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Elderly care and its contexts. Example of Poland and Albania

Abstract

The article presents a comparative development and current state of care for the elderly in Poland and Albania, as well as some of its determinants. These countries were selected for analysis both because of their post-socialist welfare state tradition and similarly strong familisation of care. The text discusses both the health and

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socio-economic situation of the elderly population and demographic trends affecting care (based on Eurostat, WHO, and national statistics) as well as the panorama of the current care system created by the state and/or the private and non-governmental sector. Based on the analyses, several conclusions were presented. The high level of internal and international migration (especially in Albania) disrupts the model of family care for seniors, especially in some regions of these countries. The countries studied vary in the types of chronic diseases older people suffer from, which should influence the type of care provided. The scale of social services in both countries is far from sufficient, however, based on numerical data it can be concluded that in Poland support, both institutional and environmental, is much more widely available. In Albania, the main provider of formal services is the private sector, and in Poland, there is a move towards a multi-sector model, increasingly entrusting the running of institutions, daycare centres and care services to non-public entities and the civic sector (volunteering, neighbours). The directions of care policy in both countries are similar, consistent with those set by the EU, and aim at deinstitutionalisation and multi-sectoralisation.

Keywords: deinstitutionalisation, long term care, ageing of the population, elderly, social policy

Introduction

In Polish literature, there are more and more studies on the support of dependent elderly people, as well as studies comparing the care systems of European countries (Golinowska & Sowa, 2013; Błędowski & Maciejarz, 2013; Łuczak, 2016; Bakalarczyk & Jurek, 2021). Meanwhile, there is no literature on the support of the elderly in Albania, despite the fact that there are articles on problems with financing healthcare (Druga, 2021, 2022), the development of social work (Ymeraj, 2018; Dhembo et al., 2020), or general direction of social policy. The current literature shows that the reforms of social policy developed in Albania, after the transformation from the totalitarian system to the current one, shape a marginal model of social policy in which social services, especially for children, the elderly, and the disabled, are significantly underfunded. The role of a woman in this system is that of the main caregiver, which hinders professional activity. Social services have a poor range and involve, without financial support from the state, civil society (volunteering in the broad sense) as well as private entities and non-governmental organisations (Poni, 2022). Meanwhile, the study of Albanian social policy seems interesting, not only for purely theoretical reasons but also because Albania has had the status of an EU candidate since 2014, and this fact seems to influence the country's current social policy. It is a kind of similarity to the social policy that is implemented in Poland, which, being a member of the EU since 2004, also conducts a coordinated state and EU policy. Belonging to supranational political structures entails obligations to provide similar responses to civilisational challenges, such as the need for taking care of a growing group of dependent elderly people. The European Union sets out the directions of care policy for seniors,

such as deinstitutionalisation or multisectorality, which are largely related to the need for reducing the cost of care (*Common European Guidelines…*, 2012). Common directions are also set by other global organisations, the World Bank, ILO and UN. For example, the United Nations recognises such principles of elderly long-term care as: (i) independence in terms of food, water, shelter, and access to income-generating opportunities; (ii) participation in terms of integration into the society; (iii) care like access to health care for physical, emotional wellbeing; (iv) self-fulfilment; (v) dignity (United Nations, 1999).

Deinstitutionalisation and multi-sectorality are among the most important concepts defining the contemporary shape of care for seniors (in addition to the influence of the directions of care policy, they also include the concepts of activation, social investments, innovations in economisation and managerisation, the use of the informal sector, goods, and public choice) (Grewiński, 2021). These directions aim to develop social services. These concepts are associated with the term service society, based on an economy in which services prevail over goods, and there are more and more service professions in the employment structure. Daniel Bell wrote that this type of transformation takes place in post-industrial societies.

The first of the mentioned concepts – deinstitutionalisation – is defined in the literature on the subject and in programme documents, especially the EU. It is presented synthetically by Krzyszkowski (2018), as an element of senior policy. Firstly, he sees it as a contemporary tendency in formal care for dependent people. Secondly, he understands it as activities undertaken to create various forms of services (including health services) in the community, aimed at ensuring proper care and extending the period of psychophysical fitness and the ability to perform social and professional roles. The development of community services is also aimed at limiting the scale of support provided in 24-hour institutions such as social welfare homes. The two leading reasons for accelerating this process are economic (considering institutional care to be more expensive) and social (customer preferences). Attention is drawn to the fact that the European Commission guidelines have intensified this process, especially in the last decade. Already in 2012, *European guidelines on the transition from institutional care to care provided at the level of local communities* were developed.

In turn, the concept of multi-sectoral refers to the implementation of local social services and involves institutional diversity in the implementation of social services (welfare pluralism). The essence of multi-sectoralism is the distribution of responsibility for the implementation of social tasks and services among a larger number of entities operating within equal sectors (governmental, non-governmental, and commercial). It involves various stakeholder groups in the provision of social services, as well as citizens who co-create more or less formal social services. This contributes to the development of the governace approach. Services are provided by the public sector (usually local government, less frequently by the state), and services are produced and implemented by non-governmental or religious organisations, market entities, and public institutions. The informal sector (family, friends, neighbors, community, local environment) also co-produces services (Grewiński, 2021).

This article aims to present in a comparative perspective selected elements of the system of care for the elderly in both countries, as well as to illustrate some of its

conditions. The authors of the article assume that when writing about care for the elderly, one should take into account not only the characteristics of the system itself but also its demographic, socio-economic, and health context, because it shapes the approach to the organisation of this system. However, due to the limited size of the article, we will focus only on demographic factors – the process of ageing of societies and factors related to health. The following research questions were formulated encompassing two spheres. The first, concerning the conditions of care: what are the similarities and differences between Poland and Albania in terms of demographic and health conditions of the system of care for the elderly[3]? And the second, regarding selected features of the care system: (i) how is care for the elderly (long-term) understood in Poland and Albania? (ii) What is the specificity of the organisation of institutional and community care in the surveyed countries? (iii) What are the main directions of development of care for the elderly specified in programme and strategic documents?

