, retrieved on 14 October 2013.

The main reason of the low employment rates of older people had been the early retirement rules, inherited from the old system. The early retirement possibilities were finally restricted in 2009, with effect from 1 January 2009. The positive impact of the new law may be illustrated by the number of newly granted old-age pensions which decreased from 341 thousand in 2008 to 243 thousand in 2009 and 92 thousand in 2010 (ZUS 2011, p. 26).

### 2.2.3 Private pensions

In the present pension system in Poland, the second pillar consists of privately managed open pension funds. As this is however an obligatory part of the statutory pension system, it has been covered in previous sections. This part concerns only the additional voluntary pension solutions.

Complementary private savings, among them the ‘employee pension programmes’ (*pracownicze programy emerytalne*, PPE) - occupational pension schemes or ‘individual retirement accounts’ (*indywidualne konta emerytalne*, IKE) constitute the voluntary ‘third pillar’. The coverage of the ‘third pillar’ has remained very low, for example in 2012 less than 4% of the employees belonged to occupational pension schemes and 5.2% of economically active persons had an individual retirement account, but only one third of those accounts were active (with payments made). The catalogue of forms of additional voluntary savings in the third ‘pillar’ of the pension system was expanded. In addition to the already existing PPE and IKE, individual accounts for pension insurance (IKZE) may be offered from 1 January 2012. The new form is exempt from income tax to a certain level. The start of the new accounts was again disappointing. During the first year of operation – 2012, only 32.8 thousand active accounts were opened (with payments made), with only about 31.9 million zloty paid (Polish Financial Supervision Authority 2013).

### 2.2.4 Summary

At present, adequacy of pensions is the major strength of the pension system in Poland. But the future adequacy of pensions from the new defined-contribution system is a real challenge, not really approached yet.

Sustainability is a real problem, now and in the future.

The government has decided to introduce changes which would lead to an end of the funded part of the general pension system (see section 2.3). Little has been done, unfortunately, to improve the sustainability of the pension system. The EU recommendations for Poland concerning the pension system have not been implemented.

In the fourth CSR 2012 for Poland, the EU recommended to „reinforce efforts to increase the labour market participation of women and raise enrolment rates of children in both early childcare and pre-school education, by ensuring stable funding and investment in public infrastructure, the provision of qualified staff and affordable access. Tackle entrenched practices of early retirement to increase exit ages from the labour market. Phase out the special pension scheme for miners with a view to integrating them into the general scheme. Take more ambitious, permanent steps to reform the social security fund for farmers (KRUS) to better reflect individual incomes". In the following, only the recommendations concerning older workers and social protection will be analyzed. Both direct recommendations have not been implemented.

Reform of the miners' pension system has not been implemented. The government seems to avoid solving this issue for political reasons. Some economists, among them the former deputy Prime Minister Professor Balcerowicz, argue that the government should make reforms to cut privileges financed from general taxes. The list of such necessary changes, postponed by the government for political reasons, includes the miners' pensions, pensions for unifomed services, reform of KRUS and some others. It is argued that instead of such necessary reforms, the government is going to "improve" public finances through taking over of money accumulated in open pension funds (see further below). The KRUS reform seems to be a "never ending story". A serious reform has been blocked by the smaller coalition party *Polskie Stronnictwo Ludowe* (Polish People's Party), ruling with the *Platforma Obywatelska* (Civic Platform) since 2007.

Restricting access to early retirement was done in 2008. Only some restricted categories of workers who have worked under special (difficult) conditions have been given a compensation in form of bridging pensions, starting in 2009 (Zieleniecki 2011). This does not mean however that early exit from the labour market disappeared from Poland at all. During negotiations within the ruling coalition of both parties, as a compromise a possibility of (earlier) partial retirement pension was introduced. Such a retirement pension will be calculated from the half of accumulated "pension capital" and will be available for women from 62 and men from 65 years of age, provided they have accumulated 35 (women) or 40 (men) years of insurance. After reaching the statutory retirement age, "normal" retirement pension will be granted, based on the "pension capital" accumulated, with deduction of the part already "consumed". Some commentators see this solution as a positive security measure for the new higher retirement age and point to the fact that the partial pension will not be very popular, as it will be much lower than the regular pension. Still, others are afraid that this solution will consume a large part of benefits from raising the statutory retirement age.

## 2.3 Reform debates

In **2013**, the debate on the structure of the general pension system in Poland continued and reached its peak in the summer. A deep change in the structure of the general pension system in Poland is planned.

On 26 June 2013 the Report "*Overview of pension system functioning. Security through balancing"* was presented jointly by the Minister of Labour and Social Policy and the Minister of Finance (Report 2013). It was named an overview of pension system functioning. On 147 pages, almost exclusively the functioning of the second pillar (open pension funds, OFE) was analysed. From 9 change options which were analysed according to the Report, six were **rejected**:

- gradual phasing out of the funded pillar;
- closing down of the funded pillar;
- no changes at all;
- temporary suspension of contributions to the second pillar;
- return to previous contribution rate to OFE at 7.3%;
- programmed withdrawal instead of annuity from OFE.

The ministers recommended for debate the three proposals:

- abolishing of the part of second pillar with investment in government bonds;
- optional membership in the second pillar;
- optional membership in the second pillar with an additional contribution.

After presenting the Report in the end of June, an intensive debate started. It included three debates organised by the Ministry of Labour and Social Policy (on 4, 18 and 22 July) with experts and representatives of social partners. The issue became one of the hottest topics in media, with articles and discussions in the largest Polish newspapers.

