



**LONG-TERM CARE POLICIES FOR OLDER POPULATIONS  
IN NEW EU MEMBER STATES AND CROATIA:  
Challenges and Opportunities**

*November, 2010*



THE WORLD BANK

EUROPE AND CENTRAL ASIA REGION  
HUMAN DEVELOPMENT DEPARTMENT

# **World Bank Report**

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**NOVEMBER , 2010**

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HUMAN DEVELOPMENT DEPARTMENT**



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## ACRONYMS AND ABBREVIATIONS

ADL	Activities of Daily Living
CIA	Central Intelligence Agency
BGN	Bulgarian Lev
EASHD	East Asia Human Development
ECSHD	Europe and Central Asia Human Development
EU	European Union
EUROSTAT	European Office for Statistics
GDP	Gross Domestic Product
HRK	Croatian Kuna
IPH	Institute for Public Health
LTC	Long Term Care
MoHSW	Ministry of Health and Social Welfare
MoFVIS	War Veterans and Intergenerational Solidarity
NATO	North Atlantic Treaty Organization
NGO	Non Governmental Organization
NOSOSCO	Nordic Social-Statistical Committee
OECD	Organization for Economic Development and Co-operation
PLZ	Polish Zloty
RISAA	Rules for the Implementation of Social Assistance Act
SAA	Social Assistance Act
SHA	System of Health Accounts
SWH	Social Welfare Home
UN	United Nations
UNDP	United Nations Development Project
WHO	World Health Organization

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## **EXECUTIVE SUMMARY**

The new EU member states and Croatia are facing a rapidly aging population. In 2025, more than 20 percent of Bulgarians will be the age of 65 and over, up from just 13 present in 1990, and the average Slovene will be 47 years old, among the oldest in the world. One of the consequences of these demographic changes is the expected increase in demand among the older population for long-term care (LTC). The term “long-term care services” refers to the organization and delivery of a broad range of services and assistance to people who are limited in their ability to live independently over an extended period of time.

Experience from OECD countries shows LTC is expensive and generates financial burden for individuals and households. There is considerable financial uncertainty over future LTC expenditures and private long-term care insurance systems are underdeveloped. The increasing “good practice” in OECD countries is to promote a policy of universal coverage. Yet, if countries are to adopt such policies, given the growing size of the older population and growing dependency ratios, they must closely examine the policies’ fiscal sustainability. Thus, the key policy challenge facing new EU member states and Croatia is how to balance the twin objectives of fair financing (where those in need are able to afford LTC) with fiscal sustainability.

The objective of this Summary Report is to highlight the main lessons learned from OECD countries with advanced LTC policies and the implications for LTC policymaking in new EU member states and Croatia. The first section examines the main findings from the Framework Report on the financing, provision and regulation of LTC services. The next section presents comparative findings from the four case study countries, including the demographic context for LTC services, the main features of the financing, provision and regulation of LTC services and the strengths and weaknesses of current LTC systems there. The last section identifies policy directions for the four case study countries.

### **The Impact of Demographic Change on Supply and Demand for LTC Services**

The future demand for LTC services will be driven by two factors: first, the size of the older population (+65), especially the very old (+75) and second, the percentage of older people dependent or severely dependent, and therefore requiring help with Activities of Daily Living (ADL). The supply of LTC services will be strongly influenced by the number of healthy people available to provide them and the amount of money available to fund them. All four case study countries are facing the double challenge of an increasingly older and more dependent society.

The question facing the case study countries, and many others around the world, is how the marked increase of the elderly population will impact future demand for LTC services. For case study countries it is clear that the aging and increasingly dependent population will boost demand for LTC services at the same time the tax base and supply of healthy people to provide them steadily shrinks.

## Organization and Financing of LTC Services in Case Study Countries

In all four countries, the financing and provision of LTC services straddle both the health and social sectors. Services are provided in both informal and formal settings, and in institutional and non-institutional settings and the mix of such services depend on the unique conditions in each country. Common characteristics of service provision in the four case study countries include:

- The provision of LTC services in both the social and health sectors are largely public.
- There has been tremendous growth in home- and community-based services in the past decade.
- Government efforts to decentralize have resulted in more services being provided at the municipal and regional level.
- There has been a limited role for the private and NGO sector in the provision of LTC services.

In terms of LTC benefits, none of the case study countries have a universal entitlement system combining home, community and institutional care. Rather, LTC benefits, both cash and in-kind, are limited and largely associated with the social assistance system. In a context where the health sector also, *de facto*, provides LTC services covered by health insurance, this could provide an incentive for the elderly to use health care institutions, which are typically more expensive than community- and home-based services.

Obtaining a clear picture of the financing of LTC in the four case study countries is a challenge due to the lack of data on current expenditures, both public and private. In general, financing for health-sector LTC services is largely through the social health insurance system, with the exception of Latvia, which has a tax financed system managed through the Ministry of Health. In the social protection sector, financing and provision is shared between the national government and municipalities, with the national governments making significant contributions to spending on the local level. The lack of data on LTC expenditures mainly stems from the undefined position of LTC between the health and social sectors, which makes it difficult to accurately collect data.

## Conclusions from the Case Study Countries

- The strong growth in home- and community-based services has helped cope with the growing number of elderly who need assistance with the activities of daily living.
- The fragmentation of services between the health and social service sectors can be seen in the types of benefits, eligibility criteria, and provision of benefits. It is also one of the main causes of the systematic lack of reliable data on LTC expenditures.
- The generally low levels of financing for LTC will have spill-over effects on the sustainability of health financing.
- The case study countries lack a coherent strategy and vision for LTC services, although it is important to note there are some incremental reform efforts underway.

## Future Policy Directions

- **Policy Direction # 1:** Develop a policy for universal LTC financing based on the concept of intergenerational fiscal sustainability. Use actuarial and other financial models to cost out the revenue and expenditure implications of expanding universal LTC coverage.

Identify the appropriate LTC package and identify the role of supplemental LTC coverage through other instruments.

- **Policy Direction # 2:** Do not expand LTC coverage on an inefficient base but use LTC financing to control demand for LTC services and channel toward the right types of services (home-based services, care coordination, convert hospitals into community centers and not LTC institutions).
- **Policy Direction # 3:** Think proactively about how to leverage LTC service delivery reforms and encourage private sector provision. This depends a great deal on LTC financing policies and the overall regulatory environment.
- **Policy Direction # 4:** Develop a strong evidence-base on LTC financing and provision. As a part of developing an LTC policy begin monitoring LTC expenditures and whether LTC expenditures pose a burden on households or how households are coping with increased LTC expenditures during old age. Build a database on coverage of LTC services and trends over time.

## Introduction

The new EU member states and Croatia are facing a rapidly aging population. In 2025, more than 20 percent of Bulgarians will be the age of 65 and over, up from just 13 percent in 1990, and the average Slovene will be 47 years old, among the oldest in the world. One of the consequences of these demographic changes is the expected increase in demand among the older population for long-term care (LTC). The term “long-term care services” refers to the organization and delivery of a broad range of services and assistance to people who are limited in their ability to live independently over an extended period of time. These services are designed to minimize, rehabilitate, or compensate for loss of independent physical or mental functioning and include assistance with Activities of Daily Living (ADLs), such as bathing, dressing, eating, or other personal care. Services may also help with Instrumental Activities of Daily Living (IADLs), including household chores like meal preparation and cleaning; life management such as shopping, money management, and medication management; and transportation.

Experience from OECD<sup>1</sup> countries shows LTC is expensive and generates financial burden for individuals and households. There is considerable financial uncertainty over future LTC expenditures; and private long-term care insurance systems are underdeveloped. Narrowly-targeted social assistance for LTC does not provide adequate coverage and protection. Therefore, the increasing “good practice” in OECD countries is to promote a policy of universal coverage. Yet, if countries are to adopt such policies, given the growing size of the older population and growing dependency ratios, they must closely examine the policies’ fiscal sustainability. Public spending on health and social benefits is already significant in new EU member states, leaving little fiscal room to make costly decisions on the organization and financing of LTC services.<sup>2</sup> The recent global economic crisis has also brought to the forefront the need for prudent monetary and fiscal policies. Therefore the key policy challenge facing new EU member states and Croatia is how to balance the twin objectives of fair financing (where those in need are able to afford LTC) with fiscal sustainability. As the experience in OECD countries shows the dual objectives are achievable. A key determinant of LTC expenditures is government policy on public benefits, cost-sharing arrangements and the supply of LTC services. In particular, policies in support of formal or informal care, in-kind services or cash benefits and institutional or community care

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<sup>1</sup> Organization for Economic Co-operation and Development

<sup>2</sup> See, for example, Chawla (2007).

have important consequences for a country's LTC sector and the share of public LTC expenditures.

The objective of this Summary Report is to highlight the main lessons learned from OECD countries with advanced LTC policies and the implications for LTC policymaking in new EU member states and Croatia. The Summary Report is divided into three sections. Section I describes the main findings from the Framework Report. Section II presents comparative findings from the four case studies, including the demographic context for LTC services, the main features of the financing, provision and regulation of LTC services and finally the strengths and weaknesses of LTC systems in the four countries. Section III identifies policy options based on the previous sections.

## **Section I: Main Findings from a Framework for the Financing, Provision and Regulation of LTC Services**

The framework for LTC services was developed from an extensive literature review of: (i) welfare economics and public finance literature, especially as it relates to the social sectors (health, social protection and social assistance); (ii) the economics of the health sector; (iii) the economics of aging and LTC; (iv) institutional economics and industrial organization; and (v) the implementation of LTC policies in OECD countries. It sought answers to the following policy considerations:

- Should the state finance LTC for all citizens, or is a safety net system that only protects those left to pay for LTC adequate?
- What are the tradeoffs in terms of equity and efficiency between different models of LTC financing? In particular, what are the tradeoffs between universal care and a safety net type model?
- Does a system based on public and private contributions provide the best model by adequately covering those in need without crowding out private spending?
- Can the supply of LTC services be organized competitively? What are the barriers to entry and how can financing of LTC services create adequate incentives for supply? What should be the regulatory framework to allow adequate private sector participation while ensuring quality of care?
- Is the nature of LTC services such that for-profit sector provision is not possible?

### **Main Findings on Financing:**

- The main findings under financing (highlighted in detail below) are that on *equity* and *efficiency* grounds, *a universal system based on basic protection for all individuals requiring LTC services is desirable.*
- *The longer people live, the higher are their chances of entering institutional care at some point in their lives.* Most people who enter a nursing home can expect to remain there for 1 to 3 years. Institutional care costs can be prohibitive for individuals and families.
- *Demand for private LTC insurance (LTCI) is low in most OECD countries.* Even in the United Kingdom and in the United States, which rely largely on social safety net systems for LTC, uptake of private LTCI is low. There are several reasons for the low uptake: (i) the perception that old-age disability is not a problem; (ii) a lack of financial literacy,

which makes it difficult for people to understand the financial dimensions of various private LTCI schemes; (iii) perceived and actual high prices of premiums generating concerns regarding affordability; and (iv) the disincentive effect of public safety net schemes such as Medicaid in the United States.

- ***Even if demand for private LTCI is increased by reducing information gaps and reforming social safety nets, there are other market failures with private LTCI.*** These include: (i) the difficulties associated with actuarially accurate estimates of LTC costs and determination of actuarially fair LTCI premiums; (ii) adverse selection due to information asymmetry and high drop-out among individuals who discover they are healthier than they had originally thought; (iii) higher risks of bankruptcy before claims are made; and (iv) risk selection of insurers among enrollees. ***All these factors emphasize the need for substantive regulation of private LTCI.***
- ***The problems described above point to the need for a stronger public sector role in financing with the objective of supporting larger risk pools and systems of intergenerational solidarity.*** Most OECD countries apply a mix of public risk-pooling instruments, consisting of (i) tax-financed social safety nets (like Medicaid in the United States); and (ii) universal entitlements, either financed from taxes (like Austria's cash benefit program) or social security contributions (like Germany, Japan, and the Netherlands). These mechanisms contribute to a more or less progressive system, where general revenues and contributions finance a basic package for all citizens with benefits graded according to levels of disability and income.
- ***In terms of outcomes, systems based on universal entitlements perform better on satisfaction, expectations and coverage of benefits.*** From the fiscal sustainability perspective, universal entitlement systems based on social insurance systems are more expensive with expenditures growing at a slightly higher rate than in the other systems.
- ***Supplemental private LTCI could make an important contribution to the financial sustainability of LTC systems and could contribute to an optimal public-private mix in financing LTC services.*** In France, simply designed private LTCI based on cash benefits rather than reimbursements for in-kind services has performed rather successfully over the last few years. This type of LTCI is modeled after financial insurance products rather than health insurance products, and could substantially increase earmarked savings for future LTC needs.

#### **Main Findings on Provision:**

- The main finding on the provision of LTC services ***is that there is no one model and countries have adopted various models based on country conditions and social acceptability.*** Unlike in financing where a strong public orientation is desirable, on the provision side there are no hard and fast rules. ***The design of financing mechanisms can play an important role in promoting private sector provision of LTC services.***
- Provision of LTC services is complicated by the fact that it straddles both the health and social sectors and the formal and informal sector. ***Medical health care and social care are frequently complementary inputs needed to ensure quality service provision.***
- ***Another characteristic of LTC service provision is that it can be provided in both informal and formal settings, and in institutional and non-institutional settings.*** The

degree to which these settings are available choices to patients depends largely on the capacity of a country to promote a balanced mix of service supply via appropriate funding and re-organized care models. Depending on the model adopted, the distinction between “formal” and “informal” may become flawed. For example, France has promoted the employment of family care-givers. In Austria, LTC regulation allows informal family care-givers to enter into a formal contract to provide 24-hour care at home.

- ***The main public policy question vis-à-vis provision is whether to “make or buy,”*** that is how much of LTC services should be provided by the public sector and how much should be contracted out to the private sector?
- There are areas in LTC amenable to private production. One important area is enhancing the information base for patients and families. Other areas include contracting out of discreet services such as laundry, catering, accounting etc. ***However, the analysis reveals that given the high complexity of LTC services and the difficulty of defining clearly measurable outcomes, contracting out of many aspects of LTC services will require time and investments in a strong regulatory environment and the development of evidence-based guidelines (as in the case of health care services).***
- In most OECD countries, the current system of providing LTC services is characterized by a high degree of diversity in the way public expenditures on LTC are used. This often reflects the underlying welfare concepts in designing LTC policies. For example, in Nordic countries, state responsibilities prevail over the primacy of the family as the nucleus for providing LTC services. In contrast, Central European Countries’ welfare policies are based on the subsidiarity principle. While in Denmark, almost three-quarters of public expenditure on LTC are spent on home-care arrangements, while Switzerland spends 80 percent of these funds in institutions. At the same time, total public spending in Denmark as a proportion of GDP is about three times higher than in Switzerland, reflecting a varying degree of risk-pooling in this area.

#### **Main Findings on Regulation:**

- ***Regulation, in the context of this paper is identified as a cross-cutting issue affecting all aspects of financing and provision.*** Regulation is defined as a rule, ordinance or law by which conduct is regulated. When applied to LTC services, it refers to the full range of rules and ordinances affecting the financing and provision of LTC services.
- ***Regulation of private LTCI is essential*** and any country considering this model must think through regulatory aspects. The U.S. has good example of LTCI regulatory practices which regulate aspects such as rate-setting, portability, etc. Enforcement, however, has been a problem and overall, regulatory interventions have not contributed to higher uptake of private LTCI there.
- ***On the LTC service provision side, the key issue is ensuring adequate quality of LTC services.*** Inspection and regulation is the cornerstone of quality assurance for LTC services. A critical element of inspection systems is more consultation rather than policing. Most OECD countries have yet to address this problem but reforms are underway. There is a need for more systematic evidence on regulation of the quality of LTC services in OECD countries.

## **Section II: Main Findings from Case Studies (Bulgaria, Croatia, Latvia and Poland)**

Section II describes the main characteristics of LTC financing, provision and regulation in four case study countries. The case study countries which are all part of the same country cluster in the World Bank (ECCU5) were selected on the basis of geographical and historical clustering: Baltic States (Latvia), central European countries (Poland), newcomers to the European Region from the Balkan region (Bulgaria), and a non-EU country with a slightly different background and history (Croatia).

The methodology for the case study countries consisted of detailed in-country reviews completed by a team of national consultants. In all cases, given the fragmentation in LTC systems and the fact that there is no single agency responsible for LTC, it was very difficult to collect data, both about service provision and financial expenditures. In Bulgaria and Croatia, the overview case studies were complemented by a second round of data collection in selected municipalities. In Poland, a database on public expenditures across all levels of government was created to be able to trace decentralized spending on LTC. A complete list of studies completed for the case country countries is included in the references.

### **Demographic Context for LTC Services in Case Study Countries**

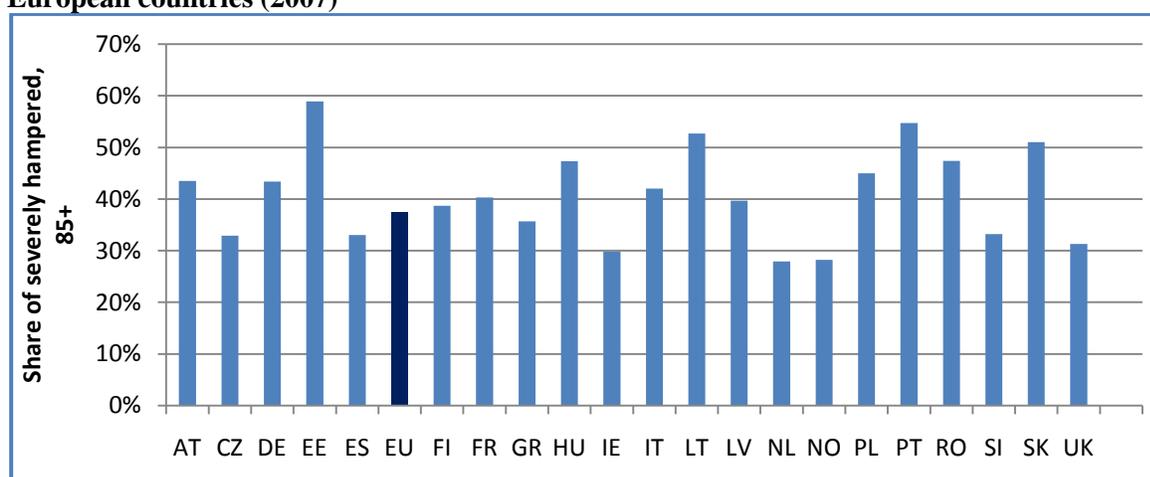
*The future demand for LTC services will be driven by two factors:* first, the size of the older population (+65), especially the very old (+75) and second, the percentage of older people dependent or severely dependent, and therefore requiring help with Activities of Daily Living (ADL). *The supply of LTC services will be strongly influenced by the number of healthy people available to provide them and the amount of money available to fund them.* All four case study countries are facing the double challenge of an increasingly older and more dependent society. In this section, we examine the role of demographic changes in the future demand and supply of LTC services.