When answering research questions, the authors refer to statistical data and Eurostat, UN, and WHO – whenever it is possible to obtain data for both countries, as data on Albania are often presented to a very limited extent. In turn, the description of the care system was developed on the basis of national (Polish and Albanian) strategic documents, programmes, departmental reports, and research reports on care for the elderly. It is worth noting that comparative comparisons are difficult to make, because long-term care systems are very diverse.

The studied countries differ in many aspects, but they also have similar features. They are diverse in terms of population, based on Eurostat data from 2021, 37,747,124 people lived in Poland, while in Albania the population was 2,811,667 (Eurostat, 2023a). However, they have a similar rate of urbanisation, around 60% (United Nations, 2023), much lower than the EU average[4], which is worth noting in the context of the topic in question. This indicator is important because rural and urban lifestyles are different, as is the structure of households in rural and urban areas, or access to social services for the elderly. On the other hand, it is predicted that in 2050, almost 80% of the population will live in the city in Albania, and about 70% in Poland (United Nations, 2023a). In both countries, there are high emigration rates, which also affects the situation of caring for the elderly, because mainly people of working age, i.e., those who can take care of the elderly, emigrate. The surveyed countries, in turn, are differentiated by another factor important from the point of view of the possibility of

[3] Long-term care is defined as a range of services provided to people with limited physical, mental or cognitive ability to function, as a result of which they become dependent on assistance in basic activities of daily living for an extended period of time. This care can be treated as a set of medical and social activities consisting in the provision of long-term nursing care, rehabilitation, therapeutic services and nursing and care services as well as the continuation of pharmacological and dietary treatment for chronically ill and dependent people who do not require hospitalisation in a hospital ward. This care may be provided by formal carers (medical staff and social assistance workers) or informal carers (family, relatives, volunteers). WHO and OECD definitions (Ministry of Labour and Social Policy, 2022).

[4] For comparison, 100% of citizens live in cities in Belgium, 85% in Finland, 74% in the Czech Republic, 72% in Hungary, 80% in Greece, 78% in Belarus, 75% in Bulgaria, 54% in Romania, 65% in Portugal, and in Great Britain 83%.

care, namely, independent living of the elderly. In Poland, 13.5% of all households are composed of the one adult of 65 years of age or above type, and in Albania only 4.3%, while the percentage of two adults, at least one aged 65 years old or above type of households is similar – in Poland 10% and in Albania 12 % (Eurostat, 2023b).

There are differences in wealth between the countries surveyed. In Poland, the nominal GDP per capita in 2021 was USD 17,815 and in Albania USD 6,375 (IMF, 2022). However, the Gini coefficient measuring income inequalities does not show large differences in the income level amounted to 32 in Albania and 30 in Poland. Albania seems to be on a different stage of demographic development than Poland, although both countries exceeded what is called the advanced ageing scale[5]. Poland has been experiencing this process for several decades now and the percentage of people over 65 is much higher here than in Albania, so social policy towards seniors also seems to be more advanced. Albania is just beginning to see the problems in the pension and healthcare systems caused by an ageing population. Public authorities are concerned that more and more elderly people live alone, while their economic situation is worse than the rest of society. The Director of the Institute of Public Health confirms that Albania is late in taking measurements for the amortisation of the problem. He suggests measurements in promoting fertility, increasing bonuses, and subsidising families with many children but also a private scheme of retirement could be a solution, along with increasing the age of retirement (*Monitor Magazine*, 2017).

It should be noted, however, that in both analysed countries the advancement of the population ageing process is definitely lower than in the countries of the old European Union, however, at the same time, preparing for the provision of services for dependent elderly people is definitely less developed, e.g., the scale of providing care services for seniors significantly differs from the scale of rich European countries. In Poland, in accordance with EU recommendations, there are heading towards deinstitutionalisation, while we have not yet reached the point where institutional services would have been sufficiently developed. An example is the institutional support for the elderly, which can be determined based on the Long-Term Care Resources and Utilisation index: beds in residential long-term care facilities per 1,000 population aged 65 years old and over. The value of this indicator shows that Poland belongs to the EU countries where this number is the smallest, and in the years 2010–2020 it systematically decreased from 12.4 to 10.7 (OECD, 2023a). Currently, a similar level is in Turkey, which bases the care system almost exclusively on the family. There, the value of this indicator in 2020 was equal to 9.6. In Poland this index is even lower than such Central European countries as Latvia, and definitely lower than Slovakia, where this index is 46.9, or Hungary 43.6, and Sweden, which has the highest index, 64.8 (OECD, 2023a). Unfortunately, OECD databases do not provide any data regarding the number of beds for Albania. However, based on other sources of and own calculations, it can be estimated that this indicator was 1.65 in 2020 (ILO, 2023)[6].

[5] The share of the population aged 65 and above exceeded 7% (Rosset, 1967, p. 75).

[6] There are in total 697 beds where 344 beds are offered by public institutions and 72 are offered by private institutions (ILO, 2023).

It is also worth noting that the countries surveyed have different crude divorce rates. In Albania it is 1.1., which is much lower than in Poland – 1.6 and, in Albania, there is also a much higher percentage of households with 2 or more children (Eurostat, 2023 c). However, the surveyed countries share the family model of senior care and the attitude to the family as a value, as well as the declared great respect for the elderly (Halman et al., 2022). In Albania, the percentage of people who are concerned about the elderly is higher – 80–89%, while in Poland it is 60–69%, the results are similar in relation to the sick. In Albania, this concern is among the highest in Europe, perhaps due to culture but also because of the limited availability of public support (Halman et al., 2022)[7].

