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# *Financing long term care in Europe*

## *Summary*

Since process of society aging became more and more recognized as unavoidable, the long term care turned to be a salient point of public policies. The article presents the achievements and connections of studies on aging society and disability policies as well as the discussion over the further needs of care. It covers the problem of carers' benefits and services provision financing in the EU countries with special reference to territory of Poland.

**Key words:** long term care, disability policy, public finance

## *Introduction*

The process of LTC system formation affects not only the health care system but also social security system as well as labor market policy, public finance and public administration. Dependency and the need of LTC is still one of main factors of poverty and exclusion. Moreover, it affects not only a dependent person directly, but indirectly this person's friends and family, who often have to give up their professional activity and become fully dependent on the system of public care services. Along with the change of economic regime, we can observe the strengthening of the care recognized as a commodity. This care, no matter the source of funding has to be bought on the market. The paper presents

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the discussion over the responsibility for LTC services delivering (public or private, local or central, single source or mixed) and, depending on the previous choice — the way of sources' collecting (contributions or taxes, public or private insurance, the central budget or an external agency).

This paper focuses on the example of Poland, where the crucial reforms are on-going, against the background of selected European examples[2].The findings are based on the critical and comparative analysis, some basic statistic methods and case studies. The elaboration introduces the initial effects of the research grant focused on the model of care funding, especially in the situation of social structures evolution and resources limitation. This project finalizes the several-year studies on the Author's theory of the costs of disability, which systemizes the expenses on disability policy and calls for transparency and concentration.

## *Impact of society ageing and disability phenomenon on long term care*

Long-term care (LTC) is the set of services provided on a daily basis, formally or informally, at home or in institutions, to people suffering from a loss of mobility and autonomy in their activity of daily living. LTC is not a new phenomenon; however, it is often stressed that the main reason of rising LTC is an aging population. Following a discussion over the problem of LTC financing, it is worth looking at the former experience of disability policy and welfare finance, which were the basis for the current solutions. Moreover, we can expect people not only to live longer but can expect them to live, excluding a few countries, in temporarily worse health conditions. This is why, when researchers and decision-makers focus on LTC dedicated to older people, it should be taken into consideration, as not to neglect the problem of younger dependents and the long-term assistance (LTA) understood as support services delivered to people with limited ability in every sense.

Looking through available research and reports may give an impression that LTC is strongly connected with medicine. However, LTC differs radically from health care (OECD 2013). While health care services aim at changing health conditions (from unwell to well), LTC merely aims at making the current conditions (unwell) bearable. Health-related LTC spending includes palliative care, long-term nursing care, personal care services and health services in support of family care. Social services provided for LTC include home help (e.g. domestic services) and care assistance, residential care services and other social services. A striking difference between spending on health and LTC is that the cost of LTC per beneficiary is roughly independent of age. Moreover, while potentially the entire population may benefit from health care, only dependent persons will benefit from LTC. Two kinds of determinants drive LTC expenditure: demographic and non-demographic. The demographic driver is related to the number of dependent people in the population. The evolution of this factor depends on the evolution of life

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expectancy and health expenditure. The non-demographic drivers are related to income developments and changes in the demand for public-financed LTC services. Income is assumed to have a direct effect via increases in living standards (GDP per capita) and an indirect effect via cost-disease (relative productivity or Baumol) effects. Given the importance of home production of LTC services, the demand for public spending on LTC is assumed to depend on developments in formal labour force participation.

The OECD Economic Policy Paper by Ch. De la Maisonneuve and J. Martins referenced above (OECD 2013) seems to be influenced by the same simplification of limiting demographic drivers mainly to old-age dependants. It is true that dependency ratios increase strongly with the rise in age, but the lower ratio for younger cohorts may be reflected in a higher number of dependants. As indicated by some authors, "Health care spending improves the probability of survival in old age; it can also push up LTC spending". This also refers to primary phases of life. Medical achievements and technology enable children and adults with severe disability to participate in mainstream life; however, this activity often requires long-term (personal, technical, medical) assistance. Addictions, asthma, stress and obesity do not exclude from the active society but only when supported with long-term counselling, coaching or training. This problem was also mentioned in an OECD Report (2011); however, the final work does not cover the schemes for young disabled (without profound grounds).

When designing any social policy sub-system, policymakers should not only include the holistic nature of a human-being in their ideas, but also a holistic nature of public finance (Rodrigues, Leichsenring, Winkelmann, 2014). When awarding a person with the status of "disabled" or "dependant", the state must become ready to finance the due supply, no matter if the right to services will be executed or not. Disability cost theory requires evaluation and forecast of not only actual expenses but all costs that may be incurred by public liabilities included in national legislation (Berthoud 1991, Saunders 2006, Marska-Dzioba 2013). When focusing on LTC delivered to older cohorts, it is easy to neglect the area of LTC that should be delivered to younger groups or to even exclude the carers of younger groups, as currently happens with carers of the elderly in a couple of countries.