There was a large polarization of opinions. Most representatives and supporters of trade unions and many socially oriented journalists and experts supported the changes, on the base of sharp criticism of pension funds. Most pension experts, economists and representatives of employers criticised the Report.

I was also highly critical of the Report, because:

1. Contrary to the title, this was not an overview of pension system's functioning. The Report was almost exclusively devoted to open pension funds (OFE). Other issues, both of the general pension system (ZUS) and of separate schemes (individual farmers, uniformed services) were completely absent or just mentioned;
2. The diagnosis of OFE was very biased, based on questionable or false premises. The Report was written with the thesis of harmfulness of OFE, especially for public finances;
3. Thus, all three proposed options should not be accepted. They are dangerous and may lead to consequences contrary to the subtitle: lowering security through increasing imbalance of the pension system;
4. The real objective of all proposed changes is lowering of public debt related to transfers to OFE. Thus, short-term fiscal objectives of the Ministry of Finance are a top priority. Proposed changes, although not including abolishing OFE directly, would lead to their marginalisation, and later disappearance;
5. The Report did not deal with issues which should be included in pension system reforms, both in the first and second pillars of the general system and in separate schemes.

On 4 September 2013 a joint press conference of the Minister of Finance and the Minister of Labour and Social Policy was held, at which conclusions from the debate and government's proposals were presented. On 5 September 2013 these proposals were discussed by the government.

According to the government's plans:

- Government bonds will be transferred from OFE to ZUS;

- Every participant of the pension system must declare if he/she wants to pay part of his/her pension contribution to OFE (2.92%), otherwise his/her whole contribution will be paid to ZUS;
- The management cost will be cut in half for both OFE and ZUS;
- OFE investment policy will be liberalised and benchmark abolished;
- A "safety zipper" will be introduced, i.e. gradual transfer of OFE assets to a sub-account in ZUS in the period of 10 years before retirement.

The implementation of the present proposals would be a departure from some basic ideas of the structural reform, especially of better balancing pay-as-you-go with funding and private with public management of pension systems. The changes will have positive impact on public finances in the short run and rather negative impact on the pension system in the long run. Thus, typically, the short perspective wins over longer perspective. The government's argumentation that OFE are the only problem of the Polish pension system and that only pay-as-you-go financing brings security of pensions are a very short-sighted policy.

It seems very likely that the government will be successful in implementing these plans. The government has the necessary majority in the Parliament, and there is no political opposition to these plans. The criticism comes from media and experts, especially economists, without any serious political support.

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

Despite plans announced already before the major pension reform which started in 1999, benefit rules **for disability pensions have not** been adjusted to the retirement pension formula. This should be done to close an alternative pathway to early retirement if future retirement pensions are lower than disability pensions.

# 3 Health care

## 3.1 System description

### 3.1.1 Major reforms that shaped the current system

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 basic law for health care in Poland is the law on health benefits financed from public means *(Ustawa o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych)* of 27 August 2004.

### 3.1.2 System characteristics

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

The main source of health care financing are insurance contributions. There is a general health insurance system, covering all categories of employees, including individual farmers, civil servants and others, beneficiaries of social security benefits, unemployed, and students. Also dependant family members are covered: spouse, children up to the age of 18 (26 for full- time students), parents living in the insured person's household (unless they are personally insured and therefore not dependent on the insured person). 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.

Doctors are contracted by a regional National Health Fund. Every doctor is paid a fixed amount for every patient that is registered with him/her, regardless of how many times that patient visits the doctor. Fees are set up by negotiations between doctors and the regional National Health Fund.

Public and private hospitals are contracted by a regional National Health Fund. There is reimbursement of the costs of medicines and benefits in kind by the National Health Fund according to the one-year-contracts concluded with public and private benefit providers.

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 2012 for the legal situation in 2012).

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. There is free choice of and direct access to certain specialists (e.g. gynaecologists, dermatologists, psychiatrists, oncologists) working in contracted health centres. In other cases a referral from the general practitioner is necessary.

There are no patient charges for medical treatment by general practitioners, specialists or in hospitals. Official list of medicines divides pharmaceuticals into 3 categories: basic medicines with a fixed price of PLN 3.25 or PLN 5.00 determined by the Minister of Health, special additional medicines: 30% to 50% of price paid by the insured person and other medicines: 100% of the price paid by the insured person.

### 3.1.3 Details on recent reforms

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 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.

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.

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

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

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

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

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

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

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

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

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

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

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

An important innovation started on 1 January 2013. The electronic verification of beneficiaries' rights *(Elektroniczna Weryfikacja Uprawnień Świadczeniobiorców, short: eWUŚ)* is a system which allows an immediate verification whether the person is entitled to benefits financed from public means, on the basis of his/her personal identification number *(PESEL)*. In the first months of the new system many problems have been reported, mainly related to transport of data between institutions gathering data on insurance status, like ZUS, KRUS, universities etc. The problems seem to have been solved.