Advancement of the ageing process in Poland and Albania

The advancement of the ageing process is related to the increase in the number of the oldest age groups and is an important variable determining care needs. The older the age group, the higher the percentage of people using care. As the Polish report *Mapa Potrzeb Zdrowotnych* shows, long-term care patients aged 65 and more constitute the vast majority of all long-term care users – people aged 65–79 make up 30.3%, and people aged 80 and more make up more than 50% of the patients (55.2%) (BAZiW, 2023).

The world is extremely diverse in terms of population ageing, the advancement of this process is the greatest in Europe, more than in North America. It can be said that the reason for this is that we are dealing with different phases of demographic development simultaneously (Van De Kaa, 1987) and the accompanying phases of epidemiological transition (Wróblewska, 2009). While in Europe it is predicted that the percentage of people aged 65 and above will be around 23% in 2030, and almost 30% in 2050, demographic processes in Africa are of a completely different nature. The population is the youngest there, in 2019 people over 65 accounted for about 4%, and forecasts for 2050 predict a maximum of 5% older than 65 (United Nations, 2019). In the context of preparing the world for a better life for the dependent elderly people, the news about the increase in the subpopulation of the elderly is also important. It turns out that in 2015 people over 80 accounted for about 4% in Europe, 3% in North America, and less than 1% in Africa. The percentage of octogenarians is projected to increase to 10% in 2050 in Europe (United Nations, 2019). Another common phenomenon is the feminisation of the old age, i.e., the number of women exceeding the number of men, which is related to the higher average life expectancy of the former. Feminisation is accompanied by singularisation, i.e., women living in one-person households.

One of the fundamental regularities related to the process of population ageing is that in countries with low and medium income per capita, the phenomenon of ageing

[7] The inhabitants of Poland and Albanians also have an attitude towards religious values, although they are followers of different religions, representatives of both countries declare that religion is very important in their lives (notably, religion is equally important for Italians). In Albania, faith in God is declared by over 90% of the inhabitants, and in Poland by about 70% (Halman et al., 2022, p.19).

is more intense than in high-income countries. Currently, two out of three older people live in low- and middle-income countries, and this proportion is projected to increase to four out of five older people by 2050 (Tessier, De Wulf, & Momose, 2022).

The problem is that ageing in these poorer countries co-occur with the economic and institutional development, which is usually much more difficult than when high--income countries such as France and Sweden begin to age. There are significant differences in the progression of this process within Europe. In Poland and Albania, although they are younger societies than the countries of Western or Northern Europe, the increase in the percentage of seniors is much faster, the negative consequences of which are felt more strongly (at the level of the entire society and households). Let us add that mass emigration in both countries strongly affects the ageing of societies, as well as limits the possibilities of caring for the elderly, which is definitely higher in Albania than in Poland[8] .

One of the population ageing indicators is the median age. In the analysed countries, it is different, in 2022 it amounted to 40.3 years in Poland and 37.6 in Albania, forecasts say that this difference will reamin unchanged and in 2030 the indicator will reach 40.3 in Albania and 44.1 in Poland, which is conditioned, among others, by higher fertility rates in Albania (United Nations, 2023 b). At the same time, the percentage of elderly people in Poland and Albania is also dissimilar. According to National Statistics of Albania (Instituti i Statistikave, INSTAT) on January 1, 2019, 12% of the total population in Albania is aged 65 and above. In turn, Poland was at this stage several decades ago and today the ageing process of the society is much more advanced, in 2019, from among 38,382,576 inhabitants, 18% were people over 65 (in 2021 already 19%) (GUS, 2023). The ageing process, however, is intense in both countries studied. From 2009 through 2019, the number of people in the post-working age category (women above 60 and men above 65) increased by 2,096,328 (33.2%), and the share of these people in the total population increased by 5.4 % (from 16.5% to 21.9%). The population projection until 2050 predicts the continuation of the existing trend (GUS, 2014). In the same period, the number of people aged over 80 increased from 1,257,221 to 1,691,736 (by 34.6%), while their share in the total population raised from 3.3% to 4.4%. The forecast until 2050 indicates a continuation of the above trend. At the end of this period, the number of octogenarians is to amount to 3,537,498, i.e., 109.1% more than in 2019, and their share in the general population is estimated to amount to 10.4% (GUS 2014)[9]. In Albania, the increase in the percentage of older people is even faster. From 1990 through 2020, the population of people over 65 increased from 5.5% to 14.8%, and forecasts for 2050 predict an increase to 26.4%. On the other hand, people above 80 accounted for 2.9% of the population in 2020, forecasts for 2050 assume an increase to 9.1% (ILO, 2022, p. 2). The government of Albania notes the populationis ageing, because of the combination of three factors: the increase in the percentage of elderly people, 65 years old and

[8] Over the last 30 years, 1.6 million Albanians have left the country, almost half of the country's population (Halman et al., 2022).

[9] According to current population projections (for 2023–2060), there will be 3 million people above the age of 80 in Poland in 2050 (GUS, 2023).

older, the decrease in the percentage of children and young people as well as emigration growth. Currently in Albania, about 46% of elderly people (65+) live in rural areas, isolated and alone (INSTAT, 2023).

Health condition of the elderly as a care influencing factor

In terms of elderly care, it is worth presenting data showing the relationship between age and the health and functional capacity of the elderly. The ageing of the population leads to an increase in chronic diseases and disabilities, which in turn is associated with greater needs in the field of care for the elderly, often intensive and continuous. The analysis of data on the health situation of the elderly in Poland and Albania leads to two conclusions. Firstly, in both countries, the scale of the incidence of diseases increases significantly with age and the group of people unable to live independently (which is a common phenomenon). Secondly, there are significant differences between the countries in question regarding the types of diseases, which prevail in this group. Probably these differences result from many economic and social differences affecting the lifestyle, the state of the environment, and healthcare. In the 1970s, Marc Lalond, researcher and Canada's Ministers of Health, wrote about the profound impact of lifestyle on health (Wysocki & Miller, 2003). This aspect was also noted by Giddens (2008) when he discussed habits protecting health or exposing a person to its loss, which are diet, physical activity, coping with old age, sexual behaviour or the use of stimulants.