*Projections for the case study countries show a steady increase in the population aged 65 and older over the next 50 years, while the working age population will shrink by almost a third.* All the four case study countries are at a relatively early stage of the demographic transition when compared with Western European countries. The largest cohort – in a Western European context called Generation X – is currently within 25 to 30 years of age. The children of this bulge generation will be born in the next 10 years and will keep the growth of the youngest age group positive for a while, but it will be negative after that. The all important working age group of 15-64 is projected to steadily decrease over the next 50 years. As the parent generation of Generation X – the so-called baby boomers – start to retire, the growth of the 65 to 79 age group will increase. This will be followed by a significant and constant expansion of the very old – the population 80 and older.

*The challenge with a shrinking and aging population is that just as the elderly population grows, the number of younger residents decreases, thus leaving fewer potential care providers—in particular of informal care—and fewer working people contributing to the tax and social security systems that fund LTC services.* This increase in the old-age dependency ratio has serious implications for both the supply and financing of LTC. For example, today there are four working age Bulgarians for every elderly resident. By 2050, however, there will be less than two working Bulgarians for every person over the age of 65. And Bulgaria is not alone. Latvia and Poland, too, will be faced with old-age dependency rates of more than 50% in the next several decades.

*Old-age dependency rates are just one variable to be considered. Another is the care-dependency ratio, which is the ratio between the dependent population or those with severe restrictions in their activities of daily living and the healthy population.* This ratio will also increase in all four case study countries. Figure 1 shows the share of the severely dependent population among those aged 85 or older in selected European countries. Unfortunately, data are not available for Bulgaria and Croatia. However, in Latvia, the percent of the population above 85 who were severely dependent was 39.7% in 2007, and in Poland it was 45 percent, which is significantly higher than the EU average. If these rates remain steady as the size of the elderly population grows there will be two or even three times as many people, depending on the country, needing LTC services on a daily basis at a time when there are a third fewer people available to provide them.

**Figure 1: Share of severely dependent population among those aged 85 or older in selected European countries (2007)**



Source: Eurostat (2009b).

*Some of the projected increase of the severely dependent population could be reduced if the health status of the elder population improves in the future.* In other words, the share of the 75+ population who can live independently might increase, leading to a less pronounced increase in the severely dependent population. Healthy life styles during younger ages, with a focus on preventive health care and a reduction of unhealthy behavior like tobacco consumption and obesity, could help to compress morbidity among elderly in the future.

In summary, the question facing the case study countries, and many others around the world, is how the marked increase of the elderly population—in particular of the 75+ population—will impact future demand for LTC services? How will improvements in overall health affect the number of people who have difficulty performing activities of daily living on their own? For case study countries it is clear that the aging and increasingly dependent population will boost demand for LTC services at the same time the tax base and supply of healthy people to provide them steadily shrinks.

### **Organization and Financing of Long-term Care Services in Case Study Countries**

**Types of Services:** Table 1 provides an overview of the types of LTC services provided in the case study countries. In all four countries, the financing and provision of LTC services straddle both the health and social sectors. Other common characteristics include:

- **The provision of LTC services in both the social and health sectors are largely public.** For example 90% of LTC services in Bulgaria are provided by the state, either at the national or local level.
- **There has been tremendous growth in home- and community-based services in the past decade.** These services have proven more effective, more cost efficient, and more culturally appropriate in most case study countries.
- **Government efforts to decentralize have resulted in more services being provided at the municipal and regional level,** even if funding is channeled from the national level.
- **There has been a limited role for the private and NGO sector in the provision of LTC services,** with the exception of Croatia where two thirds of institutional homes for the elderly are privately owned.

**Table 1: Formal long-term care services by level and type in case study countries**

LTC Services	Bulgaria	Croatia	Latvia	Poland
<b>Home-based Care</b>	<ul style="list-style-type: none"> <li>• Home helper</li> <li>• Personal assistant</li> <li>• Social assistant</li> </ul>	<ul style="list-style-type: none"> <li>• Foster family</li> <li>• Home care services from welfare centers</li> <li>• Home assistance from pensioners associations</li> </ul>		<ul style="list-style-type: none"> <li>• Outpatient nursing care</li> <li>• Home-based care services</li> </ul>
<b>Daycare and Assisted Living</b>	<ul style="list-style-type: none"> <li>• Day care center</li> <li>• Center for social rehabilitation and integration</li> </ul>	<ul style="list-style-type: none"> <li>• Centers for Welfare Services</li> <li>• Centers for Aid and Care</li> <li>• NGO programs</li> </ul>	<ul style="list-style-type: none"> <li>• Halfway and group homes</li> </ul>	<ul style="list-style-type: none"> <li>• Day centers</li> <li>• Service centers for the ill, disabled and elderly</li> </ul>
<b>Institutional Care</b>	<ul style="list-style-type: none"> <li>• Homes for adults with disabilities</li> </ul>	<ul style="list-style-type: none"> <li>• Social welfare homes</li> <li>• Family center</li> <li>• Social care home</li> <li>• Social care center</li> </ul>	<ul style="list-style-type: none"> <li>• NGO centers</li> <li>• Nursing homes</li> </ul>	<ul style="list-style-type: none"> <li>• Family welfare homes</li> <li>• Social Welfare Homes (SWH)</li> </ul>
<b>Health Care</b>	<ul style="list-style-type: none"> <li>• Hospitals for further and continuing treatment</li> <li>• Hospitals for rehabilitation</li> <li>• Hospices</li> </ul>	<ul style="list-style-type: none"> <li>• Prolonged treatment /geriatrics centers</li> <li>• Chronic lung disease centers</li> <li>• Health visitor service through primary care</li> <li>• Home-based nursing care</li> <li>• Palliative Care Services (NGOs)</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• Medical care home</li> <li>• Medical nursing home</li> <li>• Hospice</li> </ul>

**Long-Term Care Benefits:** *None of the case study countries have a universal entitlement system combining home, community and institutional care.* Rather, LTC benefits are limited and largely associated with the social assistance system (as in the case of the UK and the USA). In a context where the health sector also, *de facto*, provides LTC services covered by health insurance, this could be providing an incentive for the elderly to use health care-based institutions. The costs are typically higher in such institutions compared to community- and home-based LTC services.

In all four case study countries, LTC benefits include a combination of *cash (demand side-subsidies)* and *in-kind benefits (supply-side subsidies)*. In all the countries, the cash benefits program is managed through the social assistance system. In Croatia, Poland and Latvia, the social assistance system also includes in-kind benefits in the form of financing for social welfare homes (expenditures for salaries and wages of personnel, capital expenditures and training

programs for staff). If an older person is assigned to a social welfare home, the cash benefit is directly provided to the social welfare home. In Bulgaria and Poland, the benefits are spread across social and health sectors. In Bulgaria, the social assistance system provides cash benefits but in Latvia, informal care providers are not covered through the cash allowance.

**Table 2: LTC benefits provided by case study countries**

Country	Cash Benefits	In-kind Benefits
<b>Bulgaria</b>	<ul style="list-style-type: none"> <li>• Cash allowance based on disability</li> <li>• Old age pension</li> </ul>	<ul style="list-style-type: none"> <li>• LTC institutions under social protection sector</li> <li>• Public sector health facilities</li> <li>• Home-based care (salaries of home helper, personal assistant, social assistant)</li> <li>• Day care centers</li> </ul>
<b>Croatia</b>	<ul style="list-style-type: none"> <li>• Allowance for nursing care</li> <li>• Salary compensation for parents caring for handicapped child</li> <li>• Personal disability allowance</li> </ul>	<ul style="list-style-type: none"> <li>• LTC institutions under social protection sector</li> <li>• Public sector health facilities</li> <li>• Home-based care services</li> <li>• Day care centers</li> </ul>
<b>Latvia</b>	<ul style="list-style-type: none"> <li>• Cash allowance based on disability</li> </ul>	<ul style="list-style-type: none"> <li>• Public sector health facilities</li> <li>• LTC institutions under social assistance</li> </ul>
<b>Poland</b>	<ul style="list-style-type: none"> <li>• Two eligibility criteria: (i) frailty, (ii) above the age of 75.</li> </ul>	<ul style="list-style-type: none"> <li>• LTC institutions under social assistance</li> <li>• Public sector health facilities</li> </ul>

In Poland, two criteria are used for determining eligibility for LTC benefits: (a) frailty and (b) age. For the former, beneficiaries have to prove that they are completely incapable of working. For the latter, once the age criterion of 75 years is met everybody is eligible. In Croatia, income is used as a criterion for targeting limited public subsidies for LTC for the elderly. In order to be eligible, beneficiaries have to prove that personal resources do not suffice. If beneficiaries have property, they are required to sell their property (unless it is being used by family members) first before requesting state assistance. Croatia's targeting of public subsidies for LTC is similar to the Medicaid program in the U.S.

**Financing Long-term Care: Unfortunately the case study countries have few data on current expenditures on LTC, both public and private.** In general, financing for health-sector LTC services is largely through the social health insurance system, with the exception of Latvia, which has a tax financed system managed through the Ministry of Health. In the social protection sector, financing and provision is shared between the national government and municipalities, with the national governments making significant contributions to spending on the local level. This is done through grants to municipalities, such as those in Bulgaria to provide LTC services, especially community- and home-based care.

The lack of data on LTC expenditures mainly stems from the undefined position of LTC between the health and social sectors, which makes it difficult to accurately collect data. Although there is a classification for LTC in the System of Health Accounts (SHA),<sup>3</sup> the data are not systematically reported and cannot be compared across countries. For example, SHA data indicates that in 2005, Latvia spent 1.4 percent of GDP on LTC and in 2006, it dropped to 0.2 percent of GDP (see case

<sup>3</sup> Developed by the European Commission and the OECD.

study). This large variation may not in reality indicate a sharp drop in spending, but rather poor reporting. Nevertheless, the limited data that are available from the SHA database suggest that the case study countries spend relatively little on LTC, on average less than 1 percent of GDP (see Table 3).

**Table 3: Total LTC expenditures as a share of GDP in select countries (according to the System of Health Accounts, 2003-2007)**

	2003	2004	2005	2006	2007	Average 2003-2007
<b>Sweden</b>	3.8	3.8	3.7	3.7	3.6	3.7
<b>Norway</b>	2.4	2.3	2.2	2.1	--	2.3
<b>Switzerland</b>	2.2	2.2	2.2	2.1	2.1	2.1
<b>Finland</b>	2.0	2.1	2.2	2.1	2.1	2.1
<b>Denmark</b>	2.0	2.0	2.1	2.1	2.0	2.0
<b>Germany</b>	2.0	2.0	2.0	1.9	1.9	1.9
<b>Iceland</b>	1.9	1.9	1.9	1.9	--	1.9
<b>Japan</b>	1.6	1.7	1.7	--	--	1.7
<b>Belgium</b>	--	--	1.6	1.6	1.7	1.6
<b>France</b>	1.4	1.5	1.5	1.6	1.6	1.5
<b>Austria</b>	--	1.3	1.3	1.3	--	1.3
<b>Netherlands</b>	1.3	1.3	1.3	1.3	1.2	1.3
<b>Slovenia</b>	1.1	1.1	1.2	1.2	1.1	1.1
<b>United States</b>	1.0	1.0	1.0	1.0	--	1.0
<b>Latvia</b>	--	--	1.4	0.2	--	0.8
<b>Spain</b>	0.7	0.7	0.7	0.7	0.8	0.7
<b>Lithuania</b>	--	0.4	0.4	0.4	0.5	0.4
<b>Poland</b>	--	0.4	0.4	0.4	0.4	0.4
<b>Hungary<sup>1</sup></b>	0.3	0.3	--	0.2	0.2	0.3
<b>Czech Republic</b>	0.3	0.2	0.2	0.3	0.3	0.3
<b>Cyprus</b>	0.2	0.2	0.2	0.2	0.2	0.2
<b>Estonia</b>	0.1	0.1	0.2	0.2	0.2	0.2
<b>Portugal</b>	0.1	0.1	0.1	0.1	--	0.1
<b>Bulgaria</b>	0.0	0.1	0.2	0.0	0.0	0.1
<b>Romania</b>	0.0	0.0	0.0	0.0	0.0	0.0
<b>Average</b>	<b>1.2</b>	<b>1.2</b>	<b>1.2</b>	<b>1.1</b>	<b>1.1</b>	<b>1.2</b>

Note: 1. the 2005 value for Hungary (8.23 percent of GDP) was dismissed as an outlier.

Source: Eurostat (2010).

Although spending on LTC remains low as a percent of GDP for most countries, the annual real growth rates of expenditures is quite significant. In Poland, for example, expenditures for in-kind benefits grew at an average of 10 percent a year between 2006 and 2008 (see Table 4 below).

**Table 4: Annual real growth rates of expenditures by benefit type (percent, 2006 to 2008)**

	2006	2007	2008	Total	Average annual growth
<b>Cash benefits - total expenditure</b>	<b>7.60%</b>	<b>0.81%</b>	<b>5.22%</b>	<b>14.14%</b>	<b>4.51%</b>
<i>due to frailty</i>	3.96%	-2.09%	1.81%	3.63%	1.19%
<i>due to age</i>	10.82%	3.21%	7.89%	23.40%	7.26%
<b>In-kind benefits - total expenditure</b>	<b>8.42%</b>	<b>8.57%</b>	<b>14.89%</b>	<b>35.25%</b>	<b>10.59%</b>
<i>Inpatient</i>	8.57%	6.39%	18.63%	37.03%	11.07%
<i>Outpatient (social sector)</i>	8.30%	10.34%	11.96%	33.80%	10.19%

Source: World Bank staff calculations (Poland Case Study)

*An alternative method of financial analysis focuses on public expenditures instead of total expenditures.* A detailed analysis of such data was conducted for Poland and Latvia in the context of the LTC study. In Poland, this analysis showed that estimated public expenditures on LTC in the health and social sectors is approximately 1 percent of GDP (2007) as opposed to the 0.4 percent public and private expenditures as reported in the SHA. A similar analysis in Latvia shows that in 2008, public expenditures on LTC in the social sectors were about 0.44 percent of GDP. In both Latvia and Poland public expenditures on LTC are increasing quite sharply. For example, from 2005-2008, public expenditures on LTC in Poland increased by 30 percent in real terms, due mostly to an increase in spending on in-kind benefits rather than cash benefits.

Disaggregated data on major components of LTC expenditures are limited for the case study countries. The available data from Latvia indicate that the majority of LTC expenditures in the social sectors are in the form of in-kind LTC benefits such as remuneration, goods and services, and subsidies and grants (mainly to NGOs, public providers, and charity organizations). While the central and local governments focus on services in different areas (i.e. disability vs. elderly), they share expenditures on LTC services (see Table 5 below).

**Table 5: Central and local government expenditure on LTC services (LAT, 2006-2009)**

Code	Description	CENTRAL GOVERNMENT		LOCAL GOVERNMENT	
		2007	2008	2007	2008
<b>10.100</b>	<b>Social protection in case of incapacity</b>	<b>255,944</b>	<b>3,618</b>	<b>2,729,610</b>	<b>3,891,017</b>
1000	Remuneration	79,215		692,952	901,031
2000	Goods and services			373,056	1,619,950
3000	Subsidies and grants			1,306,082	581,816
4000	Interest payments	176,729	0		
5000	Fixed capital formation			247,129	683,798
6000	Social benefits		1,809	110,391	104,422
6400	Other benefits/compensations in kind		1,809	26,715	14,246
<b>10.110</b>	<b>Social protection in case of temporary incapacity</b>	<b>0</b>	<b>83,828</b>		
1000	Remuneration		83,828		
3000	Subsidies and grants				
<b>10.120</b>	<b>Social protection in case of disability</b>	<b>34,790,221</b>	<b>40,951,782</b>		
1000	Remuneration	17,976,478	21,624,985		
2000	Goods and services	9,385,656	10,524,515		
3000	Subsidies and grants	5,953,280	7,703,361		
5000	Fixed capital formation	1,474,247	1,097,083		
6000	Social benefits	560	1,838		
<b>10.200</b>	<b>Support for the elderly</b>			<b>21,304,872</b>	<b>27,343,030</b>
1000	Remuneration			8,934,708	11,912,908
2000	Goods and services			6,935,823	9,208,046
3000	Subsidies and grants			1,720,197	1,616,145
4000	Interest payments			89	1,557
5000	Fixed capital formation			3,493,015	4,285,872
6000	Social benefits			221,040	318,502
	<b>TOTAL Government</b>	<b>35,046,165</b>	<b>41,039,228</b>	<b>24,034,482</b>	<b>31,234,047</b>

Source: Latvia Ministry of Finance.

In contrast to Latvia, funding for in-kind services in Poland come primarily from local budgets. In 2008, for example, 84 percent of in-kind services were financed by local budgets, 15 percent came from the National Health Fund and only two percent came from the state budget (see Table 6 below).