According to the United Nations, about 10% of the global population (i.e. 650 million people) are disabled. They form the world's greatest minority. This number is expected to rise up to 14% to more than one billion. This situation has been verified by WHO's World Report on Disability (2011), as well as reports by ILO (2010). The primary limitation on research of disability is the limitation of comparable data. The most developed investigations and data sets refer to disability policy in the United States and the European Union. Based on these, the assumption that disability is one of the most important factors of poverty and exclusion risk seems to still be true. Even in countries with a well-developed system of support, such as Britain's, the actual level of poverty of a disabled person's household was twice higher than the average for the whole society (A. Sen 2005). The same can be observed in Poland, a country with a long history and great achievements in disability policy and rehabilitation. Almost half of disabled persons' households are at risk of poverty and social exclusion. If a disabled person is a child, the

level of poverty is 2.5 times higher than that for the average household. This is why when designing welfare finance as an element of public finance, we must keep in mind that the scope of expenses rises, not only because of higher expectations, quality standards and EU norms and obligations, but basically because of the rising number of recipients.

As mentioned above, health care policy is essentially connected with disability and LTC policy. When planning the framework for public systems of care, it is necessary to consider changes in the Healthy Life Years (HLY) indicator. HLY presents the number of expected years of life lived out in good health conditions without disability or any limitations, and can be considered one of several quality-of-life indicators. This is why the important goal of the European public health strategy is to achieve a higher dynamic of HLY rather than the dynamic of life expectancy to increase the share of a healthy period within a human life. Table 1 presents a comparison of dynamic increase for both indicators. The life expectancy increases in every country, with a much higher ratio for men than for women. At the same time, the HLY index decreases for most of the countries. Exceptional examples of countries with a higher average dynamic of HLY life expectancy are Sweden, Great Britain, Malta and Finland, and countries with a particularly adverse tendency are Germany and Austria. It is important to emphasize the unfavourable trend for women. With a slower increase of life expectancy, this gender group is affected with lower growth of HLY index (Ireland, France) or with a decrease of this index (Poland, Spain, Italy).

Disability policy is difficult to define and to precisely draw its borders. It concerns every element of an individual's activity: family life, occupational and general education, leisure time and social and political activity. Integrating activity of policy reflects its ability to recognize the dignity of a disabled person and this person's right to participate in every sphere of life. Therefore, it is generally accepted that the primary goal of disability policy is to create an equal and normal life in an open society and to enable different roles in family, social and professional life (equal opportunity model). This fundamental objective can be achieved only by reaching partial goals, such as (Marska-Dzioba 2013): income integration — provision of income lost as an effect of limited ability; occupational integration — support of entering or reintroducing to the labour market; social integration — support of disabled person participation in different areas of social life using such instruments as education, LTC, rehabilitation (medical, social, psychological, environmental), social protection and social welfare.

According to the approach presented above, the social integration also covers the problems of care and caregivers. However, depending on the system's construction, the direct beneficiary can be a dependent person who buys services from the providers or a carer or who receives the benefit from the public system as a replacement of remuneration given up on a market or as a payment for care. Apart from direct or indirect payment, the delivery of care and carer's remuneration are often the domain of a central system, rather than any other element of social integration, including the general LTC, which is usually the responsibility of a local authority (Graph 1).

**Table 1. HLY and life expectancy changes between 2000 and 2010 in selected European countries (gender division)**

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

* base year 2002; ** base year 2003

Source: own calculation based on Eurostat TGM Interface data; 13 April 2013.

**Graph 1. Division of tasks among levels of administration within LTC as an element of disability policy**

| Level of administration | Income integration | Social integration |
|---|---|---|
| Central | Contributory benefits: disability pension,<br>Non-contributory benefits ↑↓ | Medical rehabilitation<br>Extra care benefit<br>Nursing benefit<br>Carers' remuneration ↑↓ |
| Regional | ↕ | Social welfare ↕ |
| Local | Non-contributory benefits | Financial supplements<br>Medical rehabilitation<br>Social protection<br>Carers' remuneration and benefits |

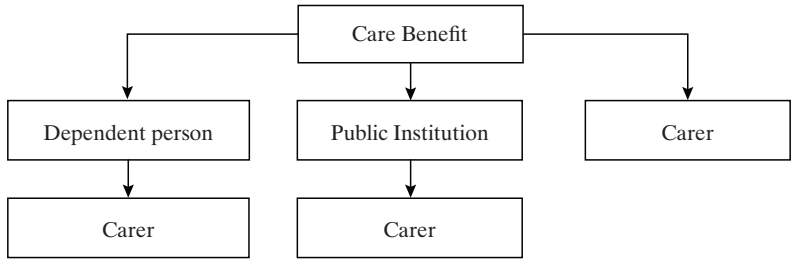
Source: own compilation

## *Benefits for carers*

No matter the age and reason of dependency, a carer plays a vital role in a dependant's life. The support of a carer is also the most heterogeneous element of social integration. As there are different statuses or forms of carers and different ways of delivering benefits, in almost every European country the implemented solutions differ. The safety net for carers reflects the social perception of their work importance, as well as the level of disability policy development.