When it comes to the differences in healthy life expectancy in Albania and Poland, it should be noted that these differences are not as significant as, e.g., those between Poland and some Western European countries (the average healthy life expectancy in Sweden is about 10 years longer than in Poland). As shown in Table 1, the health condition of men in Albania is better than in Poland, which is also evidenced by the data showing the frequency of particular types of chronic diseases in elderly men. The situation for women, however, is different. In Poland, they are healthy longer than in Albania.

Table 1. Health status in Poland and Albania in 2021

Country	Healthy life years by sex/ Male	Healthy life years by sex/ Female	Healthy life years by sex/ Male/60 years	Healthy life years by sex/ Female/60 years
Poland	71.6	79.6	17.2	22.3
Albania	73.6	77.7	17.7	20.2
UE 27	77.2	82.9	21.0	25.1

Source: Eurostat (2023d)

The PolSenior 2 research shows that over 40% of people over 60, i.e., about 3.7 million Poles, suffer from what is called great geriatric problems (falls, urinary incontinence, mobility problems, depressive and cognitive disorders, multimorbidity). Almost 70% of the elderly in their youngest age groups and over 90% in the oldest age

groups experience multiple diseases. The most common diseases include cardiovascular diseases and endocrine and metabolic diseases (Kujawska-Danecka et al., 2021; GUS, 2021). In turn, the assessment of the life independence of the elderly shows (GUS, 2016, pp. 18–19) also that after the age of 70, there is a significant increase in the percentage of people for whom independent functioning is challenging, defined both in the ADL scale (problems relate mainly to lying down and getting up out of bed or sitting down and getting up from a chair, taking a bath or showering) as well as on the IADL scale (the most frequently mentioned problems are performing easy and difficult housework and shopping). It is estimated that in Poland, constant assistance in basic everyday activities is required by 30% of people over 60 and as many as 60% of people over 80 (Dziechciaż et al., 2012). The estimated number of elderly people requiring assistance in everyday functioning in 2030 will amount to 4 million (Wilmowska-Pietruszyńska & Putz, 2009).

In Albania, according to research conducted there, the health condition of the elderly is the most important problem. Several studies carried out by the Association of Gerontology showed that about 60% of the elderly throughout the country suffer from chronic diseases. On the other hand, 21.6% of persons aged 65 or above living in private households have limitations in performing daily activities because of health problems. These results are confirmed by other studies, e.g., the Institute of Public Health in 2016 found more than two-thirds of the elderly over 650,000 are ill or suffer from a chronic disease, while one-third of them report suffering from more than one disease or health problem (*Monitor Magazine*, 2017). According to the Institute of Public Health out of 530,000 elderly people registered with the family doctor, about 405,000 use the services financed by the health insurance scheme. About 160 thousand are regular beneficiaries of the scheme, and on average they reach the value of 252 M ALL (2.3 M Euro) per month (*Monitor Magazine*, 2017). Currently, out of 90,900 people in need of care, 51,700 are women and 31,900 are men, but only 1.6% are benefitting from social care services. At least 90,900 (21.6%) aged persons above 65 years of age are estimated to be in need of long-term care, and in 2031 their number is estimated to increase to 130,000, while in 2050, there will be about 161,000 such persons (ILO, 2021). It seems, therefore, that the analysis of health condition of the oldest inhabitants of Poland and Albania indicates a greater need for care in Poland.

Due to the different income situation of Polish and Albanian populations, the possibility of providing care in the event of disability and illness may differ in both countries. In Poland, the rate of persons at risk of poverty or social exclusion at the age of 60 and above in 2020 was 19.9%, and in Albania as much as 49.2% (in the EU 20.8%) (Eurostat, 2023e).

A higher income gives a greater opportunity to pay for social services, and to reach a doctor in a situation of a long distance. The report on the reasons for the inability to meet health needs seems to confirm this relation. It is presented in Table 2. It shows that there are differences in access to health care between the countries surveyed. In addition, it is worth noting that people living in rural areas, apart from more difficult access to health care, have much lower pensions. In both countries, pensions in rural areas account for about 30% of the average salary, and about 60% from the non-agricultural system.

Table 2. Self-reported unmet needs for medical examination by sex, age, main reason declared and educational attainment level – 65 and above in 2020 year

Country	Too expensive	Too far to travel	Waiting list	No time
Poland	0.4	0.3	2.2	0.1
Albania	15.2	0.8	1.9	2.0
UE 27	1.6	0.2	0.9	0.1

Source: Eurostat (2023f)

As has already been pointed out, not only the scale of dependence but also the specificity of the diseases they experience, especially chronic ones, is of great importance for determining the nature of care for the elderly. The types of diseases and their frequency should not only be an indicator of the size of the need for assistance but also for a specific type of medical, psychological, and social care, and for a specific type of medical and social care professionals. The differences between Poland and Albania regarding the types of chronic diseases experienced by the elderly are significant, and the explanation of these differences may be an interesting research topic.