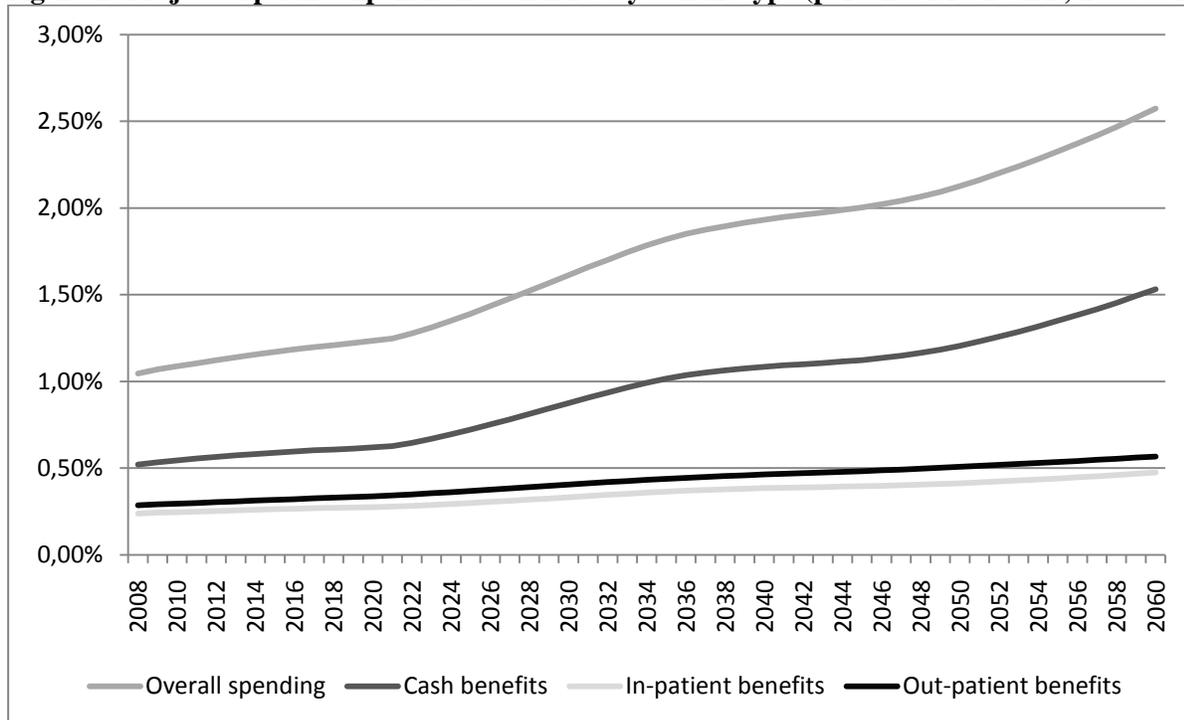
**Table 6: Annual expenditures on in-kind benefits by benefit type and funding source (current PLZ, millions, 2005 to 2008)**

	2005	2006	2007	2008
<b>Inpatient</b>	<b>2,044</b>	<b>2,242</b>	<b>2,445</b>	<b>3,022</b>
Health sector	537	599	718	988
<b>As %</b>	<b>26</b>	<b>27</b>	<b>29</b>	<b>33</b>
HIF	516	578	702	970
State budget	10	7	8	9
Local governments	11	13	7	10
Social sector	1,507	1,643	1,727	2,033
<b>As %</b>	<b>74</b>	<b>73</b>	<b>71</b>	<b>67</b>
State budget	21	42	37	46
Local governments	1,487	1,601	1,690	1,988
<b>Outpatient (social sector)</b>	<b>2,520</b>	<b>2,756</b>	<b>3,117</b>	<b>3,637</b>
State budget	36	41	48	57
Local governments	2,484	2,715	3,069	3,580
<b>Total public expenditure</b>	<b>4,564</b>	<b>4,998</b>	<b>5,562</b>	<b>6,659</b>
Total HIF	516	578	702	970
<b>As %</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>15</b>
Total state budget	66	90	93	111
<b>As %</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>2</b>
Total local governments	3,982	4,329	4,766	5,578
<b>As %</b>	<b>87</b>	<b>87</b>	<b>86</b>	<b>84</b>

Source: World Bank staff calculation based on expenditures data from Ministry of Finance.

Looking ahead, the fiscal impact of future LTC spending was estimated for just one of the four case study countries: Poland. *The projections estimate that if Poland continues at its current expenditure patterns without considerable reforms, the Polish LTC sector will quickly become fiscally unsustainable.* As was mentioned earlier, public expenditures on in-kind LTC benefits have grown substantially over the last three years, even on a per-beneficiary basis. This, to some extent, is due to an improvement in quality and an attempt to catch up to Western European care standards. If this spending growth continues at the same rate as in the past, a simple extrapolation reveals that public expenditures on LTC care as a share of GDP will essentially double every 10 years. In real terms, this means an even stronger increase; by 2020, public expenditures on LTC would stand at roughly PLZ 30 billion (compared to PLZ 13 billion today), at PLZ 78 billion by 2030 and PLZ 1,300 billion by 2060. This projection takes into account only the increase in the total number of dependents, not an increase in the share of the dependent population that actually demands formal LTC services – which in the case of Poland is currently very low at less than 20 percent. Clearly, a continuation of the strong increase of expenditures per beneficiary is not sustainable. A more realistic assumption assumes that expenditures per beneficiary will increase with GDP per capita. Even in this more optimistic scenario, public expenditures are projected to increase significantly (see Figure 2 below).

**Figure 2: Projected public expenditures on LTC by benefit type (percent of real GDP, 2008 to 2060)**



Note: Scenario 3 assumes that real public expenditures per beneficiary grow at projected rate of GDP per capita.

Source: Author's calculation.

## Conclusions

The following are the main conclusions from the four case studies:

- ***The strong growth in home- and community-based services has helped cope with the growing number of elderly who need assistance with the activities of daily living.*** These services tend to be more financially efficient and more highly rated by recipients. This is a positive trend but case study countries still need to support care outside expensive hospitals or homes for elderly. Interestingly, despite the growth in home- and community-based care, there is still limited involvement of NGOs and other private entities in the LTC sector. In Latvia, of 114 institutions providing LTC services, only 9 were private. In Bulgaria, less than 10% of services are provided by NGOs or private companies. As demand increases over the next few decades, governments will need to make “space” for private services providers to help meet the growing need for LTC services.
- ***The fragmentation of services between the health and social service sectors can be seen in the types of benefits, eligibility criteria, and provision of benefits.*** While it is difficult to quantify the efficiency impacts of such fragmentation and duplication, available global evidence shows that fragmentation and duplication generate inefficiencies and with it, resultant costs for the LTC system of these countries. Some positive reform efforts are underway in all countries. For example, both Bulgaria and Croatia are actively promoting more emphasis on home- and community-based LTC services (although it is not clear that the promotion of home- and community-based services is occurring in a context of deinstitutionalization or simply rather as an add-on). This is a good development since it enhances the menu of options available to the elderly and greater choice. On the other

hand, in Croatia, these enhanced benefits are not in the form of cash benefits but rather in-kind benefits.

- ***There is a systematic lack of reliable data on LTC expenditures due mostly to the fragmentation of services between the health and social service sectors.*** With the implementation of the System of Health Accounts (SHA), data on LTC expenditures can be expected to improve over time, but at this point the SHA data seem to suffer serious deficits from underreporting of private expenditures and public expenditures in the social sector (especially at the local level). However, it will require concerted efforts on the part of the case study countries to clarify data sources, definitions and methodologies for data collection and reporting. Data on the provision of LTC services is also difficult to obtain and there is no information in the case study countries on the quality of LTC or client satisfaction.
- ***The generally low levels of financing for LTC will have spill-over effects on the sustainability of health financing.*** Taking into account the data constraints, the study finds that the case countries spend very little on LTC, and this has implications for health sector spending and technical and allocative efficiency in the health sector. As this study shows, the average length of stay (ALOS) in some health facilities can average 50 days. This is not only expensive but also detrimental for the health of the elderly, who during their long hospital stays can be exposed to hospital-acquired infections.
- ***The case study countries lack a coherent strategy and vision for LTC services.*** In most of the case study countries (e.g. Bulgaria, Croatia), the reform of the LTC sector is taking place without a coherent vision on the financing and provision of LTC services based on global good practices and lessons learned. One glaring example of this is the recent emphasis in Bulgaria and Latvia on the conversion of small municipal hospitals into institutional LTC facilities. In both countries this is driven by over-capacity in the health sector and the fact that these municipal hospitals generally operate at very low efficiency levels (occupancy levels can be as low as 10-20%). International experience shows that many countries at some point in their history have converted redundant municipal hospitals into LTC institutions. This creates the risk of a bias towards expensive institutional care in a country's LTC system. Some years ago, Poland started to convert small hospitals into medical nursing homes, financed and managed by the health sector, that were intended to provide post-surgical treatment at lower costs than in regular hospitals. The unintended consequences were that – given the general shortage of LTC services in Poland – patients and their families continued to use the medical sector as a substitute for social LTC services, at a much higher price. Since the medical nursing homes were financed through insurance, users faced much lower costs for use as compared to the social sector LTC services. Private sector response was dampened and municipalities, who finance most of the social LTC services, also found it much cheaper to shift patients to the health sector than provide their own social services.
- ***While there is no comprehensive LTC reform strategy in any of the four case study countries, it is important to note there are some incremental reform efforts underway.*** For example Croatia has developed a Program of Development of Services for Elderly Persons within the System of Intergenerational Solidarity 2008-11. This program is the first ever program in Croatia to address the issues of LTC for the elderly with a focus on

the development of non-institutional care. In the context of the Lisbon agreement and the Open Method of Coordination, Bulgaria has identified goals for LTC services which include: (i) ensuring adequate financing for LTC; (ii) development of an adequate and affordable network of LTC services; and (iii) improving the quality of LTC services (deinstitutionalization and focus on home care, and improving quality in institutional setting). Poland has embarked on some first reform efforts by establishing a Parliamentary task force that developed a Green Book on how to reform the Polish LTC sector, but no concrete government actions have materialized to date.

### **Section III: Future Policy Directions**

As the previous sections have highlighted, while there are interesting and important developments on the financing and provision of LTC services in the case study countries, these interventions are happening in the absence of comprehensive LTC policies. The danger of this approach is that continued expansion of current interventions could eventually lead to a fiscally unsustainable situation. There are important lessons for the new EU member states and Croatia stemming from the experience of OECD countries and the global economic literature. Here we highlight a few significant lessons and policy implications:

- ***Policy Direction # 1:*** Develop a policy for universal LTC financing based on the concept of intergenerational fiscal sustainability.<sup>4</sup> Use actuarial and other financial models to cost out the revenue and expenditure implications of expanding universal LTC coverage. Identify the appropriate LTC package and identify the role of supplemental LTC coverage through other instruments.
- ***Policy Direction # 2:*** Do not expand LTC coverage on an inefficient base but use LTC financing to control demand for LTC services and channel toward the right types of services (home-based services, care coordination, convert hospitals into community centers and not LTC institutions).
- ***Policy Direction # 3:*** Think proactively about how to leverage LTC service delivery reforms and encourage private sector provision. This depends a great deal on LTC financing policies and the overall regulatory environment.
- ***Policy Direction # 4:*** Develop a strong evidence-base on LTC financing and provision. As a part of developing an LTC policy, begin monitoring LTC expenditures and whether LTC expenditures pose a burden on households, or how households are coping with increased LTC expenditures during old age. Build a database on coverage of LTC services and trends over time.

***Policy Direction # 1: Develop an LTC financing policy based on intergenerational fiscal sustainability and promote savings of the currently young for their future LTC needs.*** As our case studies have shown, the demographic transition will challenge the fiscal sustainability of the LTC sector; on the one hand, the contribution base of the tax and social security system will decrease over the coming years while the demand for LTC services will increase due to the steadily growing dependent, elderly population. This means that the currently young – the so-called Generation X, the largest cohort – will have to finance the LTC needs of their parent generation, the baby boomers, through pay-as-you-go systems. Yet, as Generation X grows older, their children will not be able to pay for their LTC needs. In other words, Generation X will have

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<sup>4</sup> Intergenerational fiscal sustainability refers to the extent to which a given set of fiscal policies for LTC does not shift too large a financial burden on future generations. See OECD. 2010

to pay for their parents LTC needs, but also for their own LTC needs. The challenge is to convince Generation X to increase their savings for future LTC needs over the next 30 years.

In this regard, France has successfully introduced private LTC insurance that is not based on in-kind benefits, but is set up as a financial product. Participants pay relatively modest premiums, and in case they become dependent, the insurance pays out a certain amount of benefit which the individual can use to buy LTC services. The amount of the benefit depends on the level of dependency. Because the benefit is purely financial, insurance companies can more accurately calculate expected benefits and do not run the risk of unpredictable cost increases of future LTC services. Therefore, they can offer competitive premiums. In the future, such products could also be offered in conjunction with life insurance or private pension insurance as a so-called enhanced annuity.

If the countries continue along their current path, public spending is likely to grow, and/or there will be *de facto* increasing dependence on private payments (out-of-pocket at point of service). Neither of these options is optimal. The first will create fiscal space problems, and the latter will generate inequity in access to LTC care. For financing policies, the countries could consider looking at the experience of other EU and OECD countries that have adopted a universal entitlement approach, while targeting the benefits well, and promoting the use of supplementary private LTC insurance (in addition to the basic LTC package). The other benefit of a largely pre-payment based LTC system is that it provides policy leverage on how these services are purchased and in the process, promotes the use of incentives to encourage optimal provider and beneficiary behavior. OECD countries, too, are experimenting with different types of LTC payment systems that promote improved coordination of care (e.g. PACE program in the US).

**Table 7: International models for LTC financing**

	<b>Financing</b>	<b>Benefit</b>	<b>Eligibility</b>	<b>Private Insurance</b>
U.S. Medicaid	General Revenue	Service/Limited Cash	Means-tested	<10%
Germany	Payroll tax	Cash or Service	Universal	<10%, Optional for high-earners
Japan	Payroll Tax/General Revenue/Income-Related Premium	Service Only	Universal for 65+	None
France	General Revenue	Cash only	Universal/Steep income-related coinsurance	Growing
U.K.	General Revenue	Service or cash	Means-tested	Very Limited

Source: Gleckman, 2009

***Policy Direction # 2: Do not expand LTC coverage on an inefficient basis but use LTC financing to control demand for LTC services and channel toward the right types of services (home-based services, care coordination, convert hospitals into community centers and not LTC institutions).*** To reduce the average length of stay (ALOS) in hospitals for the elderly population, countries need to have in place improved mechanisms for discharge management. Patient discharge management aims at reducing the length of stay in hospitals by moving patients to more cost-effective outpatient services like postsurgical treatments and rehabilitation. For the

elderly, appropriate discharge management should involve social workers who can help organize temporary (or permanent) assistance with ADLs after discharge.

Moreover, reforms should be cost-effective and be focused on the wellbeing of patients. This implies a focus on community-based services like home care and daycare. Institutional care is an important component of any LTC system but it results in higher-intensity care, and is therefore more expensive, and not the preferred form of care by many patients. Cost shifting between the health and the social sector should be avoided as much as possible. This implies that coordination of care services has to focus on the needs of patients rather than cost implication for either the health or the social sector. The current LTC patient needs assessment in several OECD countries involves both a social worker and a general practitioner. This is an excellent starting point for building a patient-focused care coordination system.

The conversion of small municipal hospitals into institutional LTC facilities is a good example of how LTC reform can run counter some of these policy objectives. International experience shows that many countries at some point in their history have converted redundant municipal hospitals into LTC institutions. The risk that is created by such reforms is that it introduces a bias towards expensive institutional care in a country's LTC system. Poland is a good recent example. Some years ago, Poland started to convert small hospitals into medical nursing homes that were operated and financed by the health sector. These medical nursing homes were intended to provide post-surgical care at a lower cost than in regular hospitals. The unintended consequences were that—given the general shortage of LTC services in Poland—patients and their families continued to use the medical sector as a substitute for social LTC services, at a much higher price than could be done in the social sector. The medical nursing homes were largely financed from the health insurance fund and came at a much lower price for patients than private or social sector LTC services. Private sector response was dampened because for-profit and even non-profit organizations could not compete with the lower user fees in medical nursing homes. Municipalities, who finance most of the social LTC services, also found it cheaper to shift patients to medical nursing homes rather than provide their own social services.

A better approach would be to convert redundant municipal hospitals into community centers—either privately or publicly owned—that provide a whole range of LTC and rehabilitative services. Such community centers would be at the center of care coordination for patients. They could serve as daycare centers for the elderly and the disabled (or even childcare), and provide outpatient services like physical therapy. They could also function as the central facility for home-based services like care assistants or community nurses who support dependent people in their homes. To the extent necessary, these community centers could also provide temporary residential care and respite care. The exact setup of such community centers would depend on local needs and circumstances and also on other costs.

Finally, cash benefits to LTC beneficiaries can also promote use of cost-effective LTC services. As the experience in OECD countries show, with cash benefits, LTC beneficiaries may choose to hire home-based care or even subsidize informal care providers. This is a cost-effective approach.

***Policy Direction# 3: Think proactively about how to leverage LTC service delivery reforms and encourage private sector provision.*** Private provision of LTC services can provide effective competition to public provision and also provide greater choice for LTC users and potentially greater user satisfaction. There are also negative sides to private provision, i.e., cream-skimming

for LTC beneficiaries. The global experience shows that optimal private sector provision of LTC services (as well as other social services) is dependent on a sound LTC financing policy and an adequate regulatory environment (to reduce the costs of doing business while guaranteeing equity and quality for LTC beneficiaries). Therefore, LTC financing policy has to adequately price LTC services and compensate providers for these services.

***Policy Direction # 4: Develop a strong evidence-base on LTC financing and provision.*** As the case studies show, there are substantial gaps in building a strong evidence-base on LTC policies. For example, data on LTC expenditures is hard to get and while the System of Health Accounts (SHA) is in place, there are concerns regarding the validity and reliability of SHA data. Yet, understanding how much is spent on LTC and the efficiency and equity of this spending is critical to building and sustaining LTC policies. The demand for and coverage of LTC services, the public-private mix of service provision, and objective measure of quality are additional areas without data which are also important for LTC policymaking.



# 1. BULGARIA

## INTRODUCTION

As gains in basic health care increase life expectancy, more people live past the age of 65, a time when the risk of dementia and other degenerative diseases is higher and people are more likely to require long-term care (LTC) services. Whether at home or in an institution, such care is an important way to protect the lives and dignity of a country's elderly citizens.

Unfortunately, the cost of LTC, especially in institutions, can be catastrophic for families. Without public social protection systems many people cannot afford the care they need or the high cost of care sends them and their families into poverty. Thus, LTC is not only a health issue, but also a fiscal issue and as the European population ages, it is crucial for states to develop comprehensive LTC systems that address this interrelated issue.

How states cope with increased expenditures for LTC depends on policy choices regarding the generosity of public benefits, cost-sharing arrangements, and the supply of LTC services. In particular, policies in support of formal or informal care, in-kind services or cash-benefits, and institutional or community care have important consequences for a country's LTC sector and the cost to the public.

Bulgaria's LTC and social service system for the elderly has grown significantly in the past few years thanks to recent reforms aimed at deinstitutionalization and providing more community and home-based services. Yet the country's National Report on Strategies for Social Protection and Social Inclusion 2008-2010 states "there is no long-term approach for establishing an adequate system for LTC" to match demographic forecasts.

The next section explores the demographic background of the Bulgarian population, which is one of the fastest aging in Europe. This is followed by a short-description of the macro-economic and fiscal framework in post-crisis Bulgaria. Next, an overview of LTC service provisions is given, followed by a section on financing of LTC services. The last section concludes by introducing some guiding principles for future policy reforms.

## 1.1 Demographic Background

Bulgaria's population of 7.6 million people is declining faster than any other country in the European Union.<sup>5</sup> After averaging an annual population growth rate of -0.6 percent in the mid 2000s, it reached -0.79 in 2009. The negative population growth can be attributed mainly to lower birth rates and higher emigration rates, especially after Bulgaria joined the EU in 2007. In addition to fewer births and more emigrants, Bulgaria also faces an aging population as the proportion of residents aged 65 and older steadily grows. In the past decade, the share of the population aged 65 or more has grown to 17.3 percent and has remained slightly higher than the EU-27 average.