A carer's situation is usually classified as individual or institutional, such as NGO, hospitals, care homes or other providers. According to the legal relationship, carers have formal or informal status, depending on the formal entitlement. Recognition of what is formal or not is also not unified, as in some countries family members helping without any contracts or remunerations are considered informal carers, where in other countries family members are legally expected to be carers and the single "blood" relations constitutes formal and obligatory status. This is why when looking at the initial requirements necessary to receive any kind of carer's benefit, they are sometimes contradictory: to obtain a benefit a person must be a family member (Hungary, Poland) or does not need to be a family member (France, Germany), sometimes must give up a previous occupation (Cyprus, Poland) and sometimes the system provides benefits or support only for carers of children. The benefits offered to carers are diverse: in cash (often with status of a remuneration), in kind, tax reliefs or tax credits, social contribution coverage, social (security) privileges as paid leave or a flexible work schedule.

**Graph 2. Paying-for-care patches**




Source: Own compilation.

As the increasing need for care forced the development of support methods, the different patches of delivering were created. The beneficiary of care benefits can be either a dependent person or a carer. In the case of a direct payment to a carer, this benefit might take the form of remuneration (with all consequences such as paid holiday or similar) or support or allowance coverage. In France, Germany or Great Britain, the dependent person decides what form of care is wanted or who the carer is. Hence, the dependent person can pay directly or through a supervisory institution (a local social agency or public insurer). In some countries, even the decision on the carers choice

belongs to dependent persons, the carer has a legal entitlement to a local administration, social security program or similar. This path helps to avoid abuse, fraud and low-quality care, and in general allows control of the care delivered.

There is a variety of carers' benefit solutions within the EU. With the exception of Germany and the Nordic countries, it is hard to define the solutions as deliberated and intentional systems, also because there are on-going public discussions and reforms of LTC and disability policy in many of the EU member states. As social policy reflects tradition and values of society, the standardisation of care is not an option. However, along with public discussion, it seems to be vitally important to propose flexible solutions of care and assistance for every stage of dependence in a person's life. Since the commodification of care recognition, it is important to reward this work, as any other, in order to avoid high indirect costs of LTC (EU 2013), such as: the negative effect on the carers' health and employment, the gender effect (80% of carers are women) and migration of carers.

## *How is LTC financed*

Before describing the ways of financing LTC, it is important to evaluate how much can be read from official statistics. This reservation is valid because of differences in spending qualifications. As mentioned earlier, LTC expenses can be classified as health care, social services, or both (EU 2012). Despite the fact that data collecting institutions such as WHO, the OECD or Eurostat, provide guidance on how to separate spending, it is consequential for researchers to include this in analysis. It is also far-reaching to remember that private expenditures can be underestimated, as in some countries they cannot be fully registered or neglected.

Looking at the theory of welfare and public finance, there are several arguments for obligatory and, in general, publicly financed social systems such as LTC. The cost of care can be high and thereby place a significant burden on users, especially those living with low-income or with high levels of dependency. There is also significant uncertainty for individuals regarding the need for LTC, especially the time the need will develop, as well as its duration and intensity. Mechanisms for raising contributions to pay for costs that may arise in the future, and pooling, can ensure protection against potentially catastrophic LTC, help to protect disposable income and the assets of users, and prevent care-dependent people from falling into poverty (OECD 2011).

There are four sources of care financing:

- social (mandatory) insurance,
- taxes,
- private (voluntary) insurance,
- Out-of-pocket money or self insurance — based on income or/and asset (reverse mortgage).

Taking the above into account three models can be distinguished: tax-based, public LTC insurance and care through the health system (B. Dougherty and D. West 2006, OECD 2011, Colombo 2012). A tax-based model provides universal, tax-funded LTC services

as an integral component of welfare and health care services for the entire population. Norway, Sweden, Denmark and Finland are the most typical examples. While the overall responsibility for care of the elderly and disabled rests with the state, local governments have large autonomy in organising service provision and in financing care, including the right to levy taxes. The state typically contributes to financing by paying non-earmarked subsidies either to municipalities (Finland) or to regional authorities (Denmark), adjusted to the population structure and need. A public LTC insurance model consists of stand-alone, dedicated social insurance arrangements for LTC services. It is usually implemented within countries that typically finance health care via social health insurance. Service coverage is generally comprehensive. Users are required to contribute to the cost of care, with very different levels of cost sharing. Personal care through the health system is based on the coverage of LTC cost entirely through the health system. Hence, LTC is viewed as a health risk, and institutional arrangements reflect a "medical model" of care delivery (as opposed to a social model). Belgium is such an example, where the health insurance system (INAMI/RIZIV) provides universal coverage of LTC cost both at homes and institutions. However, at the regional level, the Flemish government implemented a compulsory dependence insurance scheme, financed through mandatory yearly contributions.