According to the Causes of DALY, for both sexes aged 60 and above daily per 100,000 index (WHO, 2023), in both countries the most common diseases are ischemic heart disease and stroke. However, in almost every age group, stroke occurs much more often (in some age groups even thrice) in Albania than in Poland, both in the case of women and men. However, interestingly, in Albania women experience it more often than men, and in Poland it is the opposite. In the case of ischemic heart disease, the relationship is also interesting, in Albania more women than men suffer from it in each age group, and in Poland, it is the opposite (except for the oldest age group – 80 years and older). It is worth noting that much more Polish men are affected by this disease than Albanians. In addition, it can be seen that:

- differences between countries are also evident in the incidence of Alzheimer disease and other types of dementia. Among Albanian women, the scale of this disease is already significant in the age group of 70–74, and among the cluster of 75–89 year olds it is visible in both sexes. In Poland, on the other hand, this disease is visible on a larger scale only among women over 75, and among men over 80. Howenver, among Albanians of both sexes over 80 years of age and older, this disease is much more common than in Poland (twice for men, thrice for women). Statistics show that Parkinson disease affects people of both sexes above 80 in Albania (causes of DALY for both sexes aged 60– 100,000), however, this disease does not appear on a large scale in Poland;
- a significant difference between Albania and Poland is observed on the example of Diabetes mellitus. In Poland, this disease is diagnosed twice as often, and in some age categories (70–74) almost thrice as in Albania. In Poland, in the case of both sexes, it is also much more common than in Albania. As is the case with colon and rectum cancers, where the causes of DALY for both sexes aged 60+ DALY per 100,000 do not show cases of this disease in any age group.

- Poles (both women and men) suffer from chronic obstructive pulmonary disease almost twice as often in each age group of the elderly. Similarly, other types of hearing loss are more common in Poland than in Albania but in both countries it is more common in men than in women (WHO, 2023).

Caring for the elderly. The case of Albania

In Albania, long-term care is defined in Law 121/2016 on the Services of Social Care in the Republic of Albania. The law is designed for all the six categories in need, and one of these is the elderly group. The law prevents five types of services, however, in the case of the elderly it provides: *residential care services* for those with permanent health problems who cannot have their basic needs met; *home services* which are provided in a form of home-like meals and medicines supply, personal hygiene, etc.; and *daycare services* at the community centres offered by the local government (ILO, 2023, p. 10). On the other hand, social care services are organised in public social care provided by the state and non-public social services. Regarding the health care system, the respective law For the health care in the Republic of Albania does not mention the elderly (ILO, 2023, p. 10). Moreover, no profession for old age care exists in Albania. The only school existing for this profile is developed as an international project initiative from the German Agency for International Cooperation (GIZ). Even the nurses are not specialised in medical services for the elderly or other categories (Federich Ebert Fundation, 2014).

The law on the services of social care provides also the principles of the care such as: (i) universality; (ii) social justice; (iii) subsidiarity; (iv) social support; (v) deinstitutionalisation; (vi) partnership; (vii) respect for human rights and the integrity of the beneficiary; (viii) non-discrimination; (ix) confidentiality and protection of personal data (Law 121/2016, Article 4). On the other hand, the National and Action Plan for Elderly defines other principles such as empowerment at personal and community level; attention to the neediest or vulnerable groups, gender equality, intersectoral measures, financial sustainability, and cost-effectiveness (Ministre e Shëndetësisë dhe Mbrojtjes Sociale, 2019).

In Albania social care services are provided by public or non-public legal entities which can offer such services in accordance with the conditions defined in this law (Law 121/2016, Article 27). The institutions responsible for the administration of the system of social care services are the Ministry for Social Issues and its dependent institutions, the district and the municipality (Law 121/2016, Article 27, 30). Concretely, the ministry is responsible for policy preparation, such as designing and update of standards, determining criteria, and conditions, undertaking campaigns for volunteer work, etc. (Law 121/2016, Article 30). On the other hand, the Institute of Social Service, and the Services Inspectorate of Social Care, are under the supervision of the ministry. The first one is responsible for drafting standard documentation for beneficiaries of social services, assessing the performance and the needs of social care services (Law 121/2016, Article 32), while the Inspectorate of Social Care is responsible

for controlling the implementation of the criteria and conditions of public and private entities and can impose fines in case of violations of the provisions of the law (Law 121/2016, Article 34, 35).

At the local level, based on Law 139/2015 On local self-government, the municipalities are responsible for the creation and administration of community social services at the local level, construction, and administration of centers. Nevertheless, despite the decentralisation of powers the possibilities of the municipalities for the establishment, administration, and operation of social services for the elderly are limited because of the lack of financial resources. The study "Observation on local budgets spent on social care services in some municipalities of the country", supported by UNDP in 2018, showed that social care services in the municipality are almost completely financed by conditional funds (government funds). Financing from "unconditional funds" or "income of the municipality itself" is almost negligible, about 2–3%, with the exception of Tirana, where "income of the municipality itself" covers 8% of the needs (Ministre e Shëndetësisë dhe Mbrojtjes Sociale, 2020, p. 25).

From the structural point of view, all 61 municipalities have appointed one social worker for 6–10 thousand inhabitants. In the case of municipalities with a smaller population, the services are offered by the regional officers of the State Social Service (Law 121/2016, Article 36). The duty of social workers is crucial as they verify the social and economic situation of individuals and families who need social care, help with the preparation of the documents, collect information and statistics for potential and real beneficiaries of the social system, etc. On the other hand, the role of the district is just to gather the needs, the statistics, and the plans of the municipalities as well as to present them to the responsible ministry (Law 121/2016, Article 36, 37).

In Albania, in total, there are 50 types of social care services for the elderly provided by 43 institutions, where 19 (42%) are public institutions and 24 are private institutions. Regarding public institutions, 43% are financed by the municipalities and 39% by the state. On the other hand, regarding private institutions 35% are financed by NGOs and 31% by international organisations, and 34% are financed in a mixed way (ILO, 2023). In terms of types of service, 32% are community services and 26% are residential services, followed by emergency services (16%) and family services (14%). Other types of services like specialised services, consultations, alternative care, and pre-social services constitute 12% in total (ILO, 2023).

The service for the elderly in the residential centres is guaranteed, qualitative, and based on the service standards approved by the Albanian government. In the service of the elderly, there are staff with specialised employees for this type of service, multidisciplinary teams that carry out a personalised assessment of the requirements of each elderly person, who have also drawn up, at the same time, an individual intervention plan to meet the identified needs. The right to appeal for any case of dissatisfaction or dispute about the quality of food, hygiene, employee behaviour, etc. is guaranteed. However, social service centres for the elderly are insufficient, while their capacity is also limited to meet service needs (Ministre e Shëndetësisë dhe Mbrojtjes Sociale, 2019, p. 11).