**Table 1.1: Main Demographic Information**

	1998	2003	2008	2020	2030
<b>Total Population</b>	<b>8,257,000</b>	<b>7,845,841</b>	<b>7,640,238</b>	<b>7,187,743</b>	<b>6,752,644</b>
65+	1,288,092	1,333,793	1,321,761		
80+	173,397	219,684	275,049		
<i>Share of total population</i>					
65+					
Bulgaria	15.6%	17.0%	17.3%		
EU-27 average	15.3%	16.2%	17.0%		
80+					
Bulgaria	2.1%	2.8%	3.6%		
EU 27 average	3.4%	3.8%	4.3%		

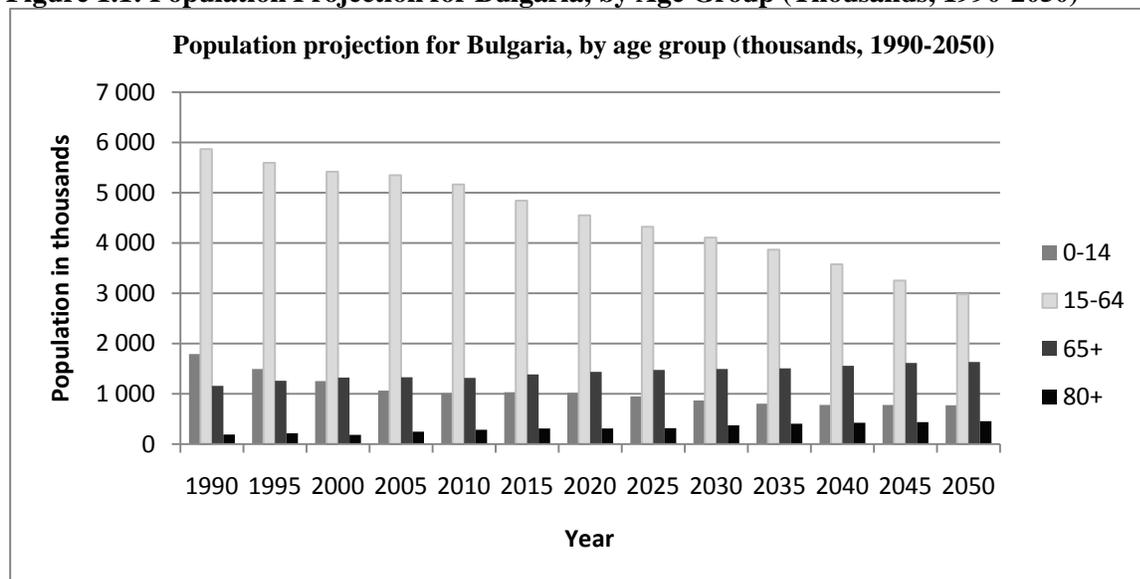
Source: Eurostat

The past 20 years have seen a steady decline in the number of working-age Bulgarians, while during the same period the number of elderly, both 65+ and 80+, has grown. Projections for the next 20 years show an even steeper decline of working-age residents as lower birthrates start to show in the 15-64 group and emigration continues. As the number of elderly grows and the number of working-age residents shrinks, Bulgaria will face the same situation of many European countries – a high dependency ratio.

Today there are four working age Bulgarians for every elderly resident. This proportion will not last long however, and by 2050 there will be less than two working age Bulgarians for every person over the age of 65. This dependency ratio of 55 percent will put the capacity of the existing social benefits system to the test, especially social and health services for elderly residents.

<sup>5</sup> CIA Fact Book (2010)

**Figure 1.1: Population Projection for Bulgaria, by Age Group (Thousands, 1990-2050)**



Source: UN Population Division 2008 World Population Prospects

In addition to a growing proportion of 65 year olds, Bulgarians are living longer than ever. Bulgarian men live an average of 69.5 years, an age that is slightly before the time when age-related diseases are most prevalent. Bulgarian women, on the other hand, live an average of 76.6 years which puts them at risk for more health-related issues. It also increases the odds of women living alone and needing additional help as they are likely to outlive their spouses. This has critical socioeconomic implications as it leaves women more vulnerable to poverty and isolation. As discussed below, elderly women are three times more likely than elderly men to live in poverty. Without strong legal protection for women, the longer lifespan and probable loss of a spouse puts them at extreme risk.

**Table 1.2: Life Expectancy at age 65**

	1998	2003	2008
<i>Bulgaria</i>			
Women	15.05	15.85	16.70
Men	12.46	12.99	13.53
<i>EU27 average</i>			
Women	n.a.	19.37	20.54*
Men	n.a.	15.88	16.99*

Notes: n.a. for data not available

\*Latest data from 2007

Source: Eurostat

While Bulgaria's share of the population aged 80+ is lower than the EU-27 average, most likely because its life expectancy is also lower, this growing subset of the population is most at risk for health issues and most in need of comprehensive long-term health and social care. Each additional year of life brings increased risk of dependency and hence increased need for support with activities of daily living (ADLs) though LTC services.

## 1.2 Macro-Economic and Fiscal Context

Bulgaria is an upper-middle income country with a GDP per capita (in purchasing power standards, PPS) of €10,400, which is well below the EU-27 average of €25,100. Bulgaria's economy, however, was growing far faster than the EU average. In 2008 the growth rate of Bulgaria's per capita GDP was 6.5 percent, compared to the EU-27's 0.3 percent. The global economic crisis in 2009 took its toll on the Bulgarian economy but the temporary contraction of GDP, trade and employment did not hit the country as hard as it did others in Europe.

Yet despite its relatively strong economic growth over the past decade, 13 percent of Bulgaria's population still falls below the poverty line. This number is significantly higher for vulnerable groups like the elderly. In 2008, 34 percent of elderly people were at risk of poverty, compared to only 19 percent for EU-27. Because women outlive men by an average of seven years, women over 65 are at particular risk. Elderly women are, in fact, three times more likely to live in poverty than their male counterparts. In 2007, 24 percent of women over the age of 65 lived in poverty compared to just 8 percent of men.

A comprehensive LTC system is all the more critical for a group that is so vulnerable to poverty. This requires investment from the state that until now has lagged behind the EU average. In 2006, for example, the Bulgarian government spent just .034 percent of GDP on care for the elderly, compared to the EU average of .48 percent. And while Bulgaria spends 6.69 percent of its GDP on health care, it only results in a per capita expenditure of €32.

**Table 1.3: Government Spending on Health (2007-2009)**

BULGARIA (BGN)							
	2007 approved budget	2007 actual expenditure	2008 approved budget	2008 actual expenditure	2009 approved budget	2009 actual expenditure	2010 approved budget
NHIF budget	1,470,005,600	1,541,698,596	1,686,116,900	1,747,825,108	2,071,182,256	1,752,775,946	1,689,431,995
MoH budget	514,362,500	539,700,000	583,700,000	698,900,000	644,764,690	537,374,124	704,094,600
Overall govt budget	20,992,000,000	22,103,400,000	25,371,000,000	25,323,400,000	30,362,000,000	25,551,167,008	26,860,700,000
Health/total	9.5%	9.4%	8.9%	9.7%	8.9%	9.0%	8.9%

Source: Ministry of Finance, Ministry of Health, and Health Insurance Fund

Spending on health care has remained relatively steady over the past several years; however, distorted incentives within the health care system have led to a proliferation of hospitals and rising financing pressures, while satisfaction with the quality of health services remains low. The government has identified the need for comprehensive health care reform, with a view to improve the efficiency and quality of the health care system.

## 1.3 Overview of the LTC and Social Services System

Long-term care and other social services for elderly are provided through two distinct systems in Bulgaria. Social services, defined as “activities which assist and expand the opportunities of persons to lead an independent way of life and which are carried out at specialized institutions and in the community”<sup>6</sup> are regulated by the Social Assistance Act (SAA) and Rules for the

<sup>6</sup> SG No. 120/2002 of Social Assistance Act of 1998 (2002 Revision)

Implementation of Social Assistance Act (RISAA). Long-term social care is defined as social services provided for a period of more than three months. There is no separate definition of LTC services in Bulgarian legislation at this time, nor an official classification of who qualifies for it.

Health services, on the other hand, are regulated by the Medical Treatment Facilities Act and are provided through different types of institutions such as hospitals for further and continuing treatment, hospitals for rehabilitation and hospices. Unlike social services, however, the legislation does not provide a definition of long-term health care.

As is the case in many countries, the social service sector and the health care sector do not have an official mechanism for coordination with regard to LTC services. Bulgaria has identified better cooperation and coordination between the health and social services as one of their priorities in the next few years. This includes concrete steps such as including health consulting rooms in homes for the elderly and disabled.

### Organization of Services

Traditionally, long-term care and other social services for the elderly are categorized as formal and informal, institutional and non-institutional. Every country has a different “menu” of services depending on cultural preferences, state capacity and funding. In Bulgaria, informal services such as home care by a family member most likely make up the bulk of LTC however there are no available data on this. What the data do show is that until recently most formal LTC and social services for the elderly were provided through institutions. After Bulgaria revamped its social service system in 2003, the share of formal services provided in the community or home grew steadily from 17 percent to 81 percent in 2008.

**Table 1.4: Number of Beneficiaries of Different Types of Social Services**

Year	2003	2004	2005	2006	2007	2008
Institutional	4,707	4,762	5,037	5,250	5,257	5,398
Non-Institutional		35,375	36,832	38,437	40,610	42,086
<i>Community-based</i>	570	801	907	1,733	1,984	2,877
<i>Home-based</i>	<i>n.a.</i>	34,574	35,925	36,704	38,626	39,209
<b>Total of all services</b>	<b>5,277</b>	<b>40,137</b>	<b>41,869</b>	<b>43,687</b>	<b>45,867</b>	<b>47,484</b>

*Note:* n.a. for data not available.

*Source:* Social Assistance Agency at the Ministry of Labor and Social Policy

In terms of service delivery, more than 90 percent of services are public, provided by either the state or municipal government. While institutional care is almost entirely public, NGOs and charities are increasingly involved in providing services at non-institutional centers for social rehabilitation and day care centers for adults. Home-based services are provided by individuals contracted by municipalities or the state, depending on the type of service.

To access social services, beneficiaries must submit a written request to the appropriate municipal or national authority for public services or to the manager of a private service provider. Based on the request, the relevant authorities conduct a social evaluation and make a recommendation for placement of the beneficiary. Access to health services is based on the insurance status of the beneficiary however every Bulgarian woman over the age of 60 and every Bulgarian man over the age of 65 has full health insurance coverage paid by the state.

In Bulgaria, the geographic coverage of LTC and other social services is uneven across districts, although this normally reflects differences in population. For the most part, more institutions with larger capacity are located in administrative centers where the population is higher. And while all types of social services have expanded in the past few years, there remains unmet need. In 2008, the number of registered beneficiaries waiting for services equaled approximately one third of existing capacity [Shopov 2009].

Accessibility to long-term health care services is more even across the country although there has been less growth in these services compared to social services. There has been a small increase in the number of hospices, though, which provide a critical service to Bulgaria's elderly who cannot receive care at home. Unfortunately the small growth in services has not been matched by increases in personnel or improvements in the patient to personnel ratio, which raises important questions about the quality of services [Shopov 2009, National Statistics Institute].

#### *Non-institutional Care: Community & Home-Based Services*

Unlike other European countries like Austria, Bulgaria does not have a cash-based LTC allowance system for family members who care for their elderly relatives. Instead, the state supports a system of personal assistants and home helpers who are paid to provide basic cooking, cleaning, personal hygiene and shopping/errand help for people who do not require institutionalization but cannot meet these basic needs on their own. This system was originally established to provide relatives of elderly and disabled residents who need constant care with a salary and insurance coverage but it is open to third parties as well.

In addition to personal assistants and other home helpers, municipalities provide daycare centers for elderly people, daycare centers for adults with disabilities, centers for social rehabilitation and integration, protected homes and care services at home. Table 1.5 below provides more details on each of these services.

**Table 1.5: Non-institutional LTC and Social Services**

<b>Type of Service</b>	<b>Services Provided</b>	<b>Service Delivery/Management</b>
<b>Personal assistant</b>	Take permanent care of a child or adult with disability or serious illness	Financed and managed by the state through the “Assistants for persons with disabilities” program. Small contribution from the municipalities that apply for this service. This is the only service that is completely free of charge for the users.
<b>Social assistant</b>	Provide a range of services to elderly or disabled person, including food delivery, shopping, personal hygiene, cleaning, errands, etc. Social assistants play an important role in avoiding institutionalization for clients.	Financed and managed by the State In the framework of the National program “Assistants for persons with disabilities.” Users pay small fees for a set number of hours per week. Fees for additional hours are higher. Municipalities – provide some financial and managerial support. Social assistants are normally a trained unemployed person hired by the national program.
<b>Home helper</b>	Provide services at home, house cleaning, cooking, shopping, errands, etc. Number of hours per week varies with individual needs.	This new service (as of 2009) is a component of the National Program “Social services at home”, financed by the state budget. User fees based on income.
<b>Daycare center</b>	Provide comprehensive services for the elderly including food, health, education, rehabilitation, and general social contact.	Funded by the state, managed by the municipality. Can be contracted out to a private organization. Clients pay 30 percent of their income.
<b>Center for social rehabilitation and integration</b>	Provide a range of social services by a team of specialists (psychologist, physical therapist, counselors, etc.) to prepare clients for integration into society and eventual independent living.	Funded by the state, managed by the municipality. Small user fees based on a set schedule. Management can be contracted to a private organization.
<b>Care services at home</b>	Social services provided at home such as food delivery, cleaning, help with personal hygiene.	Initially financed through municipal budgets but recently added to the national program: “Services in Family Conditions” which provides additional state funding to expand services. User fees apply, based on the Local Taxes & Fees Act.

*Source:* Social Assistance Agency at the Ministry of Labor and Social Policy, Shopov 2009

There has been tremendous growth in community and home-based social care services since Bulgaria reformed its social care system. In 2003 there were 21 community- or home-based social care providers. In 2008 the number was 369. With the addition of personal assistants, social assistants and home helpers, the number of beneficiaries of community and home-based care rose from just 570 in 2003 to 48,855 in 2008.

**Table 1.6: Growth in Community and Home-based LTC Services (2003-2008)**

Type of Service	2004		2008	
	Providers	Beneficiaries	Providers	Beneficiaries
Personal Assistant	0	0	11,020	n.a.
Social Assistant	0	0	2,685	n.a.
Home Helper	0	0	3,146	n.a.
Day Care Center	7	254	31	939
Center for Rehabilitation	10	547	53	1,938
Care Services Home	272	34,574	285	39,209
<b>TOTAL</b>	<b>289</b>	<b>35,375</b>	<b>369</b>	<b>n.a.</b>

Note: n.a. for data not available.

Source: Social Assistance Agency at the Ministry of Labor and Social Policy, Shopov 2009

The rapid uptake of community and home-based services reflects the suitability of these services as well as the prevailing attitudes toward institutions in Bulgaria. The traditional model of care for elderly in Bulgaria has been for children to take on the responsibility of caring for their parents or grandparents. Thus, Bulgarians are more comfortable with services provided in the neighborhood or in the home rather than in an institution where their relatives will be socially isolated.

Due to the increased demand for community and home-based services, the number of people employed by (or as) providers of such services has also increased, and fairly dramatically. In 2003 there were a mere 77 personnel working for community-based service providers. By 2008 that number was 17,980, most of which were individuals employed as personal assistants and other home helpers.

Of all community-based social services, the newer services from personal assistants, social assistants and home helpers have proven particularly effective and popular. They meet the basic needs of the elderly and disabled while keeping them in their home environment and out of institutions. They also often “employ” a family member who otherwise cannot work because of their full-time care responsibilities. And in the case of outside social assistants and home helpers, they provide a previously unemployed person with training and an official employment contract.

### *Institutional Care*

While the bulk of long-term care services are now provided by community and home-based service providers, institutional services remain a critical part of a comprehensive LTC system. In Bulgaria, institutional services consist mainly of homes for adults with disabilities, homes for elderly people, specialized hospitals for continuing treatment and rehabilitation and hospices. Beneficiaries of these services are beyond the scope of community-based services.

**Table 1.7: Institutional LTC and Social Services**

Type of Service	Services Provided	Service Delivery/Management
<b>Home for adults with disabilities</b>	Range of social services related to activities of daily living (ADL).	Financed and managed by the state through the "Assistants for persons with disabilities" program. Some user fees apply.
<b>Homes for elderly people</b>	Specialized institution, providing a range of social services to people entitled to a pension. Requires certification by an expert	Financed and managed by the state through the "Assistants for persons with disabilities" program. User fees based on income and assets.
<b>Specialized hospitals for further and continuing treatment and rehabilitation</b>	Comprehensive medical care for people with chronic diseases or conditions that require continuing care and physical rehabilitation.	Managed by commercial entities registered under the Commercial Act and based on standards laid out in the Medical Treatment Facilities Act. Funded by the state and user fees.
<b>Hospices</b>	Long-term medical observation and treatment based on personalized plans.	Managed by commercial entities registered under the Commercial Act and based on standards laid out in the Medical Treatment Facilities Act. Funded by the state and user fees.

Source: Social Assistance Agency at the Ministry of Labor and Social Policy, Shopov 2009

As of 2008 there were 11,750 places in 159 homes for adults and elderly needing institutionalized long-term care. In contrast to the rapid growth of community and home-based services, this number has remained virtually unchanged since 2003 when Bulgaria reformed its social services sector. There were, however, small changes between the types of institutions: the number of spaces for adults with disabilities decreased by 10 percent and the number of spaces for elderly increased by 15 percent. While there is a push to de-institutionalize people by providing services in the community and homes, it is interesting to note that the number of spaces for elderly increased. This suggests there was an unmet need for those places before the reforms and each bed emptied by someone who could receive services at home was filled by someone who qualified for and was waiting for institutional services.

**Table 1.8: Trends in Institutional Care (2003-2007)**

Type of Service	2003	2003	2007	2007
	Providers	Beneficiaries	Providers	Beneficiaries
<b>Homes for elderly</b>	57	4,707	70	5,257
<b>Homes for disabled</b>	86	7,038	86	6,442
<b>Specialized hospitals for further and continuing treatment and rehabilitation</b>	42	n.a.	46	n.a.
<b>Hospices</b>	38	n.a.	39	n.a.
<b>TOTAL</b>	<b>223</b>	<b>n.a.</b>	<b>241</b>	<b>n.a.</b>

Note: n.a. for data not available.

Source: Social Assistance Agency at the Ministry of Labor and Social Policy, National Statistical Institute, Shopov 2009

In terms of the geographic distribution of institutional services, not all types of institutions are available in every district. Only five of 28 districts have all types and in some cases the institutions are outside towns, which further isolate residents. While geographic coverage is uneven, it generally corresponds to the population distribution within the country.