Reviewing some reports on LTC (for example: *Opieka długoterminowa w Polsce* 2010) we can find the statements such as: „The level of expenditures does not depend on the method by which it is financed but on the scope and the level of benefits and services". This leads to the further conclusion, that the implemented method is not that important. It is however substantially vital, because an introduction or an increase of a contribution as well as a tax rate can have a different impact on the country's economy. An increase of a social security contribution is strongly labour cost' connected, as directly linked with the expenses. It raises the expectations of beneficiaries and a higher burden is usually not as general as the coverage is employment-connected. At the same time the increase of tax incomes is fundamentally GDP dependant and politically vulnerable but it is much simpler to introduce and (in general) it is a universal burden. This is why, when introducing new solutions, it is important to analyse fiscal efficiency of the selected method for the specific type of welfare state and economy. The question on welfare state type, the present or desired, is a fundamental one when choosing the financial method. Taxes are compatible with liberal welfare state and means-testing, while social contribution insurance fits with a conservative approach (Rothgang 2014).

Another fundamental feature of LTC financing is not as much the choice between pay-as-you go and funding as the level of supplementing a PAYG system with funding. Previous experience reflects more advantages of PAYG such as flexibility within a changing environment or immediate benefits. Funded systems can guarantee a certain amount of cash but not necessarily services, it requires high premiums when the expected period of savings is short but it can minimise intergenerational redistribution and is less vulnerable to demographic changes.

The private coverage of LTC risk includes private LTC insurance, combined LTC and life insurance and self-insurance through housing property (Costa-Font, Courbage

2012). The explanation for the lack of LTC insurance purchasing is that individuals are inadequately informed about the products available and ignore low-frequency, high-severity events. Insurance market underdevelopment is also caused by (intra family) moral hazard and adverse selection and the crowding-out effect of public programmes over private insurance. The LTC cost can be much higher and access reduced when covered by actuarial insurance mechanisms (N. Barr, 2011, Pestieau, Ponthiere 2012). The optional solution can be a combination of LTC insurance and life insurance. It can reduce adverse selection and the selection of risk is minimized thanks to the filtering out of individuals immediately benefiting from insurance payments. It is also possible to finance LTC expenses (or alternatively LTC insurance) using a reverse mortgage. A property then acts as a safety net and can be used as a financing of last resort.

Within European countries, there are four examples where a country implemented the separated system or a separate financial instrument. These countries are Germany, with public LTC insurance; Luxembourg, with a universal LTC insurance programme; Slovenia, with a municipality tax for care of disabilities; Belgium, with the Flemish a compulsory dependence insurance scheme. All other countries usually cover the risk of LTC within one universal or mixed system.

Table 2 presents several findings:

- Taxes are the most common instrument to collect funds for LTC; these are usually general taxes or those connected with the public health care systems.
- In several cases, the more significant instruments are local taxes, rather than central taxes. This especially refers to Sweden, where local taxation is almost the one and only way of financing (84%). In the case of Austria, Finland and France, local taxation provides more than half of funds. However, this might cause a strong effect of fiscal stress.
- Use of taxation does not exclude an insurance method and contribution implementation. This is mainly a social security contribution, and in the case of mixed systems, constitutes the major pool. In a few cases, such as Greece, Luxemburg, Malta or Romania, the contribution is the main source of funds; however, the state budget remains the main tool to execute spending (i.e. contributions are not collected in a separate agency or fund).
- In Finland and Sweden, local authorities are independently responsible for LTC performance and local budgets are the only radix. Unlike the above-mentioned countries, in most European countries the expenses from the state budget are accompanied by local budgets and generally executed separately. In several cases, the local budget does not participate in LTC spending.
- In 8 European countries, the national legislation includes individual participation as an obligatory source of financing, except for out-of-pocket money or voluntary private insurance.
- In the case of mixed financing, there are some burdens (rather taxes than contributions) dedicated directly for selected services. In cases of general or universal systems, the decision of spending structure is transferred to the responsible subject.

**Table 2. Instruments of LTC financing in EU countries**

| | Taxes* | Contributions | Statebudget** | Local budgets | Individual participation |
|---|---|---|---|---|---|
| Austria | X | | x | x | |
| Belgium | X | x | x | | |
| Bulgaria | Nd | nd | nd | nd | nd |
| Croatia | X | | x | | |
| Cyprus | X | | x | | |
| Czech Republic | X | | x | | x |
| Denmark | X | | x | x | x |
| Estonia | X | | x | x | x |
| Finland | X | | | x | x |
| France | X | x | x | x | |
| Germany | X | x | x | x | |
| Greece | | x | x | | x |
| Hungary | X | x | x | x | |
| Ireland | X | | x | | |
| Italy | X | x | x | x | |
| Latvia | X | | x | x | |
| Lithuania | X | | x | x | |
| Luxembourg | | x | x | | x |
| Malta | | x | x | | |
| Netherlands | X | x | x | x | x |
| Poland | X | x | x | x | |
| Portugal | X | | x | | |
| Romania | | x | x | | |
| Slovakia | X | | x | x | |
| Slovenia | X | x | x | x | |
| Spain | X | | x | x | x |
| Sweden | x** | | | x | |
| United Kingdom | X | | x | x | |

* General subsidies from the state budget, ** local taxes, nd– no data.