In Albania there are 91,000 persons over 65 years old, or 21% of people over 65, who needs long term care but only 2% of them (or 18,200) recieve long-term care other than

in hospitals. On the other hand, in Albania in 2021, the number of elderly receiving social services is 1,682 persons or 1.6% of population over 65 years old (ILO, 2022).

The first national plan for the elderly was developed in 2000, and it includes also the action plan of the government in terms of elderly care until 2024. It aims:

> *(i) to ensure the construction of an appropriate environment that supports and helps older women and men to be integrated into society, preserving human dignity, regardless of health status or autonomy their functional; (ii) to ensure the construction and strengthening of the social and health care system in all municipalities of the country, based on the principles of healthy ageing, guaranteeing the use of quality services for it all elderly people who need care; (iii) to enable a life as long as possible, healthy and active for all Albanians, through the awareness of society on good health, prevention of diseases as well as reducing inequalities in the treatment of the needs of the third age (Ministre e Shëndetësisë dhe Mbrojtjes Sociale, 2019, p. 18).*

Other laws and regulations affecting long-term care are Law 121/2016 For the services of social care (the most important law regulating the state help for the subjects in need); Law 57/2019 For the social assistance, Law 10107/2009 For the health care in the Republic of Albania, and Law 139/2015 on self-governance in the Republic of Albania. Forthermore, Council of Ministers Decisions also regulate specific areas of long-term care like Decision 822/2006 on Standards for social care services for elderly people in residential centres and Decision 518/2018 on community and residential social care services: procedures for their benefit and the measure of personal expenses for beneficiaries of organised services (Conkova et al., 2019; Jorgoni, 2020).

In Albania, there is a serious lack of care services and territorial differences in this aspect: 36 municipalities (out of 61) or 56% do not provide any kind of services for elderly. At the national level, social services for the elderly, granted by social care centres of all types, constitute only 15%. Therefore, from 259 centres all over Albania, 39 centres are for the elderly. From 39 centers for the elderly, 14 centers are located in Tirana, while other 25 offer services respectively in Korça (6 centres), Shkodër (5 centres), Berat (3 centres), Durrës, Vlorë, and Elbasan (from 2 centres) as well as Lezhë. Dibër, Gjirokastër, Fier, and Kukës (from 1 centre) (Ministre e Shëndetësisë dhe Mbrojtjes Sociale, 2019).

Caring for the elderly. The case of Poland

In Poland, long-term care, although it is associated mainly with medical care (MRiPS, 2022, p. 44), is divided into two sectors – health care and social assistance. Therefore, care is coordinated by two separate ministries – the Ministry of Health and the Ministry of Family and Social Policy. Long-term care services are provided in the stationary and community (de-institutional) form in both of these sectors.

In the health care sector, this service is mainly regulated by such legal acts as: (1) The Act on healthcare services financed from public funds (The Act of August

27…, 2004, item 965)); (2) Directive of Minister of Health on guaranteed services from the scope of care and welfare under long-term care (2022, Item 965)); (3) Directive of the Minister of Health on referral to care and treatment and nursing care facilities (2023, item 893).

On the other hand, in the field of social assistance, the most important legal acts regulating care issues are as follows: (i) Act on Social Assistance (The Act of March 12…, 2004, item 593); (ii) Directive of the Minister of Labour and Social Policy on Nursing Home (2017, item 734); (iii) from 2019 also the Act on the Implementation of Social Services by the Social Services Centre (2019, item 1818) as well as other acts listed later in the article. At the local government level, the coordination of care services, both in the institution and in the community, is carried out by social assistance centres (municipalities), and stationary institutions, such as social assistance homes, are also run by poviats.

In the area of health care, long-term care is defined as professional, continuous and long-term care and rehabilitation along with the continuation of pharmacological and dietary treatment, provided in an inpatient or home form for people with significant limitations in self-care but not eligible for hospital treatment. Inpatient long-term care services are provided in the form of a 24-hour stay and care provided by health care centres (Pol. *zakłady opiekuńczo-lecznicze*, ZOL) and welfare and nursing homes (Pol. *zakłady pielęgnacyjno-opiekuńcze*, ZPO) and are offered to people whose functional efficiency is determined at the level of 0–40 points on the basis of ratings according to the 100-point Barthel scale Directive of Minister of Health on guaranteed services from the scope of care and welfare under long-term care (2022, item 965). Patients can stay in these facilities after prior referral by a doctor after the end of hospital treatment. Health services provided in the centres are financed by the National Health Fund, while the person staying in the centre covers the costs of accommodation and meals (Furmańska-Maruszak & Wójtewicz, 2016; Kilian et al., 2018).

In turn, long-term home care (in other words, community, deinstitutional) is provided formally by state institutions in the form of nursing home care and by a long--term home care team for mechanically ventilated adults, children, nd adolescents (Ministerstwo Zdrowia, 2018). A doctor's referral is required to receive this type of care, similar to inpatient care. Patients whose functional efficiency does not exceed 40 points on the Barthel scale are entitled to this form of care. Its main objectives are both to provide nursing and care services in the home environment, as well as to educate and prepare the patient and her or his family for self-care. These services are provided by both long-term home care teams and long-term nursing care at home. Nurse visits usually take place several times a week, and in justified cases also on Saturdays and holidays. The services are aimed at people with respiratory failure who require respiratory therapy, carried out continuously or periodically but do not require to stay in intensive care units. The services include medical, nursing and physiotherapy visits, as well as a full range of diagnostic and imaging tests. The person under care is equipped with the necessary medical and auxiliary equipment (Ziębicka & Marcinowicz, 2015; Kilian et al., 2018). The map of Poland's health needs shows that in 2021 the total number of centres providing long-term care (in the area of health care) was 1,925,

of which 461 were stationary centres and 1,544 were community (de-institutional) centres. There are constantly and significantly more people using this type of care. The number of patients per 1,000 population in 2021 amounted to 297.27 (home benefits 182.41 and stationary 118.64) and increased compared to 2016, because then it amounted to 273.40 (home 169.95 and stationary 107.35) (BAZiW, 2023).