Interestingly, as the number of institutions remains relatively unchanged, there has been an increase in staffing since 2003 when the Ministry of Labor and Social Policy adopted quality of care guidelines. For example, the number of places in homes for elderly increased by only 15 percent but the number of staff increased by 65 percent. This means that where in 2003 each staff person was responsible for 3 patients, in 2008 each staff person was responsible for just over 2. This improvement in the staff to patient ratio is one potential indicator of quality.

The number of health institutions providing LTC has also remained steady. It increased from 80 in 2003 to 85 in 2007. Interestingly, while the number of institutions increased by 6 percent and the number of beds increased by 10 percent, the number of medical personnel working in those institutions remained nearly the same (-0.4 percent). Thus, in contrast to institutions providing social services, the personnel to patient ratio in health institutions has declined. Of particular note is the increase in the number of beds in hospices, which are crucial providers of LTC to the elderly. Between 2003 and 2007 only one new hospice opened in Bulgaria, however the number of beds more than doubled from 178 to 398. Fewer personnel supporting more patients in the same amount of space raises important questions about the quality of care, especially in hospices where doctors make up only 0.05 percent of medical personnel.

#### **1.4 Financing of LTC and Social Services**

LTC and other social services for the elderly are financed primarily from public funds. There is no LTC insurance and private contributions through fees are minimal. In general, LTC and other social services for the elderly in Bulgaria are financed by the following methods:

- **State services:** Financed by the state and funded directly to the service provider.
- **State delegated services:** Financed from the state budget based on established standards but funds are transferred to municipalities which then fund and manage the services. Municipalities are obliged to provide these services.
- **Municipal services:** Financed from local budgets and funded directly to the service provider. Provision of these services depends on local conditions and needs.
- **User fees:** Paid to municipality or state, depending on the service. All but one service (personal assistants) require user fees based on the particular service and the user's income.
- **Private services:** Financed by private organizations (NGOs, foundations, firms) that are registered with the Social Assistance Agency.

In terms of expenditures, the bulk of services are state-delegated, which means they are funded by the state but managed by the municipalities. While this ensures a minimum amount of funding available to meet local needs, it does not ensure high quality, universal coverage. Municipalities must manage services within strict budgetary limits that are based solely on the number of beds or units of service rather than the quality of service. In addition, the state provides an equal

amount of funding for state-delegated services for each municipality, regardless of the population size or level of demand.

### *Funding Sources and Flows*

Funding for state-delegated services comes from national target programs (for example, “Assistants for Persons with Disabilities”), social assistance funds, and grant schemes for social services (for example, OP “Human Resource Management”, EC structural funds with national co-financing). Until 2003, social services were funded by municipal governments whose budgets included general transfers from the state. Unfortunately municipalities were unable to provide sufficient, high-quality social services based on the funds provided by the state and more and more residents went without the services they needed.

Thus in 2003 the government began providing targeted funds to municipalities for specific social services to ensure both quality and universal coverage. These “state delegated services” now represent a majority of LTC and other social services for the elderly. This change in funding mechanism (or fiscal decentralization) has been crucial in fixing the previous imbalance between the central government’s limits on funding and the local government’s responsibility for service provision.

**Table 1.9: Funding Sources of LTC and Social Services in Bulgaria**

		<b>FUNDING &amp; MANAGEMENT</b>		
		<b>State funded and managed</b>	<b>State funded, delegated to local management</b>	<b>Locally funded and managed</b>
<b>TYPE OF SERVICE</b>	<b>Institutional</b>		<i>Homes for disabled, homes for elderly, hospitals, hospices</i>	
	<b>Community/Home-based</b>	<i>Personal assistant, Social assistant, Home helper,</i>	<i>Day care center, Center for rehabilitation,</i>	<i>Care services at home</i>

Source: Shopov 2009

For state delegated services, the central government determines the rate at which each service will be subsidized. Municipalities are expected to provide high quality services within the targeted subsidy, however they are welcome to co-finance state-delegated services from their own revenues. This is particularly important because the state provides an equal amount of funding for social services to each municipality, regardless of its size or the conditions under which it provides services. This has resulted in a significant increase in the amount of co-financing provided by municipalities. In 2003, 89 municipalities provided BGN 1.92 million in co-financing for social services. By 2008, 107 municipalities contributed BGN 9.53 million.

From 2008, the state has not only determined the rate for each social service but has also instituted uniform standards for salaries and maintenance of facilities. This aims to eliminate inequalities among institutions and service providers in different municipalities. The state also determines a national ceiling on the funds available for a particular type of service which means there is a limit on the amount of funding each municipality can receive. This has implications for municipalities meeting the needs of their residents as the demand varies across municipalities.

The use of predetermined rates for each service works relatively well for institutional care because calculating a figure based on the number of beds is straightforward. However, as the proportion of community-based services grows, it becomes more difficult to determine a fair rate. The cost of labor becomes more important rather than the number of “places” and the services can vary depending on the unique needs of each beneficiary.

User fees for state services are determined by the Council of Ministers and are “low, differentiated, socially affordable and not burdensome.” User fees are generally determined by the cost of the service and the financial position of the user. For example, users of institutional centers must pay 70-80 percent of their income while users of day care centers must pay 30-50 percent. For beneficiaries with no income, there is no fee. The fees for state-delegated services are allocated in part to the state budget and in part to the Social Assistance Fund which is an important source of funding for social services in general.

When the state began funding social services in 2003, they also asked municipalities to remit any fees collected back to the state treasury. This broke the direct link between service provision and the collection of fees, resulting in a decrease in overall fee collection. Once they had to remit any fees collected to the state, local employees were less motivated to collect them in the first place and to update their rate based on changes in the user’s income. This also broke the link between quality of service and fee payment. The municipalities receive the same fee regardless of the quality of service and users pay the same fee regardless of the quality of service.

User fees for long-term health services are directly related to the user’s health insurance status and their package with the National Health Insurance Office. For elderly, there is no risk of interruption in health insurance status due to unpaid contributions because their contributions are paid by the state budget starting at age 60 for women and 65 for men.

The government is clear that the current system of funding for LTC and other social services is unsustainable given the demographic projections. The heavy reliance on state-delegated services will need to change and local municipalities will need to find other sources of funding.

#### *Expenditures on LTC and Other Social Services*

While there are no data on services funded directly by the state (personal assistants, home helpers), Bulgaria spent BGN 133 million on state-delegated and local services in 2008 (see Table 1.10). This is a dramatic increase from 2003 when spending was just BGN 76 million and most services were funded solely by municipalities.

There has been a significant increase in staffing, expenditures, geographic coverage and the number of beneficiaries reached by state-delegated services. This may reflect the demand for services and aging population but it may also reflect the preference of municipalities to establish state-delegated services for which they receive state funding rather than local services that come directly out of their budget (see Table 1.11 below). This is especially true for services like social care at home where fees cover less than 40 percent of expenses and there are now similar state-delegated services like social assistants and home helpers.

**Table 1.10: Spending on LTC and Social Services (BGN)**

	2003	2005	2007	2008
<b>Institutional</b>				
Homes for elderly & disabled	30,382,846	43,796,817	53,289,202	72,341,548
Hospitals and hospices	22,544,412	45,012,288	38,087,070	n.a.
<b>Total</b>	<b>52,927,258</b>	<b>88,809,105</b>	<b>91,376,272</b>	<b>72,341,548</b>
<b>Community &amp; Home-based</b>				
Day care centers, rehab centers	578,780	1,746,961	5,423,871	18,533,815
Social care at home	223,10,599	28,066,221	34,322,129	42,261,276
<b>Total</b>	<b>22,889,379</b>	<b>29,813,182</b>	<b>39,746,000</b>	<b>60,795,091</b>
<b>Grand total</b>	<b>75,816,637</b>	<b>118,622,287</b>	<b>131,122,272</b>	<b>133,136,639</b>

Note: n.a. for data not available.

Source: Ministry of Finance

**Table 1.11: Structure of Expenditures Provided by the Municipalities**

Type of funded service	2003	2005	2007	2008
Municipal	44%	41%	41%	35%
State-delegated	56%	59%	59%	65%

Source: Ministry of Finance, Shopov 2009

But the growth hasn't been limited to home-based services. State-delegated services in the communities, such as day care and rehabilitation centers have also increased dramatically. For example, in 2003 only 22 municipalities (8 percent) provided social care centers but by 2008 the number had risen to 112 municipalities (42 percent). While this growth has improved accessibility to much-needed services, it still leaves many municipalities without certain types of social services. Municipalities cite the lack of resources from their own budget and from the state as the main limitation to more comprehensive social service provision. A closer look at two municipalities, one rural and one the administrative center of a district, illustrates the difference in services provided and funds spent on LTC and social services (see Table 1.12).

**Table 1.12: Comparison of LTC Service Provisioning and Financing of Two Municipalities**

	Ugarchin (rural)	Razgrad (urban)
Population	7,500	56,000
2008 municipal budget	BGN 6.2 million	BGN 34.5 million
<b>Total number of LTC and social services</b>	<b>4</b>	<b>6</b>
<b>Non-institutional (+ expenditures)</b>	<b>3</b>	<b>4</b>
Social services at home	1: BGN 526,900	1: BGN 762,776
Day care center for elderly	1: BGN 337,283	None
Center for social rehabilitation	1: BGN 46,126	1: BGN 165,663
Club of pensioners	None	1: BGN 32,956
Center for public assistance	None	1: BGN 84,648
<i>Total non-institutional 2008 expenditure</i>	<i>BGN 910,309</i>	<i>BGN 1,046,043</i>
<b>Institutional Services (+ expenditures)</b>	<b>1</b>	<b>2</b>
Home for elderly	1: BGN 54,400	1: BGN 872,228
Home for adults with disabilities	None	1: BGN 893,035
<i>Total institutional 2008 expenditure</i>	<i>BGN 54,400</i>	<i>BGN 1,765,263</i>
<b>Total 2008 Expenditures on all LTC and social services</b>	<b>BGN 964,709</b>	<b>BGN 2,811,306</b>

Source: Cost Study of Long-Term Care in Bulgaria by "Club Economika 2000," April 2009

In terms of municipal services, municipalities spent BGN 42 million in 2008 on social care at home compared to only BGN 22 million in 2003. Interestingly this is the same number of staff

serving 7,000 more people. So the average number of people serviced by each staff person increased from 8.6 to 10.8. Fees covered 39 percent of expenses. The territorial coverage of this service varies across districts with some districts covering only 1 percent of the elderly population and others covering 5-9 percent.

The number of services provided by NGOs and other private agencies is growing, too, although their share of all social services remains relatively small. Between 2004 and 2006 the number of LTC and other social services provided by NGOs and private entities increased from 153 to 264. See table 1.12 below for details.

**Table 1.13: Social Services provided by the Public Sector, NGOs and Private Entities (2006)**

Type of services	Private service unites*	Public service units	Total	Share of services by private
Homes for elderly disabled people	0	86	86	0%
Homes for elderly people	12	66	78	15%
Social assistant	48	2,574	2,622	2%
Personal assistant	8	13,955	13,963	0%
Home helper	25	n.a.	25	
Day care centre for elderly people	10	15	25	40%
Day care centre for adults with disabilities	24	22	46	52%
Centre for social rehabilitation and integration	83	30	113	73%
Care services at home	27	272	299	9%
Public canteens	20	43	63	32%
Protected homes	19	31	50	38%
<b>Total LTC social services for adults and elderly people</b>	<b>264</b>	<b>17,094</b>	<b>17,358</b>	<b>2%</b>

Notes:

n.a. for data not available.

\* One private or non-governmental organization could provide more than one service

Source: Social Assistance Agency

## 1.5 Future Policy Directions

Bulgaria has made considerable progress in providing LTC services to its elderly population, but formidable challenges still lie ahead. The aging of the Bulgarian population—projected to be one of the most pronounced in Europe—will require a careful balancing of ensuring access to the right types of LTC services and fiscal considerations. The following guiding principles might be helpful for any future policy reforms of the Bulgarian LTC sector: (i) LTC has to be provided in a **multidisciplinary setting** that encompasses health as well as social care services; (ii) **home-based, ambulatory, and community-based day care services** lead to better outcomes, are more cost-efficient, and are overwhelmingly preferred by patients; and (iii) LTC has to put the patient in the center, guarantee a continuum of care across needs and care settings, and have to ensure that **money follows the patient**.

**LTC has to be provided in a multidisciplinary setting.** LTC cannot be provided in either an exclusively medical or an exclusively social setting, but needs to encompass both sectors. This principle is not only emerging from the experiences of many OECD countries, but is also acknowledged on the EU level—as part of the Open Method of Coordination—as well as on the national level—as part of the hospital master plan of the Bulgarian Ministry of Health and as a

guiding principle of the social care work of the Bulgarian Ministry of Labor and Social Policy. People who have temporarily or permanently lost the ability to live independently, like elderly and frail people or post-surgery patients, need a whole range of services, from simple home help to regular medical monitoring and assistance. Services from the medical and social sector complement each other, but neither can work without the other. In particular home-based care services need to complement each other: if support by a home helper is not accompanied with visits from a community nurse or a general practitioner, care services will fail; if a patient is limited in his mobility after surgery, medical follow-up treatment provided at his home will fail if he does not also receive support by a home helper. Therefore, LTC has to be provided by multi-disciplinary teams from both sectors - the medical and the social sector.

**Home-based and community-based LTC is better than institutional LTC.** Experiences from other countries show that LTC services provided in patients' homes or in the community—like day-care centers—are preferable to institutional care. Home-based and community based services allow patients to live in their own home and provide support to informal care-givers, like family members and neighbors. Institutional care should be a measure of last resort, as it is significantly more expensive, and not in the interest of patients. Surveys like Euro Barometer show that patients overwhelmingly prefer to be taken care of at home.

**LTC has to be patient-centered.** Because LTC comprises social and health services, the delivery and financing of long-term is extremely fragmented, to the detriment of the patient. Typically, LTC services are financed from such diverse sources like health insurance fund, ministry of social policy, regional funds, municipalities, charities, and out-of-pocket. Since entitlement to services are not assessed in a centralized way, with a clear focus on the patients' needs, cost-shifting is a common phenomenon. A good example is Poland, which introduced LTC hospitals some years ago. Since these are financed from the health insurance fund, municipalities, which finance social welfare homes, face high incentives to shift as many dependent people as possible to medical LTC hospitals. Effectively, the introduction of LTC hospitals in Poland led to cost-shifting between municipalities and the health insurance fund, to the detriment of patients' wellbeing, who are being pushed back and forth between LTC hospitals and social welfare homes. In addition, the increased capacities of institutional LTC undermine efforts to develop much-needed capacities for community-based and home-based services. In order to address cost-shifting and fragmentation of services, a consolidation of financing would be desirable. Yet, since this is usually not feasible, a multi-disciplinary assessment team that effectively coordinates care for patients and decides about patients' entitlements to services independent of the funding source is a viable alternative. Such a multi-disciplinary assessment team should, at a minimum: (i) comprise of a medical doctor and a social worker; (ii) assess in a transparent way patients' level of dependency; and (iii) make an independent recommendation of patients' needs for medical care, social care, and financial support. For the latter, there should be a clear emphasis on out-patient, ambulatory medical care and home-based or community-based social care.

In light of these guiding principles outlined above, a series of potential policy measures come to mind. In the short-term, it will be necessary to carefully explore the implications of converting municipal hospitals into LTC hospitals. The experience of Poland (see Chapter 4) clearly shows the dangers of such a conversion. Further, significantly expanding the capacities of institutional LTC risks undermining the policy objectives of home-based and community based LTC of the Ministry of Labor and Social Policy and the Open Method of Coordination at EU level. Rather, it would be important to consider alternative policies that complement the existing LTC policy

goals of the Ministry of Labor and Social Policy. This would mean converting municipal hospitals into municipal social centers that provide a whole range of home-based and community-based social and medical services, like community nurses, mobile medical services, out-patient services, physical therapy, day-care services, and to some extent, respite care and hospice (both institutional and home-based) services.

In the medium and long-term, it will be necessary to develop a model for multidisciplinary teams—consisting of medical doctors or nurses and social workers—that can assess patients need for LTC services in a transparent way. Here, the experience of Latvia (see Chapter 4) seems particularly relevant. Finally, in order to overcome fragmentation of financing and cost-shifting behavior, it will be necessary to consider options to consolidate financing of LTC services across the social and health ministries as well as municipalities.

## 2. CROATIA

### INTRODUCTION

The focus of this chapter is on the role of social welfare institutions in the provision of LTC since they are undergoing changes in terms of their ownership, as well as the scope and diversity of services provided. The most detailed account is presented on the LTC for the elderly as the principal recipient of LTC in Croatia.

The chapter begins with a summary of demographic trends followed by current regulatory guidelines governing the provision and finance of LTC in Croatia. Next, trends and key benefits of LTC will be reviewed. Current LTC system will then be examined for the elderly and infirm persons. This section will be analyzed by services provided under institutional arrangements and those provided through non-institutional services. For comparative purposes, there will be a brief summary of other LTC services, namely for the disabled, the mentally ill, and long-term health care services. The next two sections will look at the cost of care and projections for public expenditure for long term care benefits. The concluding section will discuss implications of the trends and offer recommendations for policy.

### 2.1 Demographic Trends in Croatia

The demographic trend in Croatia resembles the recent trends throughout other European countries. In Croatia, the population aged 65 and over now makes up more than 17 percent of the population (see Table 2.1). The share of this age group has been growing since the 1990s. This is consistent with the demographic phenomenon occurring in other European countries where the elderly aged 65 and over account for between 17 percent (EU-25) and 17.2 percent (EU-15) of the population.