## 3.2 Assessment of strengths and weaknesses

### 3.2.1 Coverage and access to services

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

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

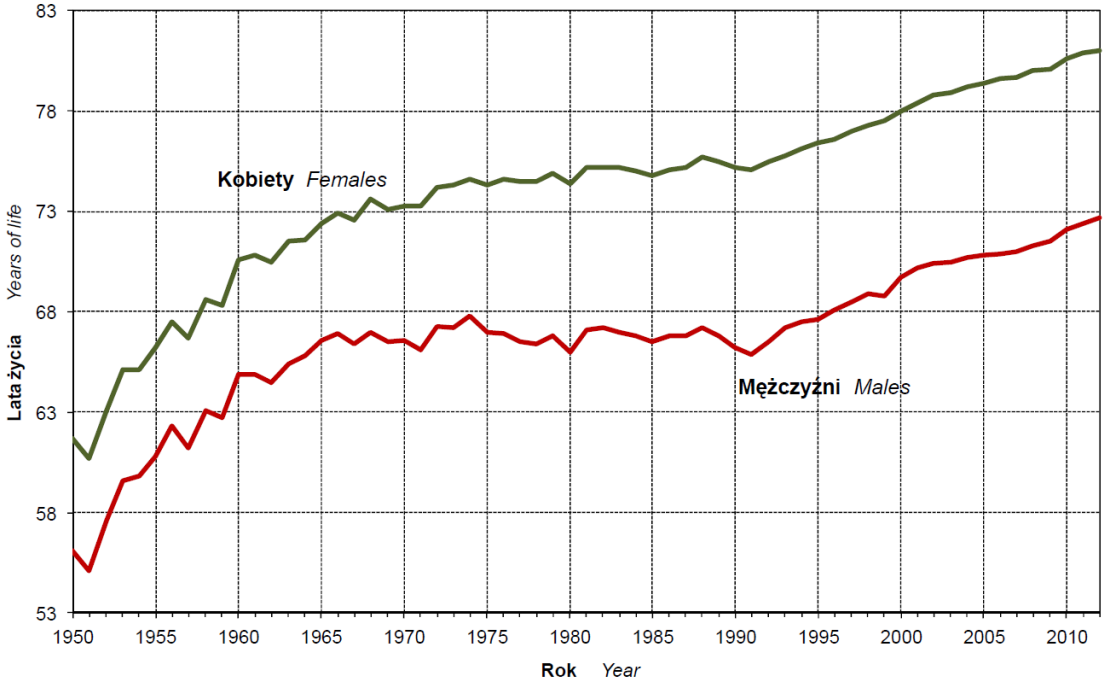
There are however concerns that the new law on corporatisation of hospitals will increase inequalities in access to health care.

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

The experience of the two and half years between July 2011 and October 2013 has been however rather positive and no negative consequences of corporatisation of public hospitals have been reported. In this period 34 hospitals were transferred into corporate units - 1 in 2011, 13 in 2012 and 20 in 2013 (Ministry of Health 2013). To understand the numbers – on 31 December 2011 there were 853 general hospitals in Poland (GUS 2012c, p. 232).

Life expectancy is growing in Poland since the start of transition, after more than twenty years of stagnation in the last period of the communist Poland (figure 1). This is presented here as a general indicator of improvement in health status, attributed to many factors, health care playing only a role in this process.

Figure 1: Life expectancy at birth in Poland, 1950-2012




Source: GUS 2013b, p. 19.

### 3.2.2 Quality and performance indicators

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, anaesthesiology 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).

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).

### 3.2.3 Sustainability

Table 7 presents the most recent data, published on 23 July 2013, on expenditure on health care in 2010 and 2011, based on National Health Accounts.

Current private expenditure on health care remained on a similar level in relation to GDP in 2010 and 2011 (1.85% and 1.86% of GDP respectively). Public current expenditure decreased in the same period from 4.69% to 4.53% of GDP.

Unlike for pensions, public expenditure for health care is low in Poland in terms of GDP share. Health care clearly needs more public financing. Decreasing economic growth, as a result of the financial crisis clearly worsened the financial situation of the health care system.

Table 7: Expenditure on health care in Poland in 2010 and 2011

| Specification | 2010 | | 2011 | |
|---|---|---|---|---|
| | Mio. PLN | % GDP | Mio. PLN | % GDP |
| **Gross domestic product** | **1 416 585** | **100,00** | **1 528 127** | **100,00** |
| **Current public expenditure** | **66 500** | **4.69** | **69 224** | **4.53** |
| *of which* State budget expenditure | 1 880 | 0.13 | 1 973 | 0.13 |
| Local self-government budget expenditure | 3 547 | 0.25 | 4 220 | 0.28 |
| Social security funds | 61 074 | 4.31 | 63 031 | 4.12 |
| **Current private expenditure** | **26 274** | **1.85** | **28 450** | **1.86** |
| *of which* Private households out-of-pocket expenditure | 22 001 | 1.55 | 23 397 | 1.53 |
| Other private expenditure | 4 273 | 0.30 | 5 052 | 0.33 |
| **Total current expenditure** | **92 775** | **6.55** | **97 673** | **6.39** |
| Capital formation | 6 710 | 0.47 | 7 323 | 0.48 |
| **Total health care expenditure** | **99 485** | **7.02** | **104 997** | **6.87** |

Source: GUS 2013a, p. 2.

Private financing is relatively high in Polish health care. Out-of-pocket payments accounted for 22.3% of total expenditure on health care in 2011 (Table 7). This share belongs to the highest among the OECD countries. In 2011 the OECD average was 19.6%, and in many EU countries much lower, e.g. in UK 9.9%, Germany 13.2%, Czech Republic 14.7% (OECD 2013). The high share of out-of-pocket payments in Poland results from an insufficient public expenditure. Positive is however the decrease of this share: in 1998 it was as high as 34.6% (OECD 2013).

Health care workforce density per 1000 population is lower in Poland than in OECD average (OECD 2013). In 2011 Poland had 2.2 physicians per 1000 population (for OECD it was 3.2, UK 2.8, Germany 3.8, Czech Republic 3.6). For nurses the situation was even worse – Poland had 5.2 nurses per 1000 population (for OECD it was 8.7, UK 8.6, Germany 11.4, Czech Republic 8.0). This is due to limited funding for medical education, which is entirely public and very costly. Rising problems with public finances caused freezing of expenditure on medical education. This led to growing discrepancy between high demand for medical education and limited supply of study places.