Source: Own compilation based on EU's Mutual Information System on Social Protection (MISSOC) — April 2014, OECD (2011).

As mentioned above, the data on LTC spending vary among institutions. Columns 2 and 3 in Table 3 present data on public LTC expenditure versus public health care (HC) expenditure in 2010, according to Eurostat data. The HC spending is at least double for Sweden and up to 24 times higher for Portugal. This reflects the significant differences in spending levels among EU countries, but the trends of both categories differ. The countries with high spending on HC are not necessarily as generous for LTC, and vice versa.

The average level of public expenditure on LTC for the 2006-2010 period, as reported by the OECD (Table 3, column 6), slightly differs from previous data. The projections for the spending level up to 2060 are even more interesting. The data presented in Table 3, column 7, shows the increase of LTC public expenses, including demographic and non-demographic determinants for the cost-containment scenario. For example, the calculations indicate that in Austria the expenses will increase from 1.1% of GDP to 1.8% in 2060. For current lower-level countries, estimates predict on average a tripling of expenses. For countries already spending highly, the increase expected equals 50 to 80%. Regardless of the considerable difference in data of the OECD and Eurostat, the regularity seems to be undeniable and all the developed countries will face a substantial increase in expenses.

**Table 3. Public and private expenditure as percentage of GDP**

| Country | Public LTC expenditure in 2010 | Public HC expenditure in 2010 | Public LTC expenditure (% GDP) in 2008 | Private LTC expenditure (% GDP) in 2008 | Public expenditure on LTC average for 2006–2010 | Public expenditure on LTC expected increase to 2060 |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Austria | 1,63 | 7,41 | 1,1 | 0,2 | 1,1 | 0,7 |
| Belgium | 2,35 | 6,31 | 1,7 | 0,2 | 1,7 | 0,7 |
| Bulgaria | 0,47 | 4,29 | nd | nd | nd | nd |
| Cyprus | 0,16 | 2,55 | nd | nd | nd | nd |
| Czech Republic | 0,81 | 6,89 | 0,2 | 0,0 | 0,3 | 0,9 |
| Denmark | 4,50 | 7,44 | 1,8 | 0,2 | 2,2 | 0,6 |
| Estonia | 0,82 | 6,52 | nd | nd | 0,2 | 0,9 |
| Finland | 2,51 | 8,02 | 1,8 | 0,4 | 0,8 | 0,5 |
| France | 2,16 | 8,02 | 1,7 | 0,0 | 1,1 | 0,6 |
| Germany | 1,43 | 8,00 | 0,9 | 0,4 | 0,9 | 0,7 |
| Greece | 1,36 | 6,50 | nd | nd | 0,5 | 0,9 |
| Hungary | 0,84 | 4,94 | 0,3 | 0,0 | 0,3 | 1,0 |

**Table 3 – continuation**

| Country | Public LTC expenditure in 2010 | Public HC expenditure in 2010 | Public LTC expenditure (% GDP) in 2008 | Private LTC expenditure (% GDP) in 2008 | Public expenditure on LTC average for 2006–2010 | Public expenditure on LTC expected increase to 2060 |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Ireland | 0,53 | 5,16 | nd | nd | 0,4 | 0,7 |
| Italy | 1,91 | 6,58 | nd | nd | 0,7 | 0,8 |
| Latvia | 0,67 | 3,73 | nd | nd | nd | nd |
| Lithuania | 1,22 | 4,93 | nd | nd | nd | nd |
| Luxembourg | 0,98 | 3,75 | 1,4 | 0,0 | 0,9 | 0,7 |
| Malta | 0,65 | 5,38 | nd | nd | nd | nd |
| Netherlands | 3,82 | 6,99 | 3,5 | 0,0 | 2,3 | 0,8 |
| Poland | 0,73 | 4,94 | 0,4 | 0,0 | 0,4 | 1,0 |
| Portugal | 0,31 | 7,15 | 0,1 | 0,0 | 0,1 | 0,8 |
| Romania | 0,63 | 3,66 | nd | nd | nd | nd |
| Slovakia | 0,27 | 6,19 | 0,2 | 0,0 | 0,0 | 1,1 |
| Slovenia | 1,43 | 6,14 | 0,8 | 0,3 | 0,7 | 0,9 |
| Spain | 1,11 | 6,52 | 0,6 | 0,2 | 0,5 | 1,0 |
| Sweden | 3,88 | 7,48 | 3,6 | 0,0 | 0,7 | 0,5 |
| United Kingdom | 1,97 | 7,20 | nd | nd | 0,9 | 0,5 |

Source: OECD 2013, OECD 2011, EU 2012, nd - no data available.

The available data (Table 3, columns 4 and 5) unquestionably shows that public funding is the most important and prevailing way of LTC financing. Private spending in Europe is the highest in Germany, Slovenia and Spain and very low in Sweden and Central European countries. The data available present some reasonable doubts, as the reported lack of private expenditure can be an effect of reporting bias and not the actual absence of private spending. Private costs often cover nursing expenses and remain in the area of "shadow labour market" (unregistered because of tax or legal requirements). In several countries, such as Poland or Italy, medical services in private clinics are also not fully registered. The author's research shows evaluation of private expenses as much higher than those officially reported.