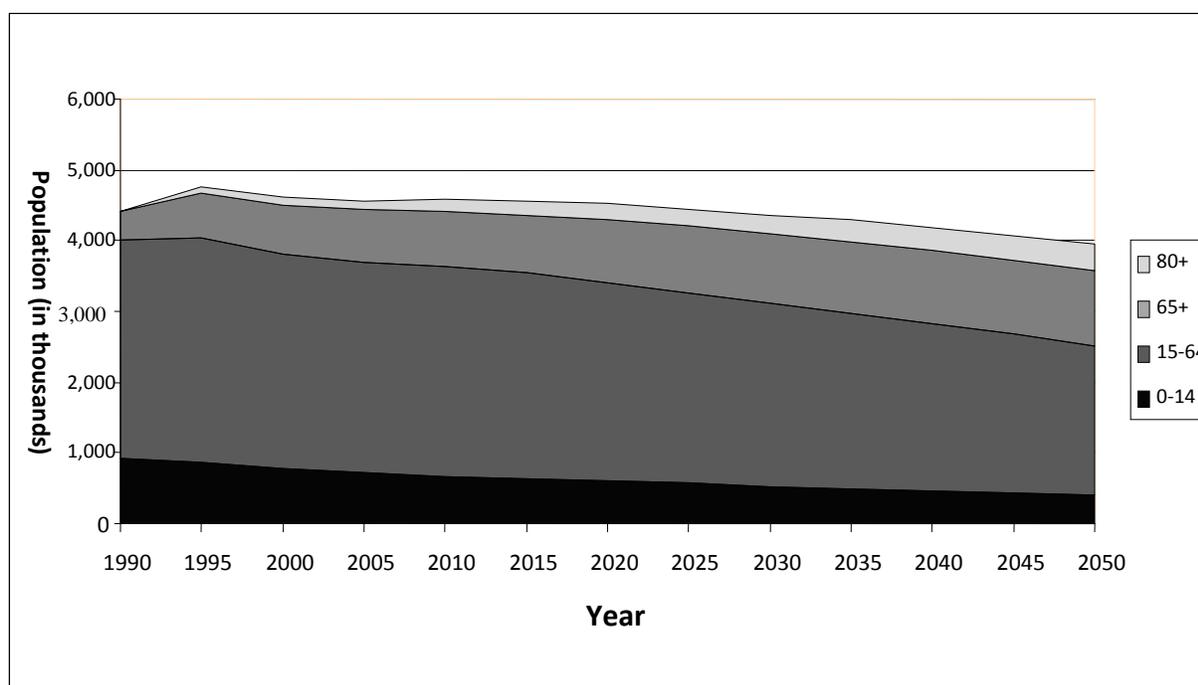
Similarly, the proportion of the very old, aged 80 and over has been increasing as well since the 1990s in Croatia. This trend is also similar to the general trend in EU-27 and EU-15 countries. The share of the elderly has been growing while the overall population growth has been declining (see Table 2.1). Further there is an increasingly elderly population both 65 and over and 80 and over while there is a declining working population aged 15-64. The projection shows that in the future, the share of the elderly will continue to grow while the share of the working and younger population will continue to decline. Over the next 40 years, the Croatian population will decline from approximately 4.5 million in 2010 to 3.9 million in 2050 (see Figure 2.1). The working age population, aged 15 to 64, will decline 30 percent from approximately 3 million to 2.1 million in 2050. These changes will occur while the elderly aged 65 and over will increase by 41 percent from 764,000 to 1,080,000; and while the very elderly aged 80 and over increases by 100 percent from 170,000 to 354,000. The WHO (2009) estimates that as early as 2020, 20.4 percent of the Croatian population will be 65 and over. This means that more than one in five people in Croatia will at or above the age of 65.

**Table 2.1: Proportion of the Elderly in Europe and in Croatia (as a percentage, 1990-2008)**

	1990	2000	2002	2004	2006	2008
<b>EU-27</b>						
65+	13.7	15.6	16.0	16.4	16.8	17.0
80+	3.1	3.3	3.6	3.9	4.1	4.3
<b>EU-15</b>						
65+	14.2	16.3	16.8	17.2	17.7	17.2
80+	3.3	3.6	3.9	4.2	4.5	3.2
<b>Croatia</b>						
65+	11.6	16.4	15.9	16.4	16.9	17.2
80+	2.2	2.6	2.4	2.6	2.9	3.2
Population Growth rate (crude rate of increase)	-2.0	-13.2	0.4	0.5	-0.4	-0.3

Source: Eurostat (2010)

**Figure 2.1: Population Projection for Croatia, by Age Group (Thousands, 1990-2050)**



Source: Author's calculation based on UN Population Division (2009) World Population Prospects

A rapidly aging population will also have implications for the old-age dependency ratio. Table 2.2 shows the shifting trends in the old-age dependency ratio. Between 1990 and 2008, there has been an almost 10 percent increase in the elderly dependency ratio from 17 percent to almost 26 percent. Figure 2.1 illustrates the past impact of an increasingly dependent population on the working population in Croatia. The future projection is based on the assumption that the elderly dependency ratio will remain constant from 2010 through 2050. There is an increasingly large dependent population that is being supported by a declining working population. In other words, the number of working population is decreasing while the number of the dependent elderly is

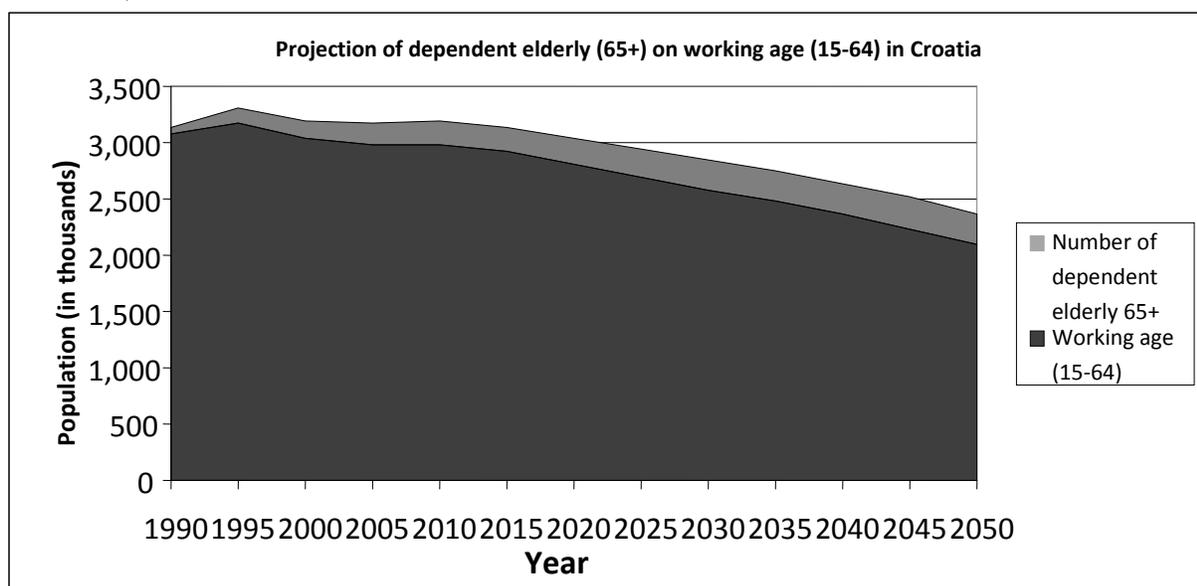
increasing. If the current demographic trend continues in Croatia, the elderly dependency ratio will likely continue to increase.

**Table 2.2: Dependency Ratio of Elderly Population 65+ on Working Population (15-64) in Croatia and EU (percent)**

	1990	1995	2000	2004	2005	2006	2007	2008
EU-27	20.6	21.9	23.2	24.3	24.6	24.9	25.2	25.2
EA-15	21.0	22.6	24.2	25.7	26.1	26.5	26.8	26.9
Croatia	17.0	18.2	24.4	24.6	24.9	25.2	25.4	25.6

Source: Eurostat (2010)

**Figure 2.2: Population Projection of Dependent elderly (65+) on Working Age (15-64) (thousands, 1990-2050)**



Source: Author's calculation based on UN Population Division (2009) World Population Prospects

The demographic trend in Croatia resembles the overall pattern in other European countries: the share of the elderly is becoming increasingly larger while the share of the working population is declining.

## 2.2 Trends in Institutional Long-Term Care in Croatia 2003-2007

Between 2003 and 2007, there was a clear trend of an overall increase in institutional capacity for long-term social care provision, as evidenced by the 22 percent rise in the total number of beneficiaries and an 18 percent rise in the number of institutions for the disabled, the elderly and people with mental illnesses.

In 2007, the three main types of long-term social services were provided to 23,109 persons in 186 facilities (see Table 2.3). Generally, the elderly and infirm are the target group for institutional care services as they made up 61 percent of all beneficiaries in 2007. The proportion of institutional care services received has slightly increased since 2003, followed by the disabled whose percentage of received institutional care services has remained constant at 21 percent and finally, by persons with mental illnesses, who made up 17 percent of institutional care recipients in 2007, a figure slightly lower than 2003. Over the period 2003-07, out of 3,476 new beneficiaries, 68 percent were the elderly and infirm persons, 28 percent were disabled, while persons with mental illnesses made up only three percent of the new recipients of institutional care.

The other important trend is the rise of non-state institutions, a number of which has grown by 28 percent, in comparison to a 5 percent rise of state institutions. In 2007, 70 percent of all beneficiaries of institutional long-term care for the three main categories of services were accommodated in non-state institutions, compared to 66 percent in 2003. The high percentage of LTC recipients in non-state institutions can be contributed to the fact that since 2001, the entire institutional social care system for the elderly is provided in non-state institutions, including facilities managed by regional government, local government and private organizations.

The primacy of non-state institutions is also evident from the fact that non-state institutions make up 91 percent (27 out of 33) of all newly established facilities since 2003, among which homes for the elderly and infirm persons predominate (27 out of 33), especially those founded by local governments or the private sector (26 out of 33). This is consistent with decentralization efforts since 2001 to place institutional homes under the management of regional authorities.

At the same time, the number of homes for the elderly founded by counties has mostly been constant, with only 1 out of 47 facilities founded since 2003.

There are differences in the size of long-term care institutions, which may also potentially indicate differences in internal organization and modes of social care provision. On average, there are 124 beneficiaries per institution and the average number of beneficiary is 35 percent higher in state institutions than in those run by counties or other non-state facilities (compare 155 versus 115 on average). Across categories of services, non-state institutions seem to accommodate fewer beneficiaries, with the exception of county homes for the elderly where the average number of beneficiary is 220; the highest among all type of institutions. Interestingly, this is also 4.2 times higher than the average of 52 beneficiaries accommodated by other non-state homes for the elderly and infirm persons, the latter being the lowest among all types encompassed in this analysis.

The funding sources for long-term social services is based on the classification used by the MoHSW, including full coverage by the state, full coverage by beneficiary, state-beneficiary cost-sharing and coverage from “other sources” which are not specified. The main trend in the structure of funding of long-term social care services is the rise in the financial participation of beneficiaries. In 2007, 48 percent of beneficiaries were able to fully finance their social service costs, compared to 37 percent in 2003 (see Figure 2.1 and Figure 2.2). The share of the other three sources of funding (full state coverage, state beneficiary cost-sharing, and coverage from “other sources”) has been declining over the past five years (see Table 2.4). Full state subsidies

have declined gradually from 51 percent in 2003 to 44 percent in 2007; the share of “other sources” also dropped sharply in 2004 and has remained below 10 percent.

The trend of beneficiary financing is generally evident in non-state long-term institutional homes. Table 2.3 illustrates a relatively constant proportion of beneficiary financing from 2003-2007. In non-state homes on the other hand, there is an increasing trend of full beneficiary financing from 50 percent in 2003 to 64 percent in 2007. This can be associated with the significant increase both in the total number of the elderly and infirm persons among all new beneficiaries, and in the ratio of full self-financing within this group of beneficiaries. The structure of funding for the elderly and infirm is completely opposite to that of the other two beneficiary groups, both of whom primarily rely on full or partial state funding (95 percent of the disabled and 72 percent of persons with mental illnesses), regardless of accommodation in state or non-state institutions.

State funding is primarily directed towards state institutions where it made up more than 85 percent of all funding through the five-year period (2003-2007), while the share of beneficiary funding was 11 percent and funding from other sources remained at a low 4 percent. It is apparent that the overall decrease in state funding is related to significant increase in the share of fully self-financed beneficiaries in non-state institutions, which has risen from a half in 2003 to over two thirds in 2007.

There is a need for more specific data on the ratio of beneficiary vs. state cost-sharing in the combined model of funding; as well as on the structure of other sources, in order to determine the extent of private funding from guardians and family members, and the extent and share of state funding and revenues from private insurance.

**Table 2.3: Distribution of Social Welfare Homes by LTC Needs, Number of Beneficiary and Number of Homes (2003-07)**

Type of homes	2003		2004		2005		2006		2007	
	No of Homes	No of Beneficiaries								
<i>Homes for people with disability</i>										
	<b>38</b>	<b>4,055</b>	<b>40</b>	<b>4,468</b>	<b>41</b>	<b>4,371</b>	<b>40</b>	<b>4,574</b>	<b>40</b>	<b>5,038</b>
State	24	3,086	25	3,052	26	3,072	26	3,153	26	3,567
Non-state	14	969	15	1,416	15	1,299	14	1,421	14	1,471
<i>Homes for elderly and infirm persons</i>										
	<b>94</b>	<b>11,794</b>	<b>103</b>	<b>12,482</b>	<b>108</b>	<b>12,946</b>	<b>112</b>	<b>13,263</b>	<b>121</b>	<b>14,168</b>
Non state-county	46	9,965	46	10,168	46	10,175	46	10,205	47	10,337
Other non-state	48	1,829	57	2,314	62	2,771	66	3,058	74	3,831
<i>Homes for people with mental illnesses</i>										
	<b>21</b>	<b>3,784</b>	<b>22</b>	<b>3,794</b>	<b>22</b>	<b>3,703</b>	<b>22</b>	<b>3,729</b>	<b>25</b>	<b>3,903</b>
State	18	3,590	18	3,471	18	3,371	18	3,294	18	3,260
Non-state	3	194	4	323	4	332	4	435	7	643
<b>TOTAL</b>	<b>153</b>	<b>19633</b>	<b>165</b>	<b>20744</b>	<b>171</b>	<b>21020</b>	<b>174</b>	<b>21566</b>	<b>186</b>	<b>23109</b>

Sources: Ministry of Health and Social Welfare – Annual statistical reports on social welfare homes and beneficiaries in 2003, 2004, 2005, 2006, 2007 (May 2008)

**Table 2.4: Trends in the funding sources of social welfare homes 2003 to 2007**

Sources of funding	2003				2004				2005				2006				2007			
	No. of beneficiaries according to source of funding																			
	Beneficiary	Beneficiary + State	State	Other sources	Beneficiary	Beneficiary + State	State	Other sources	Beneficiary	Beneficiary + State	State	Other sources	Beneficiary	Beneficiary + State	State	Other sources	Beneficiary	Beneficiary + State	State	Other sources
Type of homes																				
State	733	2,099	3,639	205	779	2,177	3,358	209	687	2,223	3,278	255	723	2,361	3,127	236	771	2,285	3,498	273
<i>Homes for people with disability</i>	4	972	2,069	41	29	1,027	1,887	109	23	1,099	1,819	131	36	1,340	1,729	48	53	1,294	2,141	79
<i>Homes for people with mental illnesses</i>	729	1,127	1,570	164	750	1,150	1,471	100	664	1,124	1,459	124	687	1,021	1,398	188	718	991	1,357	194
Non-state	6,477	2,269	2,076	2,135	6,812	2,323	2,389	2,697	9,005	2,139	2,211	1,222	9,100	2,197	2,223	1,599	10,349	2,040	2,235	1,658
<i>Homes for people with disability</i>	22	122	818	7	4	247	1,106	59	3	281	974	41	12	367	1,008	34	18	344	985	124
<i>Homes for elderly and infirm person</i>	6,430	2,084	1,164	2,116	6,764	1,970	1,125	2,623	8,944	1,756	1,079	1,167	9,008	1,677	1,029	1,549	10,181	1,485	1,009	1,493
<i>Homes for people with mental illnesses</i>	25	63	94	12	44	106	158	15	58	102	158	14	80	153	186	16	150	211	241	41
<b>Total beneficiaries</b>	<b>7,210</b>	<b>4,368</b>	<b>5,715</b>	<b>2,340</b>	<b>7,591</b>	<b>4,500</b>	<b>5,747</b>	<b>2,906</b>	<b>9,692</b>	<b>4,362</b>	<b>5,489</b>	<b>1,477</b>	<b>9,823</b>	<b>4,558</b>	<b>5,350</b>	<b>1,835</b>	<b>11,120</b>	<b>4,325</b>	<b>5,733</b>	<b>1,931</b>
	<b>19,633</b>				<b>20,744</b>				<b>21,020</b>				<b>21,566</b>				<b>23,109</b>			
<b>Total %</b>	36.72	22.25	29.11	11.92	36.59	21.69	27.70	14.01	46.11	20.75	26.11	7.03	45.55	21.14	24.81	8.51	48.12	18.72	24.81	8.36

Sources: Ministry of Health and Social Welfare – Annual statistical reports on social welfare homes and beneficiaries in 2003,2004, 2005,2006, 2007 (May 2008)

## **2.3 Provision, Regulation and Financing of Long-Term Care**

National regulations address public provision and financing of LTC in Croatia. According to *The Law on Social Care*, elderly care falls under the responsibility of the Ministry of Health and Social Welfare (MoHSW) as well as the Ministry of Family, War Veterans and Intergenerational Solidarity (MoFVIS).

### *Provision of Care*

Under existing regulations, the Centre for Social Welfare is the responsible agency for selecting a social welfare home for the individual based on their care needs, financial situation, natural environment and occupancy capacity of social welfare homes. Social care institutions include: family centre, social care centre, social care home, and centre for aid and care. Social welfare homes are public institutions that provide care services for the disabled, mentally ill, substance (alcohol and drug) abusers and other individuals which are in the need of LTC and health protection and care. If there is no vacancy in a state, local or regional institutional care, the Centre for Social Welfare can place the individual in privately owned home in accordance with the Law on Social Care.

In Croatia, elderly care is provided mostly by the social sector and not the hospital system. Institutional and non-institutional care is available for the elderly. Non-institutional care and welfare is provided to the elderly via the Centres for Welfare Services, Centres for Aid and Care and a wide net of non-governmental organizations (NGOs). Programs and services offered by these centres are financed mostly by the state.

### *Pricing and Financing Care*

A social welfare home for adults and its branch offices are classified according to: the type, extent and quality of services it renders to individual beneficiaries; the number and expertise of employees; the number, size, purpose and quality of premises; and according to available technology and equipment. The criteria for classification of social welfare homes are determined by the Minister of Health and Social Welfare and are subject to approval from an expert committee appointed by the Minister.

Classification of the social welfare home helps determine the cost of services to be provided in the home. However, the national pricing system does not apply to private social care homes that do not receive public funding. Prices in such homes are established by the private owner. Also, individuals who enter social care homes without going through a social care centre can be responsible for setting up contracts with the facility. Such a contractual agreement is not the responsibility of a social care centre.

The MoHSW establishes contractual agreements with social welfare homes for the provision of LTC service. Contract generally outline price according to type of care and service, payment method, coverage, and duration for care services. The Ministry of Health and Social Welfare also determines pricing for particular assistance and in-home care services that are publically financed.

In Croatia, payment responsibility is outlined in a succession like pattern. An adult who seeks LTC services in state owned institutions is required to finance the cost of care from personal financial resources. If their income and financial resources do not suffice for the cost of LTC services, they are required to sell their property (if it is not used by family members) in order to pay for the LTC costs. In the event the beneficiary's resources do not suffice for LTC cost, the difference is covered by MoHSW.

### *Eligibility Criteria for Benefits*

Regulatory policy outlines specific eligibility criteria for individuals who wish to receive publically funded LTC benefits. In order to receive these benefits, the potential beneficiary must demonstrate a high degree of disability, and lack family support or lack of sufficient income.