These problems have become even bigger due to the emigration of medical staff, especially after the EU accession. It has been estimated that about 5 thousand physicians have left Poland after 1 May 2004 (to compare: there were more than 80 thousand physicians in Poland in 2008). Emigration of physicians from Poland may be analysed as a rational choice to maximise their human capital (Murdoch 2011). But for Poland it has been a loss of human capital. The expensive medical education was financed by the relatively poorer Polish taxpayers, and richer societies of emigration countries are benefiting from it, without having to pay for this education.

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

### 3.2.4 Summary

Health indicators have improved during the transformation period, due to improvements in many areas, including rising income and living standard, growing enrolment in education, better environment protection and many others. Health care has played also a role in this process.

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.

## 3.3 Reform debates

Unlike in the area of pensions, there have been relatively little major reform proposals in health care in Poland recently.

In spring 2013 plans to decentralize the health care system have been announced in media. The central National Health Fund should be dismantled and the regional branches of the National Health Fund should be given autonomy. Local self-governments should receive direct influence on functioning of health care in their region through participation of their representatives in supervisory boards. Instead of the central NFZ, a new office should be created – Office of Health Insurance, which should be responsible for valuation of medical services. This would change the present "illogical" situation as the Minister of Health said that now the same institution – the National Health Fund, first sets down the value of services and than pays for them. The new office would also be responsible for the quality assessment of hospitals and health centres. The plans have remained at a very general level and no draft law has been prepared so far.

After successful implementation of the system of electronic verification of beneficiaries' rights *(eWUŚ)*, the National Health Fund is going to start collect money for services offered to persons not covered by health insurance and thus not eligible for health care financed from public means. It has been announced in October that approximately one million persons may have no right to health insurance. This has provoked discussion on lack in protection for a substantial part of Polish population, like graduates who cannot find the first job.

There are some other issues which appear in debates, although with different intensity.

Increasing public expenditure on health care, especially through raising the contribution rate to the general health insurance could contribute to improving the health care functioning. However, this is politically a very difficult change and thus a rather unpopular idea.

Raising expenditure on medical staff (doctors, nurses) education would be necessary to approach the problem of lacking medical workforce. This is equally difficult because it would require an increase of taxes or cutting other expenditure. It is difficult especially at time of crisis.

The same is true for the demand to raise salaries of doctors and especially nurses in public health care.

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.

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. Investment in health protection infrastructure of supra-regional importance in order to increase accessibility and quality of health services has been mentioned in the Polish NRP 2013 within the European Platform against Poverty and Social Exclusion.

# 4 Long-term care

## 4.1 System description

### 4.1.1 Major reforms that shaped the current system

The current system of long-term care in Poland is based on the following laws:
- Law on Health Care Services financed from Public Means (Ustawa o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych) of 27 August 2004;
- Law on Social Assistance (Ustawa o pomocy społecznej) of 12 March 2004;
- Law on Family Benefits (Ustawa o świadczeniach rodzinnych) of 28 November 2003;
- Law on Social Pension (Ustawa o rencie socjalnej) of 27.6.2003;
- Law on Social Insurance Fund Pensions (Ustawa o emeryturach i rentach z Funduszu Ubezpieczeń Społecznych) of 17 December 1998;
- Law on Vocational and Social Rehabilitation and Employment of Disabled Persons (Ustawa o rehabilitacji zawodowej i społecznej oraz zatrudnianiu osób niepełnosprawnych) of 27 August 1997.

### 4.1.2 System characteristics

Long-term care is very fragmented in Poland. It 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 mainly 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 (Golinowska 2010, p. 5):

- 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'),
- insufficient institutional offer of publicly financed care,
- lack of affordable private care establishments.

There are both cash benefits and in kind benefits in the long-term care in Poland. Cash benefits include, apart from social assistance benefits which may also be awarded to persons in need of long-term care in difficult situations: medical care supplement and medical care allowance.

Medical care supplement *(dodatek pielęgnacyjny)* is granted to persons entitled to an old-age, invalidity or survivors' pension who have reached the age of 75, as well as to persons of any age entitled to an old-age, invalidity or survivors' pension who are totally incapable of work and require assistance from another person.

Medical care allowance *(zasiłek pielęgnacyjny)* is paid to persons fulfilling the health and age criteria, regardless of family income:

- children up to the age of 16 requiring permanent assistance from another person,
- children over the age of 16 with a moderate disability that began at the age of entitlement to the family allowance, or seriously disabled persons, without age criteria.

The formal long-term care in Poland operates within both the health and social assistance sectors – see table 8.

Table 8: Providers of long-term care in Poland

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

In 2011 there were 865 social assistance centres in Poland, including 635 in the public sector and 230 in the private one (GUS 2012b, p. 119). In the health care sector, there were 32.3 long-term beds (except psychiatric) in hospitals per 100 000 inhabitants in Poland, which is above the EU-27 average (Annex, table 8).

Long-term care is financed on the public - private basis in Poland (Golinowska 2010, p. 15). The prevailing informal care is financed on a private basis. The health care services are financed from health insurance contributions and social assistance homes from general taxes. It is estimated that (formal) long-term care spending was 0.7% of GDP in 2010, including 0.30% in institutions, 0.07% at home and 0.37% cash benefits. It is projected that the spending will increase much faster than in most EU countries, reaching 1.9% of GDP in 2060 (Annex, table 9).