## *Long term care in Poland — a call for a construct*

The issue of a long term care provision is exceptionally complex in the case of Poland. As presented before there are several factors that affect public policy negatively as: decrease of a HLY indicator combined with an increase of life expectancy, the lack of an integrated care system as well as diversity of funding sources. The impact of elements mentioned above is enhanced by public expectation of the state's responsibility for the LTC delivering. In the 90s the process of the Polish economy marketization was not accompanied with the collective discussion and the intergenerational contract over the welfare policy. Therefore, the aversion to public burdens occurs in Poland in parallel with the high social expectations for state performance, which seems to be a difficult to solve paradox.

The long term care services in Poland are delivered through the health care system and the social protection system at the same time. The health sector is responsible for healthcare units and benefits while the social sector is responsible for family benefits and old age disability pensions. Territorial governments are responsible for home care and the coordination of long-term care at the local level. Since 1999, public LTC institutions have been developed outside of hospitals but parts of the LTC system remain within the health system. This construction automatically induces the lack of integration as the health care system standards and rules for these services are rather managed at a central level while the social services are delivered by local authorities (Golinowska 2010).

All public LTC residential institutions are subject to a maximum co-payment of 70% of the recipient's monthly income. Funding for LTC services within the social assistance system is divided amongst four payers. The state is estimated to cover 75% of the overall cost of welfare home. This is supplemented by co-payments from the care recipient, the family and the local social budget. According to the Polish Civil Code, a family is the primary entity responsible for care delivery and, if not performing personally, responsible for care financing (Błedowski P., Maciejasz M., 2013). This is reflected in more frequent lawsuits brought by communities against dependent persons' families, who are forced to cover costs.

There is not a coherent care system in Poland. The rules and provision channels vary significantly according to the moment of a life cycle when the care is needed. The care for children is much better organized and financed than it is for adults. The increasing awareness of society and administrative regulations made an environment more accessible for those with movement limitation, while there is dramatically limited support for those with mental illnesses. Based on the findings of the report *Opieka długoterminowa w Polsce* (2010), the long term care delivered in Poland is highly limited or/and inadequate. Moreover the disability policy in Poland, including care and integration, is not efficacious and effective (Marska-Dzioba 2013). This is why there is an urgent call to rethink the principles of care provision, with no regard to the age or status of beneficiaries.

There are several factors affecting long term care in Poland particularly negatively. These are:

- much faster increase of the dependency ratio in following decades than in other European countries;
- "contribution gap" understood as fast decrease of systemic ratio and the expected deficit within the social funds dedicated for care purposes. It is caused by the high migration of people in working age, the high level of unemployment, the phenomenon of tax and social contribution avoidance, replacement of permanent contracts with short term agreements connected with reluctance or avoidance of social contribution payment;

"care gap" — caused by the high migration of women of age group 40–60 age, who used to be the main provider of care. The main care givers were women, particularly the daughter or daughter-in-law, who were educated to a secondary level in cities and to elementary level in rural areas. They now constitute the main source of well-skilled care services for Germany, Italy or UK additionally increased by the families structures polarisation. With the exception of disability pension the LTC benefits and services are tax based. In majority they are also means-tested. The long term care obligation (especially over a child) is the main cause of poverty and social exclusion as well as financial deprivation (Schraad-Tischler D., Kroll Ch., 2014).

The benefits for carers (with preferences for child carers) are very mean, even compared to other social assistance benefits as unemployment or maternity ones. A nursing allowance is exclusively available for carers who have given up jobs to care for family members with certified significant disability. For child carers the level of this allowance had been increased to the level of a minimum wage, while for the others it still remains much below this level. The nursing allowance awarded within the social security system and the eligibility criteria are very strict. This allowance is accompanied with a couple of additional nursing benefits (as for those over 75, or fully dependant), but their value is insignificant. Working carers can take time off work with compensation, up to 14 days per year. However, in general a carer is expected to resign from professional occupation rather than remain professionally active.

As there is no relevant data on LTC integrated expenses in Poland, the benchmark can be taken from the research over disability policy. Tables 4 and 5 present the level and the structure of disability policy expenses in Poland in 2010[3]. The investigation includes the structure of the direct disability policy expenses as well as the total expenses, which, besides the above mentioned, include the sickness benefits as the first step for disable status application.