**Table 2.5: Overview of the Key Benefits and Eligibility Criteria for Long-term Care in the Social Welfare System**

<b>Legal basis for entitlement</b>	<b>Base for benefit</b>	<b>Eligibility criteria</b>
SW Act, Article 43	400 kn (reduced amount 280 kn) - <b>Assistance and care in the home</b>	Based on physical or mental impairment or permanent changes of his or her health or old age, indispensably needs permanent assistance and care of another person
SW Act, Article 50	400 kn - <b>Personal disability allowance</b>	Based on physical or mental impairment or permanent changes to the health or because of old age, the person concerned is in a compelling need of assistance and care of another person
SW Act, Article 55	400 kn	Severe physical or mental impairment or a person with permanent changes to his or her health, provided that such impairment or illness occurred before he or she reached 18 years of age; the person concerned has not been provided with permanent or weekly accommodation outside of his or her own family

*Source:* Skrbic (2008)

### *Long-term Care Allowance Benefits*

Over a period of five years (2003-2007), there was an increase in the number of beneficiaries who received the following types of allowances: personal disability allowance (30 percent higher), supplement/allowance for nursing care (53 percent higher), and salary compensation for parents who provide care for their severely handicapped child (45 percent higher).

While these allowances targeted all age groups, it is evident that the major recipient group for supplement/allowance and nursing and care was the 65 and over age group; over the five-year period, the elderly made up more than half of these recipients (see Table 2.6). The allowance system generally does not support informal care givers who provide long-term support for the elderly - only a minor number of informal caregivers are compensated for their care through the nursing and care at home allowance category.

**Table 2.6: Type of Benefits for Long-Term Care in the Social Welfare System, by Number of Beneficiaries (2003-07)**

Types of benefits/year	Number of beneficiaries				
	2003	2004	2005	2006	2007
<b>1. Personal disability allowance</b>					
1.1. full amount (250% of the base)	10,989	12,278	13,214	13,692	14,326
1.2. reduced amount (125% of the base)	725	727	832	993	897
<b>Total beneficiary (1.1. + 1.2.)</b>	<b>11,714</b>	<b>13,005</b>	<b>14,046</b>	<b>14,685</b>	<b>15,223</b>
<b>2. Supplement for assistance and care/ Allowance for nursing and care</b>					
2.1. full amount (100% of the base)	32,757	40,181	45,657	47,736	49,458
2.2. reduced amount (70% of the base)	16,047	21,290	24,068	24,819	25,439
<b>Total beneficiary (2.1. + 2.2.)</b>	<b>48,804</b>	<b>61,471</b>	<b>69,725</b>	<b>72,555</b>	<b>74,897</b>
<b>Beneficiary age 65 +</b>	<b>26,575</b>	<b>35,382</b>	<b>40,669</b>	<b>42,464</b>	<b>43,741</b>
<b>3. Nursing and care at home</b>					
<b>Total beneficiary</b>	<b>680</b>	<b>726</b>	<b>634</b>	<b>603</b>	<b>569</b>
<b>5. Allowance for personal needs of beneficiaries living in permanent accommodation facilities</b>					
5.1. Beneficiaries in social welfare home	8,336	8,399	8,302	8,219	-
5.2. Beneficiaries in foster family	3,874	4,124	4,503	4,492	-
<b>Total beneficiary (4.1+4.2)</b>	<b>12,210</b>	<b>12,523</b>	<b>1,805</b>	<b>12,711</b>	<b>11,477</b>
<b>6. Allowance for substitute care/foster family*</b>					
6.1. Adults and elderly	3,066	3,457	3,628	3,724	3,439

Notes: \* The data refers to all adult and elderly beneficiaries of foster care, since the ratio of the elderly for all five years is not segregated. The estimation is that the elderly make up one-half of all adult beneficiaries of foster care, over the years.

Source: Annual statistical reports on legal entitlements, beneficiaries and SW homes. Ministry of Health and Social Welfare (2003-2007 pre-finals)

## 2.4 Long- term Social Care for Elderly and Infirm Persons

The elderly and infirm are the main recipients of long-term social care, paralleling the aging trend of the Croatian population. – while the elderly made up 15.63 percent of all population in 2001, their ratio is expected to rise to 26.8 percent in 2050, including 9.7 percent makeup of the elderly over the age of 80. However the percent of elderly Croatians receiving institutional social care is lower than the European average (2 percent and 5.1 percent<sup>7</sup>, respectively). At the same time, homes for the elderly and infirm persons are the fastest growing type of long-term institutional care facilities, attracting considerable interest from the private sector in the last five years.

<sup>7</sup> Žganec et al., 2008:180.

### *Institutional Services*

In 2007, there were 121 institutional homes for the elderly and infirm, accommodating 14,168 people in all 21 Croatian counties (see Table 2.7). Over two thirds of these institutions are privately owned, see Figure 2.3. While homes for the elderly and infirm persons are available in all counties, they are heavily concentrated around five regional centers – Zagreb, Rijeka, Osijek, Split, Pula and Varaždin. These regions combined, account for 52 percent of all facilities and 58 percent of all beneficiaries of institutional care services. The City of Zagreb (Grad Zagreb) leads other cities and counties; 30 out of the total 121 institutional homes are situated here, accommodating 31 percent of all institutional home beneficiaries (see Table 2.8). This uneven distribution is possibly indicative of the greater socio-economic capacities in these regions, and not necessarily a distribution based on need.

**Table 2.7: Distribution of Social Welfare Homes for Elderly and Infirm, by County (2007-08)**

No.	County	Type of Ownership			Total Homes	Total No. Beneficiary per County	% total beneficiary in county	% Total Elderly 65+ Population per County*
		County/City	Private	NGO/Religious assoc.				
	Bjelovarsko-bilogorska	1	2	0	3	327	2.31%	3.13%
	Brodsko-posavska	1	1	0	2	286	2.02%	3.83%
	Dubrovačko-neretvanska	5	0	0	5	413	2.92%	2.91%
	Istarska	4	2	0	6	691	4.88%	4.84%
	Karlovačka	1	1	1	3	307	2.17%	3.87%
	Koprivničko-križevačka	1	1	0	2	309	2.18%	2.82%
	Krapinsko-zagorska	0	2	1	3	232	1.64%	3.22%
	Ličko-senjska	2	1	0	3	287	2.03%	1.68%
	Međimurska	1	5	0	6	508	3.59%	2.28%
	Osječko-baranjska	3	3	0	6	850	6.00%	7.10%
	Požeško-slavonska	2	2	0	4	394	2.78%	1.91%
	Primorsko-goranska	4	5	0	9	1,255	8.86%	7.23%
	Sisačko-Moslavačka	2	3	0	5	512	3.61%	4.65%
	Splitsko-Dalmatinska	4	9	0	13	1,206	8.51%	9.91%
	Šibensko-kninska	2	0	1	3	436	3.08%	3.19%
	Varaždinska	1	3	1	5	675	4.76%	3.95%
	Virovitičko-podravska	0	4	0	4	135	0.95%	2.04%
	Vukovarsko-srijemska	2	0	1	3	377	2.66%	4.28%
	Zadarska	1	0	0	1	328	2.32%	3.83%
	Zagrebačka	0	4	1	5	224	1.58%	6.33%
	Grad Zagreb	10	20	0	30	4,416	31.17%	16.99%
<b>Croatia – TOTAL</b>		<b>47</b>	<b>68</b>	<b>6</b>	<b>121</b>	<b>14,168</b>	<b>100%</b>	<b>100%</b>

*Note:* \* Residence of the Referral Centre of the Ministry of Health, Croatia for Health and Social Care of the Old People - Gerontological Public Health Annual in Croatia, 2004 – 06 (Zagreb, 2007/08), Figure 2.8. "Ratio of the elderly above 65 years of age per county, in the total population of elderly population (N=744619, estimation of June 30, 2005), page 33.

*Sources:* MoHSW– Annual statistical report on social welfare homes and beneficiaries in 2007 (May 2008)

Center of Gerontology of the Institute for Public Health, City of Zagreb and Republic of Croatia (2008-data collected by June 10 2008)

**Table 2.8: Number of Beneficiaries in Homes for the Elderly and Infirm, by Type of Care, and Ownership (2007)**

Type of Homes	No. of Homes	Total Capacity	Current no. of Potential Beneficiaries *	Total no. of Beneficiaries	Residential type no. of Beneficiaries	Stationary /Intensive care	Day Care **	Other out-institutional	No. of Employees
County	47	10,418	17,361	10,337	5,387	4,950	312	2,710	3,204
Private NGO/religious	74	4,512	658	3,831	2,024	1,807	72	99	1,394
<b>Total</b>	<b>121</b>	<b>14,930</b>	<b>18,019</b>	<b>14,168</b>	<b>7,411</b>	<b>6,757</b>	<b>384</b>	<b>2,809</b>	<b>4,598</b>

Notes:

\* Current number of potential beneficiaries refers to the number of received requests for admission in 2007.

\*\*Day Care data difficult to establish accurately: these are from Center of Gerontology since MoHSW reports less data (226/County/City and 5/Private)

Sources: Center of Gerontology of the Institute for Public Health, City of Zagreb and Republic of Croatia (2008-data collected by June 10 2008);

Ministry of Health and Social Welfare – Annual statistical report on social welfare homes and beneficiaries in 2007 (May 2008);

Ministry of Health and Social Welfare – Annual statistical report on employees in centers for social welfare and social welfare homes in 2007 (May 2008).

The analysis of the most recent official data on the capacity and type of services provided by 121 homes for the elderly and infirm persons in 2007 shows the actual capacities for institutional services are close to maximum capacity (95 percent). County homes seem to be particularly stretched, as they operate at 99 percent of their capacity, with 1.7 times more potential beneficiaries than the actual ones. Interest in residential accommodation is particularly great, as expressed by 76 percent of all current requests for admission, 97 percent of which are directed towards county homes, due to lower prices and greater scope of state subsidies.

An insight into the structure of beneficiaries in homes for the elderly and infirm persons indicates that the long-term social care services are targeted towards the elderly with limited functional ability for activities of daily living, limited mobility, chronic illness, infirmity and disability. Over 90 percent of all beneficiaries are older than 65, with a significant number of very old people over the age of 80, making up almost half of beneficiaries in county homes and as many as 51 percent of beneficiaries in private homes (See Table 2.9). Over half of all beneficiaries in county homes and close to two thirds in private homes have limited mobility.

**Table 2.9: Number of Beneficiaries in Homes for the Elderly and Infirm, by Age and Functional Difficulties (2007)**

	County Homes	Private Homes	Total Homes
No of Homes	47	74	121
Total no. of Beneficiaries	10,337	3,831	14,168
<b>No. of Beneficiaries of age 65+</b>	9,598	3,535	13,133
<b>%</b>	<b>93%</b>	<b>92%</b>	<b>93%</b>
<b>No. of Beneficiaries of age 80+</b>	5,037	1,971	7,008
<b>%</b>	<b>49%</b>	<b>51%</b>	<b>49%</b>
<b>No. of Beneficiaries with Limited or no Mobility</b>	5,390	2,507	7,897
<b>%</b>	<b>52%</b>	<b>65%</b>	<b>56%</b>
<b>No. of Beneficiaries with Illness, Infirmity or Disability</b>	7,091	3,334	10,425
<b>%</b>	<b>69%</b>	<b>87%</b>	<b>74%</b>

Source: Ministry of Health and Social Welfare – Annual statistical report on social welfare homes and beneficiaries in 2007 (May 2008)

County and private homes provide a similar proportion of residential care (52 percent) and stationary care (48 percent), which is a combination of social and health care services. There is an average of three beneficiaries per one employee across all homes, although the figure is slightly higher in county homes (3.2) than in the private ones (2.7). This statistical average should be treated with caution, as it does not provide a more refined insight into the structure of the employees and the number of direct caregivers (medical nurses and nursing assistants in particular).

In addition to institutional care, some social welfare homes for the elderly and infirm provide day care services and other forms of assistance and care outside of the institution and in homes of the elderly. This form of assistance includes meal delivery services, maintenance of personal hygiene (help in dressing and undressing, bathing and other hygiene needs), household chores, purchasing and delivering supplies and other activities that help the beneficiary with everyday needs. While the exact number of homes engaged in such care is not available, it can be assumed that the scope of provision and the number of beneficiaries is large based estimated data from MoHSW, which shows 3,193 beneficiaries of non-institutional care in 2007 are served by county and private homes, accounting for an additional 22 percent of beneficiaries served outside of the institution by these facilities. Among beneficiaries who receive at home care services from institutions; over 90 percent are aged 60 and over. The general impression is that long-term social welfare institutions for the elderly are increasingly oriented towards provision of a range of social services, both institution-based and through outreach at the community level.

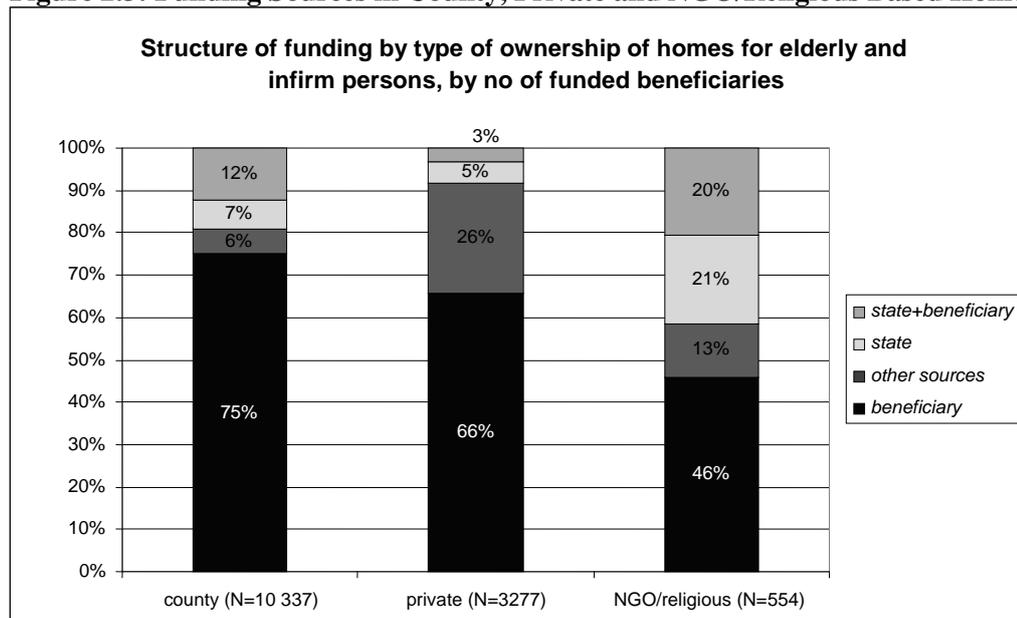
Regarding the funding sources for homes for elderly and infirm persons, as already mentioned, these institutions primarily rely on beneficiary self-financing, regardless of the type of ownership. State funding provides full coverage for seven percent and partial coverage for 10 percent of all beneficiaries.

A closer look at the structure of funding in homes for elderly reveals significant differences between institutions founded by counties, private initiative, and NGOs and religious organizations (see Table 2.8). While all three types of homes primarily rely on beneficiary funding<sup>8</sup>, the percent ranges from approximately three quarters in county institutions, two thirds in private homes and close to one half in NGO/religious homes. Private homes rely heavily on other sources of funding. Considering the higher absolute number of beneficiaries accommodated in county homes, these facilities receive the majority of state funding. Of the total full state coverage, 72 percent goes towards beneficiaries in county homes and of the total partial state coverage, 82 percent is directed to beneficiaries in county homes.

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<sup>8</sup> It is though important to note that the price of accommodation in county's home is severally times cheaper than in private homes and difference subsidized by State.

**Figure 2.3: Funding Sources in County, Private and NGO/Religious Based Homes**



Source: Ministry of Health and Social Welfare – Annual statistical report on social welfare homes and beneficiaries in 2007 (May 2008)

### *Non-institutional services*

The following is only a fragmented insight into the main types and providers of non-institutional services for the elderly, as there is a general lack of a comprehensive inventory and reporting on non-institutional social services in Croatia. It is also likely that official data on homes for the elderly does not include non-institutional LTC services funded by special government and international assistance programs.

An initial attempt to map non-institutional social care provision was undertaken by the United Nations Development Programme (UNDP) in 2007<sup>9</sup>. Based on UNDP's review of the main funding sources for non-institutional and alternative social services, a total of 30 million EUR was provided for non-institutional services. The findings indicate that non-institutional social services for the elderly make up 24 percent of all funding for alternative social services, and the elderly as a group, are leading beneficiaries, across the different categories of social services. This is largely due to their larger population compared to people with disability and other non-elderly recipients.

According to the UNDP research, homes for the elderly and other social welfare homes are also the primary providers of non-institutional care through community outreach programs for the elderly, as opposed to NGOs and other community-based organization. This is evidenced by the fact that these types of homes absorb over two thirds of all funding for non-institutional services for the elderly. In addition to NGOs, a large majority of pensioners associations also provide different kinds of home assistance to elderly who are low-income and live in single-households and to elderly who lack support from family members. It is however difficult to estimate the

<sup>9</sup> Source: UNDP Hrvatska. (2008). *Mapiranje alternativnih socijalnih usluga/ programa po županijama. [Mapping Alternative Social Services/Programs by Counties]*. Report prepared by Nataša Škrbić and Lidija Japec for UNDP Croatia. The analysis is based on the review of the following funding sources for non-institutional and alternative social services in Croatia, in 2007: central government budget allocations for special programs, 21 regional budgets, local budgets of 20 regional centers, three international assistance programs (WB loans for "Social Innovation Fund", and "Social and Economic Recovery Project" and CARDS 2004 Grant Scheme "Social Service delivery by the Non-profit Sector, all managed by the Croatian Government), and National Foundation for Civil society development.

magnitude of these service because they are usually financed from various sources on a short-term basis.

The main non-institutional social services for the elderly identified in the UNDP research includes home care (both nursing and housekeeping assistance), day-care provided in local homes or in NGO homes, transportation services and availability of 24 hours assistance to persons living at home; this is especially important for elderly single-headed households.

Since 2005, there have been several social service development grant schemes and special government programs, available to both public and privately owned social care institutions, NGOs and religious communities. The grants and new programs encourage and promote the development of non-institutional or community-based services. Examples of such programs include the “Social Innovation Fund”, “Social and Economic Recovery Project” (both financed by the World Bank loan), CARDS 2004, “Social Service Delivery by the Non-Profit Sector” and two pilot programs for the provision of daycare and home-care to the elderly initiated by the Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity (MoFVIS). The two multi-year government programs piloted by MoFVIS present the most important innovation in the system of long-term care for the elderly.