Only the medical care supplement *(dodatek pielęgnacyjny)* granted to persons entitled to an old-age, invalidity or survivors' pension who have reached the age of 75 is universal. All in-kind benefits require a co-payment by the patient. In the health sector only the cost of accommodation and board has to be covered. The monthly payment of care recipients in social assistance sector is not more than 70% of the monthly individual income of the care recipient.

### 4.1.3 Details on recent reforms in the past 2-3 years

No major reforms have been implemented in the long-term care in Poland in recent years. There were several plans of reforms which will be mentioned in section 4.3.

## 4.2 Assessment of strengths and weaknesses

### 4.2.1 Coverage and access to services

The very low level of coverage by formal long-term care in Poland can be seen at the share of disabled people (15+) receiving informal or no care. It was 92.9% in Poland in 2010, the second highest share in the EU after Bulgaria, with only 5.2% covered by institutional care and 1.9% by home care. The projected change of this situation until 2060 is relatively modest: still 89.7% will receive informal or no care (Annex, table 10). Only some 0.9% of the Polish population over the age of 65 received long-term care in an institution setting in 2008, well below the OECD average of 4.2% (OECD 2011).

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.

### 4.2.2 Quality and performance indicators

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 brought forward for more private solutions in residential care, supported by state (inter alia fiscal) incentives, like e.g. more competition, better information and more involvement of non-governmental organisations in monitoring the quality (Jurek 2011).

### 4.2.3 Sustainability

Informal carers clearly dominate in the long-term care in Poland. According to a recent comprehensive survey, families provide care to 93.5% of all dependent elderly people (Łuczak 2013, p. 170). The absolute majority of carers are women. Traditionally, the

retirement age for women has been low (60, with many early retirement possibilities), which was partly motivated with the traditional role of women as carers for their grandchildren and/or parents (parents in law). Culture strongly supported such a solution: public support for informal care provided by families is in Poland the highest in the EU, which however may be also related to underdeveloped formal care. The average person taking care of the frail elderly is a woman aged 51 (Łuczak 2013, p. 171).

Nursing benefit *(świadczenie pielęgnacyjne)* was established to support people who do not undertake or resign from employment or other paid work due to the necessity of taking care of a disabled child. The amount of money paid directly to the caregiver is in 2013 PLN620 (€152) per month. The caregiver can have his/her social insurance contributions paid from the State budget.

A social assistance centre pays the contribution to old-age and pension insurance, in the amount subject to income criterion per person in the family, to a person that gives up employment due to the necessity to exercise direct, personal care for a member of the family suffering from a long-term or serious disease, and for non-cohabiting mother, father, or siblings, provided that the actual income per person in the family of the person exercising such a care does not exceed 150% of the amount subject to income criterion per person in the family, and the person exercising such a care is not covered by mandatory old-age or disability pension insurance under other titles, and receives no old-age or disability pension (MISSOC 2013).

Professional carers within the health care sector included in 2007: 896 doctors, 4,499 nurses, 918 specialists for rehabilitation, 703 carers (Augustyn 2010, p. 75). In social assistance sector, in 2008 34,000 persons were employed in primary jobs in social assistance homes (Augustyn 2010, p. 110).

It is widely accepted that education in long-term care of general practitioners should be improved (through appropriate life-long training). And even more, increased education and motivation of nurses to work with the elderly with functional limitations are needed.

There is a possibility to award certain “accompanying measures” to persons who have the legal assessment of disability. Such measures include possibilities to obtain the co-financing of, for example,

- the participation of disabled persons and their attendants in rehabilitation stays,
- provision of rehabilitation equipment, orthopaedic equipment and auxiliary devices allocated to disabled persons under separate provisions,
- liquidation of architectural and technical barriers in connection with individual needs of disabled persons,
- rehabilitation of children and the young.

### 4.2.4 Summary

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.

## 4.3 Reform debates

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

Two main arguments for the introduction of this new solution were presented. Firstly, the needs for long-term care will grow due to the rapid ageing of the population. According to estimates of GUS (Central Statistical Office), the number of older persons in need of permanent care will grow from about 1 million at present to 2.5 million in 2035. Secondly, whereas families now provide care for their elderly, it will change dramatically due to decrease of the number of young persons, longer working lives and also because of higher retirement age. The 'nursing vouchers' would be a very valuable strengthening of long-term care in Poland. The proposed solution is based on freedom of choice between care at home and semi-residential or residential care as well as between public and private establishments.

On 13 February 2012 a conference on „Long-term care in Poland – in need of changes" was organised by the Committee of Family and Social Policy of the Senate (the upper house of the Polish Parliament) and a new version of the proposal of a long-term care system was presented. The proposal included again introduction of a nursing voucher and financing of social insurance contributions of those caring for their family members from state budget. This is based on the fact that some 80% of long-term care in Poland is provided by family members. The project assumed a gradual introduction of the new system, starting in 2013 with those mostly dependent. It did not happen however, due to growing problems in public finances.

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. 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.

# 5 References

ANNEX (2013), *Tables on long-term care*, European Commission.

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

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

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

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

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

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

GUS (2011), Ochrona zdrowia w gospodarstwach domowych w 2010 r. *(Health care in households in 2010)*, Central Statistical Office, Warsaw, retrieved on 10 October 2013 from http://www.stat.gov.pl/cps/rde/xbcr/gus/zo_ochrona_zdrowia_w_gospodarstwach_domowych_2010.pdf

GUS (2012a), *Demographic Yearbook of Poland 2012*, Central Statistical Office, Warsaw.

GUS (2012b), *Social Assistance – Infrastructure, Beneficiaries, Benefits in 2011*, Central Statistical Office, Warsaw.