The disability pensions are the most important element of disability expenses. For those, who were not eligible for the pension from the employment system the so called social pensions are awarded. It is granted to disabled individuals over 16 years old whose disability was certified before the completion of 21 years of age and eligible seniors over 75 years old who are not pensioners. It is essentially an income-support measure, granted

[3] The limitation for just one year is caused by the significant lack of integrated data for supported education, which is a domain of local authorities and is not reported as a one bulk.

by the state budget. Once income eligibility is assessed, the amount is fixed and not related to the beneficiary's income level. The expenses directly connected with long term care as medical rehabilitation, social protection and care benefits constitute around 15,81 percent of total disability policy expenses. Assuming, that the 5 percent of disabled persons are assessed as fully disabled and not able for independent living, the expenses dedicated for the LTC over this group amount at least 0,04 proc. GDP of 2010. Based on data from 2008, S. Golinowska has estimated LTC public expenses, both from the health and social system, as 0.25 percent of GDP. In the World Bank Report (2010) the total expenses, both private and public, were estimated an even 0.8 percent of Polish GDP. As the credible data is not available, the life experience requires the assumption it is rather higher than lower.

**Table 4. The structure of disability policy expenses in Poland in 2010**

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

Source: N. Marska-Dzioba 2013, p. 249.

**Table 5. The level of disability policy expenses in Poland in 2010**

| | as % of GDP | Per capita | per disabled person |
|---|---|---|---|
| Total integration expenses | 4,86% | 512 EUR | 4108 EUR |
| Total including sickness benefits | 5,34% | 563 EUR | 4516 EUR |

Source: N. Marska-Dzioba 2013, p. 250.

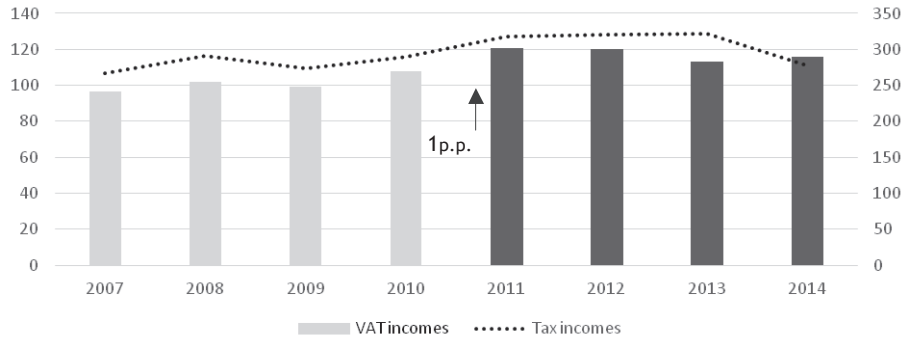
The discussion on the necessity of LTC system creation, that is currently timidly undertaken in Poland, does not focus much on financial issues. As mentioned before, the method of financing is rather considered as a secondary to the coherence structure of medical and social services. However, the possibility of relatively effective funds collection can become a milestone for further changes. The report *Opieka długoterminowa w Polsce* (2010) suggested the gradual implementation of changes. It was reflected in the project of an Act on dependant person support (July 2013), which so far is the only proposal of a LTC

quasi-system construction (with exception of author's recommendations presented below). It includes the new model of LTC financing. It consists of the direct provisions from the budget (I$^{st}$ pillar), voluntary private insurances (II$^{nd}$ pillar) and an obligatory social insurance (III$^{rd}$ pillar). The I$^{st}$ pillar would be created from the sources presently designed for nursing and extra care benefits with additional costs covered by local authorities. The II$^{nd}$ and III$^{rd}$ pillar would be created as the new instruments. As the general direction of the project is acceptable, the financial issues seem to be overestimated. The former experience of the old age pension system reform requires much more mistrust according to market solutions built into an obligatory public system.

Aside from the problem of an acceptance for the increase of the social contribution and unsuccessful implementation of private LTC insurance (with exception of France), it is important to mention the fiscal sensitivity of each of the solutions. Addressing the necessity of changes, it is important to take into account the unique legal, social and structural features of each economy, which determine the system performance. The international economic situation, the public funds crisis, tax avoidance in reference to Laffer curve phenomenon or changes within the old-age pension systems can limit increase of expected incomes even if a tax or a contribution rate became higher. For the Polish economy this comparison can be made for VAT and disability fund contribution changes.

In 2011 the rate of VAT was increased by 1 percentage point in general. The two main rates were changed from 22 and 7 percent into 23 and 8 percent respectively and remained unchanged until now (II$^{nd}$ half of 2014). As presented in graph 3 the increase in incomes between 2010 and 2011 achieved 12 percent, remained constant in 2012 and afterwards decreased in 2013 with 6 percent. The year 2014 is expected to record VAT incomes higher compared on an annual base. The changes in VAT incomes were consistent with the main trend line of cumulative tax incomes and arise rather from the general economic situation than the VAT rate increase (Gadomski 2012, Pałka 2014).