Care services are also provided under the social assistance system and include residential and community care. Assistance in the stationary form is mainly a stay in nursing homes, and relatively recently also in a new type of institutions – care and residential centres (MRiPS, 2021). The cost of staying in a nursing home is partly covered by the person being cared for, and partly by the family or the commune in the event of a difficult financial situation of an elderly person (Act on Social Assistance (2004, item 593), Directive of the Minister of Labour and Social Policy on Nursing Home (2017, item 734).

Among the many types of nursing homes, the elderly are most often directed to geriatric homes, although for various reasons they can also live in other facilities, e.g., homes for somatically ill or physically disabled people. Between 2016 and 2020, the total number of communal, municipial, and regional nursing homes increased slightly from 816 to 826, which means that mainly community services are being developed in Poland. On the other hand, the number of inhabitants, among the 11 types of houses distinguished by the legislator, is decreasing, e.g., in terms of houses for the elderly their number was systematically reduced from 7,104 in 2016 to 5,719 in 2021, and in houses for the elderly and physically disabled 1,569 to 1,453. According to the data at the end of 2020, 1,478 elderly people were waiting to be placed in social welfare homes (i.e., in an institutional form) (at the end of 2010, there were 1,901 of them). In 2020, the number of residents of nursing homes decreased (this was due to, among others, the epidemic caused by the spread of the COVID-19 in 2020 and a significant increase in the prices of stay) (Strategy for the Development of Social Services, Public Policy to 2030 (with an Outlook to 2035). (Resolution 2022, No 165 Polish Official Gazette, p. 28).

Various forms of community support and the programmes of the Ministry of Family and Social Policy developing them seem to support multi-sectoralism and deinstitutionalisation as well as accelerate their implementation. Analysing the current legal and organisational solutions proposed in the social assistance sector for the elderly requiring support due to disability or serious illness, one can distinguish forms of assistance that allow them to stay at home (care services, assistant services, respite care services for carers and day care homes), as well as in the current local environment but in a different apartment than before, i.e., in alternative 24-hour stay centres (protected housing, family nursing homes).

The social assistance sector, through communes, provides community (de-institutional) assistance to the elderly, mainly in the form of care services (Błędowski & Maciejarz, 2013). According to the current Act on Social Assistance (2004, item 593, Art. 50), they are dedicated mainly to people living alone who, due to age, illness or other reasons, require assistance. These services should help in meeting everyday life needs, maintaining hygiene, care recommended by a doctor, and ensuring contact with the environment. On the other hand, specialist care services Act on Social Assistance (2004, item 593, Art. 50(4)) are adapted to specific needs resulting from the

type of illness or disability. Both types of these services can also be used by dependent people living in multi-person households when the family cannot provide such assistance. In order to increase the availability of this type of support for the elderly, the Ministry of Family and Social Policy has prepared the "Opieka 75+" ("Care 75+") Programme. Between 2016 and 2020, the number of municipalities that provided care services increased from 82.65% to 89.34% (MRiPS, 2023a).

Stationary and environmental services can be provided by the public sector, the private sector and non-governmental organisations, as well as by social economy entities. As a result, private nursing homes, non-public health care facilities, and long-term care facilities are established, which are run by associations, foundations, and church organisations[10]. There is an intensive effort to provide the non-governmental sector, social economy entities, and private entities with the implementation of care services, running day support centres as well as family nursing homes (Ziębińska, 2022).

The analysis of the social assistance law, the ministerial programmes of the Ministry of Family and Social Policy and the strategies defining the principles of social policy towards the elderly, or the strategy for the development of social services show that support and care for the elderly in Poland should be organised in accordance with the assumptions of modern social policy in in the public, non-governmental, and private sectors, i.e., in a multi-sectoral and de-institutionalised manner. When looking for evidence for the pursuit of these ideas, it is worth recalling the document promoting the above-mentioned principles of social policy towards the elderly, namely, Social Policy Towards Older Persons 2030. Safety – Participation – Solidarity. (Resolution 2018, No 161, Polish Official Gazette), which talks about moving towards deinstitutionalisation, understood as the development of services in the existing apartments of the elderly and the development of alternative institutions to traditional social welfare homes. Deinstitutionalisation is also clearly mentioned in the Strategy for the development of services social: the process of transition from institutional care to care provided at the level of local communities, in the case of the diagnosed situation in our country, requires long-term actions – in the perspective of several decades – including the following stages and blocks of departments: "(i) increasing the supply, availability and ensuring appropriate quality of services provided in place of residence and in deinstitutionalised forms; (iii) preparation and implementation of local and regional plans for the development of long-term care services; (iii) gradual transformation and then possible closure of brick-and-mortar facilities" (Social Policy Towards Older Persons 2030. Safety – Participation – Solidarity Resolution 2018, No 161, Polish Official Gazette, p. 99).