GUS (2012c), Zdrowie i ochrona zdrowia w 2011 r. – *Health and health care in 2011*, Central Statistical Office, Warsaw, retrieved on 10 October 2013 from http://www.stat.gov.pl/gus/5840_12706_PLK_HTML.htm

GUS (2013a), Narodowy Rachunek Zdrowia za 2011 rok *(National Health Accounts for 2011)*, Central Statistical Office, Warsaw, retrieved on 10 October 2013 from http://www.stat.gov.pl/gus/5840_4459_PLK_HTML.htm

GUS (2013b), Trwanie życia w 2012 r. – Life expectancy tables of Poland 2012, Central Statistical Office, Warsaw, retrieved on 12 October 2013 from http://www.stat.gov.pl/cps/rde/xbcr/gus/LUD_trwanie_zycia_2012.pdf

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

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

ŁUCZAK, PAWEŁ (2013), *Long-term care for the elderly in Poland*. In: Michoń, Piotr,

Orczyk, Józef, Żukowski, Maciej (eds.), *Facing the challenges. Social policy in Poland after 1990*, Poznań University of Economics Press, Poznań, pp. 169-179.

MINISTRY OF HEALTH (2013), Informacja w zakresie realizacji art. 196-203 ustawy o działalności leczniczej z 15 kwietnia 2011 r. Stan na 31 października 2013 r. *(Information on implementation of art. 196-203 of the law on health care activity of 15 April 2011. Situation on 31 October 2013)*, retrieved on 10 November 2013 from http://www.mz.gov.pl/wwwmz/index?mr=b3&ms=0&ml=pl&mi=4&mx=0&mt=&my=180&ma=032868

MINISTRY OF LABOUR AND SOCIAL POLICY, MINISTRY OF FINANCE (2013), *Przegląd funkcjonowania system emerytalnego. Bezpieczeństwo dzięki zrównoważeniu (Overview of pension system functioning. Security through balancing)*, Warsaw, June 2013.

MISSOC (2013), *MISSOC Comparative Tables Database 1 January 2013*, European Commission, Brussels.

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

OECD (2011), Poland – Long-term care, in Help Wanted? Providing and Paying for Long-term Care, OECD, Paris, retrieved on 15 September 2013 from http://www.oecd.org/dataoecd/61/23/47877986.pdf

OECD (2013), OECD Health Data 2013 – Frequently Requested Data, Paris, June 2013, OECD, Paris, retrieved on 12 October 2013 from http://www.oecd.org/els/health-systems/oecdhealthdata2013-frequentlyrequesteddata.htm

ORENSTEIN, Mitchell, A. (2011), *Pension Privatization in Crisis: Death or Rebirth of a Global Policy Trend?*, International Social Security Review, vol. 64, no. 3, pp. 65-80.

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

POLISH FINANCIAL SUPERVISION AUTHORITY (2013), Rynek emerytalny *(Pension system)*, Polish Financial Supervision Authority, Warsaw, retrieved on [9 May 2013] from *http://www.knf.gov.pl/opracowania/rynek_emerytalny/index.html*

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

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

TYSZKA, Norbert (ed.) (2012). Świadczenia opieki zdrowotnej finansowane ze środków publicznych – Vademecum 2012 *(Health care benefits financed from public sources – Vademecum 2012)*, Warszawa: Narodowy Fundusz Zdrowia, retrieved on 14 September 2013 from http://www.nfz.gov.pl/new/art/4816/vademecum_2012_09_25.pdf

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

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

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

ZUS (2008), Ważniejsze informacje z zakresu ubezpieczeń społecznych 2007 r. *(Essential information on social insurance in 2007)*, Zakład Ubezpieczeń Społecznych, Departament Statystyki, Warszawa, May 2008, retrieved on 12 October 2013 from http://www.zus.pl/files/dane2007.pdf

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

ZUS (2009b), Ważniejsze informacje z zakresu ubezpieczeń społecznych 2008 r. *(Essential information on social insurance in 2008)*, Zakład Ubezpieczeń Społecznych, Departament Statystyki, Warszawa, May 2009, retrieved on 12 October 2013 from http://www.zus.pl/files/dane2008.pdf

ZUS (2010), Ważniejsze informacje z zakresu ubezpieczeń społecznych 2009 r. *(Essential information on social insurance in 2009)*, Zakład Ubezpieczeń Społecznych, Departament Statystyki, Warszawa, May 2010, retrieved on 12 October 2013 from http://www.zus.pl/files/Wa%C5%BCniejsze%202009.pdf

ZUS (2011), Ważniejsze informacje z zakresu ubezpieczeń społecznych 2010 r. *(Essential information on social insurance in 2010)*, Zakład Ubezpieczeń Społecznych, Departament Statystyki, Warszawa, June 2011, retrieved on 12 October 2013 from http://www.zus.pl/files/Wa%C5%BCniejsze%202010.pdf

ZUS (2012a), Rocznik Statystyczny Ubezpieczeń Społecznych 2009-2011, *(Statistical Yearbook of Social Insurance 2009-2011)*, Warszawa, Zakład Ubezpieczeń Społecznych, retrieved on 5 October 2013 from http://www.zus.pl/files/Rocznik%20Statystyczny%20Ubezpiecze%C5%84%20Spo%C5%82ecznych%202009-2011.pdf

ZUS (2012b), Ważniejsze informacje z zakresu ubezpieczeń społecznych 2011 r. *(Essential information on social insurance in 2011)*, Zakład Ubezpieczeń Społecznych, Departament Statystyki, Warszawa, June 2012, retrieved on 12 October 2013 from http://www.zus.pl/files/Wa%C5%BCniejsze%20informacje%20z%20zakresu%20ubezpiecze%C5%84%20spo%C5%82ecznych%202011%20r.pdf