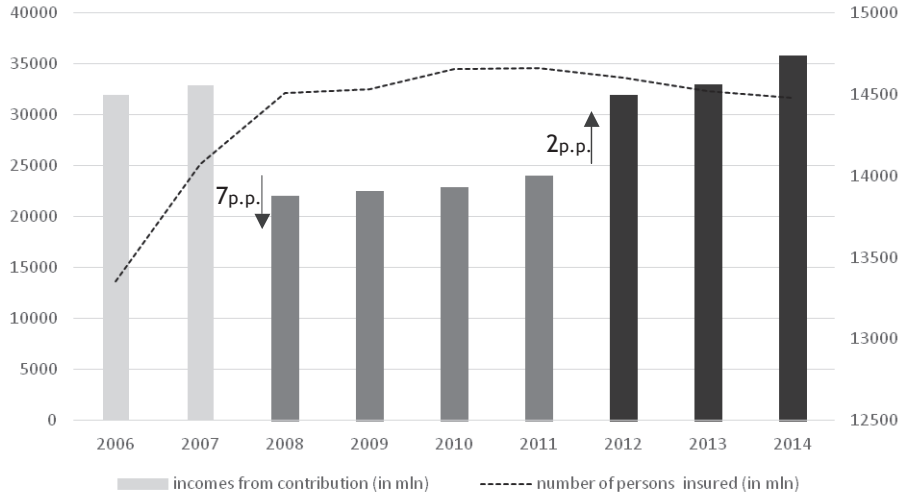
**Graph 3. VAT and total tax incomes in Poland during 2007–2014**




Source: Own calculation based on Ministry of Finance reports on budget performance and on budgetary act.

The disability pension fund is the sub-fund of Social Security. In 2007 the contribution rate (calculated on the base of a wage) had been gradually decreased from 13 percent to 10 percent in the second half of 2007 and then down to 6 percent from February 2008. As presented on graph 4 incomes of the disability fund had fallen in 2008 down by 33 percent and remained relatively constant within the 4 following years despite the increase of persons insured[4]. In February 2012 the disability fund contribution rate increased again up to 8 percent, what resulted in a 16.5 percent increase in incomes. In the following years the incomes increased by 3 present in 2013 and (expected) 12 percent in 2014.

**Graph 4. Disability fund incomes during 2006–2014**




Source: Own calculation based on Ministry of Finance reports on budget performance and on budgetary act.

The brief comparison of data presented above indicates that a 1 percent change in the VAT average rate resulted in a 2 percent change in the income, while the 1 percent change in contribution resulted in only 0.66 percent change**.** Higher sensitivity of VAT could become an argument for using tax incomes rather than contributions if there is a need for immediate source aggregating. However, it is important to take into account the increasing amount of VAT tax gap as well as an estimated growth of deficit in the disability pension fund.

The experience of 14 years of theold-age pension system in Poland indicated the inefficiency of the three-pillars model. It also proved how much time is required to produce a new, coherent legislation within a highly complicated security system. Therefore, the optimal scenario for LTC integrated system should be established initially as a tax based

[4] As there are shortcomings in public statistic the number of persons insured is not equivalent to the number of contribution payers.

model and later it could be replaced with the new kind of obligatory social insurance assisted with tax reductions. This would demand not only political consensus but also the broad public discussion and growth of social awareness. Apart from the political and social context, there are three requirements which need to be met. These are 3Cs of the future Polish LTC system:

- **Connection** - the LTC should be perceived as an element of (preferably) disability policy than (exclusively) senior policy;
- **Commodification** of care — simple, flexible contracts for carers (no matter the ties), tax preferences for voluntary LTC insurances;
- **Coordination** - The State Fund for the Disabled and Rehabilitation could become a central supervisory and executive institution.

## *Conclusions*

Paying for care has become an obligation and not a privilege. Following this expectation, the policy makers should introduce new solutions to the existing social system or propose separate systems for financing LTC. The pressure is even stronger, because with the increase of care demand, the informal care becomes more formal, and as a result, the private sources tend to be, or are required to be, replaced by public sources. Moreover, private expenses statistically omitted grow very fast. Facing the unavoidable increase of total expenses, it is important to create coherent solutions for all recipients: old and young, dependants and carers, families and institutions. With the exceptions of Germany and the Nordic countries, the present structure of care financing, even supported with a growing amount of research, is rather inconsistent and hollow. When creating further solutions, and possibly a coherent LTC system, it is worth considering mandatory social insurance as a possible rational solution. Social insurance is able to reduce market insurance problems, is well understood politically, and can cover both medical and social costs without changing the standards and equality criteria (Barr 2011). The problem of adverse selection can also be avoided through early age of accession and universal participation (Pestieau, Ponthiere 2012). Nevertheless, the implementation of LTC social insurance seems to be almost the final stage of unavoidable changes.

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***Streszczenie***

Od momentu, gdy w publicznej świadomości zjawisko starzenia się społeczeństwa uznane zostało za nieuniknione, konieczność zapewnienia opieki osobom niesamodzielnym stała się istotnym zadaniem publicznym. Artykuł przedstawia doświadczenia i osiągnięcia badań nad relacjami pomiędzy konsekwencjami starzenia się społeczeństwa i polityką integracji osób niepełnosprawnych a także nad poziomem przyszłych potrzeb opiekuńczych. Omówiono w nim złożoność finansowania usług i świadczeń opiekuńczych w krajach Unii Europejskiej, ze szczególnym odniesieniem do sytuacji Polski.

**Słowa kluczowe:** opieka długoterminowa, niepełnosprawność, finanse publiczne

***Cytowanie***

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