Another principle according to which the contemporary care system in Poland is organised is multi-sectorality, which can be proved by the recommendations regarding

[10] The catalogue of social economy entities includes primarily: social cooperatives, non-governmental organisations and entities referred to in art. 3 ust. 3 The Law on Public Benefit Activity and Volunteerism (2022, item 1327, 1265), as well as work cooperatives and cooperatives for the disabled and the blind, as well as reintegration units (including centre for social integration CIS, social integration club KIS, therapy workshops WTZ and vocational activity workshops ZAZ.

the transfer of social services to non-governmental entities such as family social welfare homes, or the inclusion of social economy entities in the document Act on Social Assistance (2004, item 593) as entities which can perform such tasks. The main directions of the policy towards dependent elderly people, which are included in the act, Strategy for the Development of Social Services, Public Policy by 2030 (with an Outlook to 2035; Resolution 2022, No 135, Polish Official Gazette, Item 767) are:

> *(i) building an effective and sustainable system providing social services for people: in need of support in everyday functioning; (ii) implementing a coordination and standardisation system for social services; (iii) support of the family and people taking care of the person in need of support in everyday functioning; (v) development of environmental forms of support in the form of social services; (vi) change in the functioning of a stationary long-term care institution (nursing homes), inter alia by transforming it into community care centres; (vii) a sustainable system of financing long-term care in the area of social services; (viii) support and development of staff providing social services* (Resolution 2022, No 135, Polish Official Gazette 2022, Item 767).

On the other hand, in the document Social Policy Towards Older Persons 2030. Safety – Participation – Solidarity (Resolution 2018, No 161, Polish Official Gazette 2018) among the numerous directions of activities addressed to independent people, there is also a direction referring to dependent elderly people: (i) reducing the scale of dependence on others by facilitating access to services that strengthen independence and adapting the living environment to the functional capabilities of dependent elderly people; (ii) ensuring optimal access to health, rehabilitation, and care as well as nursing services tailored to the needs of dependent elderly people; (iii) a network of community and institutional services provided to dependent elderly people; (v) a system of support for informal carers of dependent elderly people by public institutions.

Actions that are part of the idea of deinstitutionalisation of social services addressed to the elderly, currently undertaken by the Ministry of Family and Social Policy, include such programmes as: "Opieka 75+" ("Care 75+"), "Rodzinne domy pomocy" ("Family Nursing Homes"), "Usługi asystenta osobistego osoby niepełnosprawnej" ("Services of a personal assistant to a disabled person"), "Opieka wytchnieniowa" ("Respite Care"), and "Senior+" (MRiPS, 2023b).

Conclusions

We can list various factors that influence the shape of the welfare systems of Poland and Albania differently but they are also similar. Poland is characterised by a higher degree of the ageing of the population than Alabania and, at the same time, by a higher percentage of elderly people living alone but also by a lower risk of poverty among Polish seniors and a declared greater possibility of using medical services. The results of this study confirm research reports on the care system in Albania (Poni, 2022), which identify significant problems of underfinancing the care system in this country

and the need to cover the costs of treatment and care out of one's own pocket (Druga, 2021). There is a large scale of migration in both Albania and Poland (although much larger in Albania) and there are large regional differences in both formal and informal care. Albanian researchers (Conkova et al., 2019) draw attention to the phenomenon of negative effects of migration for dependent seniors, writing about the loss of close family ties as a result of separation from adult children, especially in rural areas. This study shows that in both countries, there are regions characterised by a high migration balance, where elderly people are left alone, without family support, which is severe, and both Albania and Poland base their care systems mainly on family support.

An interesting and new topic which has not been explored in the literature on the subject is the differences between the studied countries regarding the health status of the population. What distinguishes Poland and Albania from one another, and is strongly related to the type of care, are also the types of chronic diseases experienced by elderly people in the surveyed countries. In Poland, apart from cardiovascular diseases, the main causes of disability include diabetes, digestive system diseases and respiratory system diseases. In Albania, on the other hand, neurological diseases appear much earlier than in Poland. It is also worth noting that the diseases women and men suffer from in both countries are distinct.

The scale of social services provided in both countries is far from sufficient, however, based on the figures, it can be said that support, both institutional and community, is much more widely available in Poland. Let us take into account the fact that in Poland only in every 10th commune no care services are provided, and in Albania only 40% of communes provide such services. The large differences in the forms and scope of social services for older people observed in post-communist countries have also been proven in comparative studies of these countries (Golinowska & Sowa, 2013). It was emphasised that deinstitutionalisation is limited by staff shortages in the field of medical and social care and the unsuitability of housing conditions for home care.

In Albania, the main provider of formal services is the private sector, and Poland is moving towards a multi-sectoral model, increasingly handing over the running of institutions, day care centers and care services to non-public entities, including more and more to the civil sector (volunteering, neighbours), and social economy entities. The directions of the care policy in both countries are similar, they aim at deinstitutionalisation and multi-sectoralisation. The system of care in Albania, based on service standards developed and enforced by the government, seems to be more in line with EU recommendations on care policy and limiting the public cost of care. This is evidenced by the organisational structure of the service system in Albania. Public entities play the role of coordinating, commissioning, and controlling services, while private entities perform the services. This model seems to be similar to the UK service model. The multi-sectoral nature of welfare systems in post-socialist countries is written by researchers of the Polish system (Błędowski & Maciejarz, 2013; Ziębińska, 2022), researchers comparing these welfare systems (Golinowska & Sowa, 2013; Bakalarczyk & Jurek, 2021) and those analysing the Albanian system (Poni, 2022) or Czech (Łuczak, 2016). Analyses of the Czech Republic and Albania emphasise the significant role of the private sector.

Albania is in the design and direction phase of care for the elderly and seems to be doing so in line with EU policy. In turn, recent years have shown that the policy of multi-sectoralism and de-institutional analysis is strong in Poland, despite the fact that the number of 24-hour care institutions and places in these institutions is much smaller than in other European countries. The implementation of the above-mentioned assumptions is evidenced not only by the policy directions set out in the programmes and strategies mentioned in the article but also by specific statutory solutions. In Poland, financing of care is mainly at the level of the municipality and beneficiary's funds (both in institutions and community care from the commune), long-term care from the healthcare system (nursing at home and institutions such as ZOL) is covered by health insurance. State funds cover only co-financing for community care development programmes (de-institutionalisation) – development of day care facilities and other types of care.

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