ZUS (2013a), Ważniejsze informacje z zakresu ubezpieczeń społecznych 2012 r. *(Essential information on social insurance in 2012)*, Zakład Ubezpieczeń Społecznych, Departament Statystyki, Warszawa, June 2013, retrieved on 12 October 2013 from http://www.zus.pl/files/Wa%C5%BCniejsze%20informacje%20z%20zakresu%20ubezpiecze%C5%84%20spo%C5%82ecznych%202012%20r.pdf

ZUS (2013b), Prognoza wpływów i wydatków Funduszu Emerytalnego do 2060 roku *(Forecast of revenues and expenditures of Old-Age Insurance Fund until 2060)*, Zakład Ubezpieczeń Społecznych, Departament Statystyki, Warszawa, May 2013, retrieved on 10 October 2013 from http://www.zus.pl/bip/pliki/Prognoza_fundusz_emerytalny_2015_2060.pdf

# Annex – Key publications

**[Pensions]**

CHŁOŃ-DOMIŃCZAK, Agnieszka, KAWIŃSKI, Marcin, STAŃKO, Dariusz (2013), System oceny i prezentacji wyników inwestycyjnych kapitałowych systemów emerytalnych, Oficyna Wydawnicza Szkoły Głównej Handlowej w Warszawie, Warszawa, 224 pp.

*„System of assessment and presentation of investment results of funded pension systems"*

The book presents results of a research project which aimed at presenting determinants and optimal construction of benchmarks for funded pension systems, and particularly for the Polish open pension funds. It also aimed at analysis of how the benchmarks influence behaviour of managers and members of pension funds.

GÓRA, Marek (2013), *Political economy of pension reforms: selected general issues and the Polish pension reform case*, IZA Journal of Labour & Development, 2/2013, 31 pp.

In this paper the author analyses selected political economy issues related to pension reforms, such as the worker-retiree conflict of interest, distribution by age of the costs of the loss of demographic dividend, and key goals behind pension reforms. The focus of this paper is on pension reforms in Poland, which actually was an implementation of a thoroughly new pension system. Its design is analysed and discussed from a political economy viewpoint. Furthermore, analysis of the Polish pension system is presented in a broader European context.

MINISTRY OF LABOUR AND SOCIAL POLICY, MINISTRY OF FINANCE (2013), *Przegląd funkcjonowania system emerytalnego. Bezpieczeństwo dzięki zrównoważeniu*, Warsaw, June 2013, 147 pp.

*"Overview of pension system functioning. Security through balancing"*

On 147 pages, almost exclusively the functioning of the second pillar (open pension funds, OFE) are analysed. From 9 change options which were analysed according to the Report, six were **rejected**:

- gradual phasing out of the funded pillar;
- closing down of the funded pillar;
- no changes at all;
- temporary suspension of contributions to the second pillar;
- return to previous contribution rate to OFE at 7.3%;
- programmed withdrawal instead of annuity from OFE.

The ministers recommended for debate the three proposals:

- abolishing of the part of second pillar with investment in government bonds;
- optional membership in the second pillar;
- optional membership in the second pillar with an additional contribution.

SZCZEPAŃSKI, Marek (ed.) (2013), Reformowanie systemów emerytalnych – porównania i oceny – Pension reforms – comparison and evaluation, Publishing House of Poznan University of Technology, Poznań, 379 pp.

Collection of 23 papers, some in Polish and some in English, on various aspects of recent pension reforms in different countries, especially in Poland: both on the structure of the system, on open pension funds and the third voluntary pillar.

ZUS (2012), Rocznik Statystyczny Ubezpieczeń Społecznych 2009-2011, *(Statistical Yearbook of Social Insurance 2009-2011)*, Warszawa, Zakład Ubezpieczeń Społecznych, 258 pp., retrieved on 5 October 2013 from http://www.zus.pl/files/Rocznik%20Statystyczny%20Ubezpiecze%C5%84%20Spo%C5%82ecznych%202009-2011.pdf

This is the latest edition of the publication issued by the Social Insurance Institution since 1987. The Yearbook, published in August 2012, completely in two languages: Polish and English, is composed of the following chapters:
- Population. The insured. Contribution payers
- Finances
- Old-age and other pensions
- Allowances
- Benefits in respect of accidents at work and occupational diseases
- Medical evaluation and certification of incapacity for work
- Medical rehabilitation within the framework of disability pension prevention and accident prevention
- Pre-retirement benefits and allowances, social pensions, bridging pensions and teachers' compensatory benefits
- Social Insurance Institution. Appellate bodies.

ZUS (2013), Ważniejsze informacje z zakresu ubezpieczeń społecznych 2012 r. *(Essential information on social insurance in 2012)*, Zakład Ubezpieczeń Społecznych, Departament Statystyki, Warszawa, June 2013, 51 pp., retrieved on 12 October 2013 from http://www.zus.pl/files/Wa%C5%BCniejsze%20informacje%20z%20zakresu%20ubezpiecze%C5%84%20spo%C5%82ecznych%202012%20r.pdf

The basic statistical information on the whole social insurance system administered by the Social Insurance Institution (ZUS), published every year in June for the previous year. It covers data on the insured, finances, old-age and other pensions, beneficiaries in regions, allowances, medical evaluation and certification of incapacity for work, other benefits.

ZUS (2013), Prognoza wpływów i wydatków Funduszu Emerytalnego do 2060 roku *(Forecast of revenues and expenditures of Old-Age Insurance Fund until 2060)*, Zakład Ubezpieczeń Społecznych, Departament Statystyki, Warszawa, May 2013, 55 pp., retrieved on 10 October 2013 from http://www.zus.pl/bip/pliki/Prognoza_fundusz_emerytalny_2015_2060.pdf

The most recent forecast of revenues and expenditures of Old-Age Insurance Fund, from which old-age pensions are paid by ZUS, published in May 2013. This is an update of the forecast until 2060, done in 2010. New demographic forecast was used as well as new law on pensions was taken as the basis. The results are presented in 3 variants. According to every of them, there should be a deficit of the Fund until the end of the forecast period.

**[Health care]**

GUS (2012), Zdrowie i ochrona zdrowia w 2011 r. – Health and health care in 2011, Central Statistical Office, Warsaw, 303 pp., retrieved on 10 October 2013 from http://www.stat.gov.pl/gus/5840_12706_PLK_HTML.htm

The publication is a successive edition of annual publication on health care issued in the series entitled ―Statistical Information and Papers‖, published by the Central Statistical Office since 1991. The Yearbook consists of an analytical part presenting the basic situation and trends, and the part with tables. The tables present basic statistics on the health status of the Polish population, data on medical staff, number and activities of out-patient and in-patient health care institutions, blood donations, emergency services, generally available pharmacies and pharmacy outlets, nurseries, as well as, statistics on public expenditure on health care. In addition to this, the results of the National Health Accounts for 2010 are presented.

GUS (2013), Narodowy Rachunek Zdrowia za 2011 rok *(National Health Accounts for 2011)*, Central Statistical Office, Warsaw, 7 pp., retrieved on 10 October 2013 from http://www.stat.gov.pl/gus/5840_4459_PLK_HTML.htm

A brief information note prepared for a press conference on 23 July 2013. It presents the results of the National Health Accounts for 2011.

KOLASA, Katarzyna (2012), Współpłacenie za zdrowie – Za i przeciw, Polityka Społeczna, 2012 no. 10, p. 19-21.
*„Co-payments for the health care: pro and con"*

The introduction of co-payments on the healthcare market has been discussed continuously by health policy as well as social policy experts. There are many arguments for and against cost sharing. On the one hand, it is proven that the system of co-payments will reduce the use of ineffective healthcare services and consequently improve the optimal allocation of healthcare resources. On the other, there are voices that co-payments will reduce the needed healthcare services and consequently trigger the poverty. In order to understand the potential implications of the introduction of co-payments on the Polish market, the experience from other jurisdictions should be learned.

RYBARCZYK, Anna (2012), Akredytacja podmiotów leczniczych w polskim systemie ochrony zdrowia – stan prawny i zamierzenia legislacyjne, Polityka Społeczna 2012 no. 11-12, p. 24-27.

*„Health care accreditation system in Poland – The legal status and legislation proposed"*

The article presents the reform of the Polish health care system in the context of regulations relating to assessing and measuring quality of service provided by medical institutions. It is stressed that accreditation is the only way in which the Ministry of Health sees the opportunity to influence the quality of services. This article is divided into three main parts: (1) characterizes the process of accreditation in Poland, (2) discusses the law on accreditation of health care, (3) presents the draft law on quality in health care.

SOWADA, Christoph (2013), Łączenie solidaryzmu z wolnością w ubezpieczeniach

Zdrowotnych, Wydawnictwo Naukowe SCHOLAR, Warszawa, 425 pp.

*„Connecting solidarity with freedom in health insurance"*

Major study on health care systems and their reforms. Solidarity has been treated here not only as a value (objective) but rather as an instrument of socio-economic order, parallel to market and state.

**[Long term care]**

GOLINOWSKA, Stanisława, SOWA, Agnieszka (2012), Zdrowie i sprawność. Przemiany w Polsce, Polityka Społeczna, numer monograficzny, Warszawa 2012, p. 6-14.

*„Health status and functional limitation. Changes in Poland"*

Social changes of the last two decades in Poland have an impact on many dimensions of life, including important elements of human capital such as health and daily living activity both functional and instrumental of the population. The article contains overview of available data and indicators on the health status, morbidity and disability. It presents changes in the level of functional and legal disability and aims at showing reasons of these trends. Functional disability is highlighted as a major challenge for the social and health policy, including long-term care, in the next few decades in the context of dynamic ageing.

GOLINOWSKA, Stanisława, SOWA, Agnieszka (2013), The Development of long-term care in post-socialist Member States of the EU, CASE Network Studies & Analyses, No. 451/2013, Warsaw, 50 pp.

Long-term care (LTC) in the new EU member states, which used to belong to the former socialist countries, is not yet a legally separated sector of social security. However, the ageing dynamics are more intensive in these states than in the old EU member states. This paper analyses the process of creating an LTC sector in the context of institutional reforms of social protection systems during the transition period. The authors explain LTC's position straddling the health and social sectors, the underdevelopment of formal LTC, and the current policies regarding the risk of LTC dependency. The paper is based mainly on the analysis of information provided by country experts in the ANCIEN project.

ŁUCZAK, Paweł (2013), *Long-term care for the elderly in Poland*. In: Michoń, Piotr, Orczyk, Józef, Żukowski, Maciej (eds.), *Facing the challenges. Social policy in Poland after 1990*, Poznań University of Economics Press, Poznań, pp. 169-179.

The paper starts with the predominance of informal care in the LTC in Poland. The next parts present LTC services in both health care and social assistance sector. In the following, LTC cash transfers for the elderly are presented. The paper ends with prospects of LTC reform in Poland.

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