#### *Development of Non-institutional Care for the Elderly by MoFVIS (2005-08)*

In 2005, MoFVIS, Department for Intergenerational Solidarity, started two pilot programs targeting social care for the elderly. One program combined day-care and home-care provisions and the other focused exclusively on home-care provision. After the pilot phase ended, the Government of Croatia officially adopted the *Program of Development of Services for Elderly Persons within the System of Intergenerational Solidarity* 2008-11 in August of 2007<sup>10</sup>. This is the first and only comprehensive government program primarily focused on enabling continuous provision of non-institutional care to the elderly, with expected improvements in the availability and diversity of long-term care to the elderly, throughout the country.

The provision of non-institutional social care is organized by means of sub-contracting and on the principle of subsidiarity – the Ministry signs a contract on cooperation with the units of regional/local self-administration, which then select care providers (e.g. homes for elderly, NGO's or others). The Ministry defines the standards and scope of services to be sub-contracted, while the specifics are negotiated locally, depending on the specific needs and local prices of communities. Day-care and home-care services are provided by teams with five members on average and a team-leader (geronto-hostess, a nurse and others, depending on the needs of the beneficiaries at different locations).

Services are divided into four main categories; (1) meals delivery or preparation in beneficiary home; (2) maintenance of personal hygiene and basic health type services; (3) assistance with home chores; and (4) help with activities related to legal or administrative issues for health or social welfare institutions. The combined daycare and home care program includes socializing events to help reduce social isolation of the elderly.

The average annual cost for combined day care and home care is 3,200 kn per beneficiary, while the annual cost for only home care service is 2,600 kn per beneficiary. Organizations that offer this type of care are also eligible for additional funding from the Ministry for infrastructure

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<sup>10</sup> Source: Vlada RH, *Program razvoja usluga za starije osobe u sustavu međugeneracijske solidarnosti od 2008 do 2011 godine*, usvojen na sjednici Vlade 23. kolovoza 2007.

development and additional investments into daycare facilities (3,500 kn per beneficiary per year) and home care equipment (2,800 kn per beneficiary per year). The social services provided through the Program are currently free of charge for all beneficiaries, who primarily comprise of people over 65 years of age, living alone and/or without social or community support. The structure of care recipients from 2005 to 2008 shows that more than 70 percent of beneficiaries are in the 68-80 age group and 21 percent are above 80 years old.

In 2008, a total of 12,625 elderly were provided with community-based social care (see Table 2.9). A positive outcome of this program is the stimulation of employment opportunities for disadvantaged groups, especially middle-aged women with low or medium-level education and a lack of formal employment. Details on the geographic distribution of the programs, number of beneficiaries, allocation of funds, and number of employees over the three-year period are presented in Tables 2.9-2.10).

**Table 2.9: Number of Beneficiary in MoFVIS Pilot Project for Non-institutional Care for Elderly, by Type of Care (2008)**

Type of care	No. of providers	No. of beneficiaries	No. of employees	Total Funds	%
Day care and home care	27	5,075	367	17,208,725.00	49.96%
Home care	43	7,550	478	17,235,900.00	50.04%
<b>Total</b>	<b>70</b>	<b>12,625</b>	<b>845</b>	<b>34,444,625.00</b>	<b>100%</b>

*Note:* data refer to contracts signed by July 2008.

*Source:* Ministry of Family, War veterans and Inter-generational solidarity – Department for Inter-generational solidarity (2008)

**Table 2.10: MoFVIS Non-Institutional Programs for Elderly Trends 2006 - 2008**

Non-institutional care for the elderly	2006	2007	2008
No of beneficiaries		7,804	8,241
No of employees		505	538
No of counties targeted		20	20
<b>Total funds/state</b>	<b>20,699,675.00</b>	<b>23,639,764.00</b>	<b>34,444,625.00</b>
<b>Increase per year %</b>		<b>N.A.</b>	<b>14.20%</b>

*Source:* Ministry of Family, War veterans and Inter-generational solidarity – Department for Inter-generational solidarity (2008)

Currently, the Ministry supports the implementation of 70 programs in 20 counties. It seems that MoFVIS is playing a leading and significant role in the overall development and funding of the non-institutional care program for the elderly. There is no evidence of concerted coordination between MoFVIS and MoHSW, which would potentially be instrumental for the eventual development of an integrated and coherent system of social care for the elderly, where institutional and non-institutional services are complemented and well targeted. Integration of MoFVIS's program with other LTC programming is important as it continues to grow and receive more government funding. The government has announced an increase of up to 40 million kuna per year.

### Gerontological Centers

The Institute for Public Health (IPH), Center of Gerontology, the referential center for gerontology in MoHSW, is currently developing a national network of Gerontological centers at a county and local community level. The main idea behind this initiative is to establish specialized institutional network for non-institutional care for the elderly, in consultations with

the family physicians to monitor and coordinate all activities related to the needs of elderly. An assessment of coordinating mechanisms among agencies (primarily the Program for the elderly implemented by MoFVIS) and the needed coverage level among the elderly population for requires further research.

The services of gerontological centers are primarily intended for the so-called “young-old age individuals” who have some functional ability. Currently, 31 gerontological centers are operating and providing recreational-occupational activities, meals on wheels, day care, aid, and rehabilitation for the elderly in coordination with their primary health care needs.

### **Centers for Nursing and Care**

Another source of non-institutional care is centers for nursing and care, which provide long-term care, including day-care and home care services for the elderly and infirm. These centers are founded by county and local governments, private companies, NGOs and faith based organizations, in particular Caritas and Red Cross. The actual number of these type of centers cannot be determined because there is no comprehensive registry system.

### **Foster Family Care**

Foster care is a form of non-institutional social care provided at the community level, and by a family for the elderly and infirm Foster care is particularly targeted towards persons without family, home or income. According to official MoHSW data, in 2007, there were 3,439 adults placed in 1,241 foster families. Over half of the care recipients were the elderly and infirm. Compared to 2003, the number of foster care providers has increased by 23 percent in 2007, while the ratio of the elderly who receives foster care appears to be constant.

### **Informal Care Givers**

It is difficult to identify reliable data regarding informal caregivers for the elderly. Recent literature has examined the extent and quality of informal care in relation to potential care providers<sup>11</sup>. Changes in family structure, marked by a decreasing number of children per family, and separate living arrangements of adults from elderly parent(s), coupled with a large ageing population, makes continued reliance on relatives for LTC needs challenging. The current trend will likely continue to further weakening of traditional social systems of inter-generational support.

Despite these changes in the social structure, spouses play an important role in the provision of informal LTC. In Croatia, spouses, especially wives, are primary caregivers for the elderly. Many single and widowed men even remarry as a way of ensuring informal care in old age. Nevertheless, there is still a large number of the elderly population who live alone and who are at risk for having unmet LTC needs. Out of all single-headed households in Croatia, elderly people over the age 60 make up 64 percent (195,000) of which 78 percent are women. The spousal support that is available for men is probably available less for women. Informal care is also provided by friends and neighbors in Croatia. Research findings show that help and support elderly receive from friends is similar in cities and in villages, although neighborly help is somewhat greater in non-urban areas (for example in Istria and on the islands). The elderly who reside in rural and semi-urban areas however, have fewer opportunities for LTC because of the weak network, organization and availability of both informal and formal LTC services overall.

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<sup>11</sup> Podgorelec S., Klempec S., “Starenje i neformalna skrb o starim osobama u Hrvatskoj”. [ “Ageing and Non-Formal Care For Elderly Persons In Croatia” ]. *Migracije i etničke teme*, no. 23, 2007, pp. 111-134.

## 2.5 Long-term Health Care Services

### Institutional Services

The scope of institutional services for long-term health care needs to be viewed in the context of two decades of a **steady decline in overall hospital capacity**, as evidenced by a decrease from 7.4 beds per 1000 population in 1990, to 5.46 in 2006. Based on data for 1990-2000, general hospitals have suffered the greatest loss of bed capacity (37.6 percent), followed by special hospitals (21.1 percent), while clinics and clinical hospitals lost only 7.9 percent of beds.

According to 2006 data<sup>12</sup>, there are 71 hospital facilities in Croatia, among which 22 are general hospitals, 26 special hospitals, 2 clinical centers and various clinical hospitals and clinics. The distribution of beds in these facilities area highest for acute treatment (3.60 beds per 1000 people) followed by the number of beds for treatment of chronically ill (1.86 beds per 1000 people). The ratio of beds for acute treatment per bed for chronic treatment seems to be constant over the 2003-2007 period, while the general availability of beds for both types of accommodation has declined. Table 2.11 shows the number of beds in hospitals for chronically ill and geriatric patients. It is important to note that elderly are makeup a large portion of hospital patients in Croatia. In 2006, there were a total of 752,453 hospital patients in Croatia, of whom 33 percent were over 65 years of age. In the context of reduced hospital capacity, in 2008, the MoHSW Committee for Geriatrics proposed the need for three times more geriatric beds than the actual capacity in the year 2007 (1,905 compared to 633 beds). Based on feedback from MoHSW, the likelihood of the proposal to turn into a policy is uncertain, as it is still being considered<sup>13</sup>.

**Table 2.11: Contracted Beds in Hospitals for Chronic Patient Treatment and Prolonged Treatment (geriatrics) in the Period 2007 until 2009**

Health institutions' specialty	Total no. of beds in special hospitals	Total no. of beds in special + general hospitals
Prolonged treatment/geriatrics	520	<b>633*</b>
Chronic psychiatric disease	2,868	2,868
Chronic child disease	180	180
Chronic lung disease	301	301
Physical medicine and rehabilitation	1,970	1,970
<b>TOTAL</b>	<b>5,839</b>	<b>5,952</b>

Notes: \*Difference makes beds for geriatric patients in two general hospitals Sisak and Sibenik  
Source: MoHSW Odjel za bolničko liječenje/Department for hospital treatment

<sup>12</sup> Source for this section includes data from publication Croatian Health Service Yearbook 2006, *Croatian National Institute of Public Health*, Zagreb 2007. Same publication is used for gathering data on previous years.

<sup>13</sup> Consultation meeting with dr. Velibor Drakulić, the Head of Department of Hospital Treatment in MoHSW, July 2008.

## Non-Institutional Services

### *Health visitor service*

Health visitor service is an integral part of primary health care, is free of charge, and takes place in family and community settings. It is financed by the Croatian Institute for Health Insurance (CIHI), which sets standards and develops programs. The central provider of health visits are specially trained medical nurses who assess nursing needs of home-based patients, mediate in the selection process of nursing assistance providers, and can also coordinate among different professional and informal actors in healthcare provision at the community level. Health visitors place special emphasis on education and behavior modification that may prevent further health deterioration and to ensure maximum possible quality of life. Table 2.12 shows the number of personnel and the visits they made in 2006 across all Croatian counties.

**Table 2.12: Health Visitor Services in Croatia, by the Number of Nurses, Health Workers and the Number of Visits (2006)**

Croatia	<i>No. of Nurses</i>		<i>Health Workers</i>		<i>The number of health visits</i>	
	Full timer	Part timer	Junior college	High school	Chronic conditions	Total visits
<b>Total RH</b>	<b>768</b>	<b>159</b>	<b>767</b>	<b>115</b>	<b>765,487*</b>	<b>1,296,498</b>

*Note:* \* Contribution of visits to people with chronic conditions is 59,04%

*Sources:* Croatian Health Service Yearbook 2006, November 2007, page 15-187

### *Home-based Nursing Care*

Home-based nursing care is available through mandatory health insurance as well as through private payment. Croatian Institute for Health Insurance is responsible for organizing this primary healthcare service, by specifying eligibility criteria for services financed by the insurance system and subcontracting providers. Direct providers of nursing care are medical nurses who assess patient needs, propose the scope and type of nursing, and make payment arrangements. According to the current rulebook on nursing care of CIHI, each request for nursing care needs to be approved by primary healthcare doctor. The nursing care services are limited to seven times per week, lasting no more than 135 minutes per day.

For the period 2007-09, CIHI sub-contracted 242 nursing care institutions and private practices, which utilized 1,339 medical nurses to provide nursing care (see Table 2.13). This led to 2,153,905 home-based nursing care visits in 2006 of which 86 percent was provided to patients with chronic conditions.

Ongoing issues in the home-based nursing care industry revolve around the problem of insufficient regulation for the structure and standards of this type of care. Another problem is the low fees for services paid to these institutions by CIHI, causing financial difficulties. Usually, the monthly revenue received does not cover expenses and salaries of these home-based institutions.

**Table 2.13: Number of Home-based Nursing Care Providers in Croatia (2007-09)**

Type of provider	No. of providers	No. of medical nurses	Counties	Number of Visits
Nursing care institution	136	1,174	21	n.a.
Private practice	106	165	19	n.a.
<b>Total</b>	<b>242</b>	<b>1,339</b>		<b>2,153,905</b>

Notes:

\* Records for 19 counties (Splitsko-dalmatinska and Ličko-senjska county are not reported)

\*\* Contribution of health visits for people with Chronic conditions is 86.47%

Source: Croatian Health Insurance Institute, data available on official website [www.hzzo.hr](http://www.hzzo.hr), last accessed on July 25, 2008, and Croatian Health Service Yearbook 2006, November 2007, page 15-187

Recognizing the inadequate standards and regulations for this level of care, two years ago, the Croatian Chamber of Medical Nurses, developed a protocol for the provision of nursing care, which envisions a more precise and standardized process of assessing care needs, and the opportunity make recommendations for further hospital treatment if necessary. The proposed protocol also sets education standards for nurses. The adoption of the protocol is current being considered by MoHSW.

#### *Palliative Care Provided by NGOs*

It appears that palliative care services are in great demand and there is actually an unmet need for these types of services among the Croatian population. Although NGOs provide palliative services, they do not have the resources to cover everyone in need. The legal structure has provisions for palliative care agencies to receive funding if they meet certain requirements. However, it is difficult for most of the organizations to meet these requirements, and thus far, they have received little to no public funding. NGOs are beginning to submit applications for registration of specialized institution for palliative care.

Ideally, palliative care should be provided through fully equipped hospice, dispensary, daycare and home visit services. It appears to be challenging to establish an institutional network for palliative care. NGOs are therefore advocating for the adoption of a special law on palliative care, which seems to be in the preparation phase by MoHSW; in line with current health reforms and programs to integrate palliative care in the health system by the end of 2008. Palliative care is also, to a limited degree, available in the for-profit sector through private nursing care institutions. However the cost is often prohibitive for most people.

## **2.6 Cost of Long-Term Care**

Croatia is currently spending a significant share of its GDP on various social protection expenditures. Table 2.14 categorizes public expenditure as percent of GDP.

**Table 2.14: Social Protection Expenditures (as % GDP)**

	1999	2000	2001	2002	2003	2004
<b>Total expenditure</b>	26.2	26.7	26.5	25.0	23.7	23.4
<b>Health affairs and services</b>	7.2	7.5	7.2	6.7	6.4	6.6
<b>Social security affairs and services</b>	16.3	16.5	16.9	16.0	13.9	13.6
<b>Welfare affairs and services</b>	2.1	2.1	2.0	1.8	2.7	2.6
<b>Other expenditure on social security and welfare</b>	0.5	0.5	0.4	0.5	0.6	0.6

*Note:* Data include expenditure by consolidated central government and by non-consolidated local and regional self-government. Since 2002, data pertaining to local and regional self-government cover only the 53 largest units of local and regional self-government, which account for 70-80% of the total transactions of local and regional self-government.

*Source:* Ministry of Finance (Classification according to GFS Manual 1986, IMF).

Cost of care is calculated based on labor and wage cost and costs for tangible goods. Compensation for employees is fixed. Social welfare homes and the MoHSW have limited influence on the salary of employees, but can determine the number of staff employed. Labor wages and salaries as well as other staff costs are determined by collective agreements for the social care sector, while contributions for social insurance are determined by the law.

Cost estimates for care in social welfare homes for the elderly and infirm are based on The Book of rules for the type of the home for children and adults and the type of provided services, as well as space, equipment, expert and other workers in the homes of social care ("Pravilnik o vrsti doma za djecu i doma za odrasle i njihovoj djelatnosti, te uvjetima glede prostora, opreme i potrebnih stručnih i drugih djelatnika doma socijalne skrbi" (Official Gazette, 101/99, 120/02 and 74/04). The Book of Rules specifies minimal standards and services to be provided in homes for the elderly and infirm.

The cost of services is calculated based on the required number of staff per beneficiary. Labor costs for staff depend on their level of education. Monetary supplements are also included for all employees who working under strenuous conditions with elderly and infirm. These supplements are determined by collective agreements for the sector of social welfare. The costs of food, accommodation, heating, electricity, water supply etc, were calculated and added to the relevant category of care provided.

#### *Cost of Care for the Elderly*

In homes for the elderly and infirm persons costs depend on the type of accommodation that is provided to the beneficiaries. For example, in the surveyed facilities, stationary homes cost consistently more than residence homes (see Table 2.15). The *Book of Rules requires that 50 percent of capacity be reserved or used by hardly mobile and immobile persons as well as by people with specific needs – in maintaining personal hygiene and satisfying personal needs.* Cost for hardly mobile, immobile and other persons with specific needs who are accommodated in *stationaries* (Croatian terminology, mostly hospices) include all of the mentioned costs plus costs related to the additional provision of health care services. For mobile persons, the following costs are considered: material costs, wages and salaries for staff that provide psycho-social rehabilitation, organization and management, auxiliary workers (cleaners) and workers in book-keeping departments. The *Book of Rules* does not include workers like physiotherapists who are commonly employed in *stationaries*.

**Table 2.15: Cost of Care in State Homes for the Elderly and Infirm – (Per Beneficiary/Month\*)**

Type of Care	Type of Accommodation	Total Expenditure per Beneficiary (HRK)
Home till 50 Beneficiaries	Stationary	5,050.73
	Residence	3,190.57
Home from 50 till 100 Beneficiaries	Stationary	5,002.27
	Residence	3,162.64
Home from 100 till 150 Beneficiaries	Stationary	4,464.24
	Residence	2,624.61
Homes from 150 till 200 Beneficiaries	Stationary	4,323.51
	Residence	2,500.25

Note: 1. Material costs: - from 50 and from 50 to 100 beneficiaries as an example is used from selected counties the Home Zadar  
Source: Bejakovic (2009).

In the three observed counties, the cost of care was similar in social welfare homes for the elderly and infirm. The cost ratio of wage/salary to material was approximately 1:1 and similar across the counties; see Table 2.16. The average cost of care per beneficiary in Croatia is HRK 3,207 and the State covers approximately HRK 1,900 of this cost. This difference between actual cost of care and State coverage is approximately HRK 1,300.

**Table 2.16: Average Cost of Care in State Homes for the Elderly and Infirm – (Per Beneficiary/Month\* 2007)**

County	Number of beneficiary	Cost for wages and salaries per a beneficiary (HRK)	Cost for material goods per a beneficiary (HRK)	Total cost per a beneficiary (HRK)
Zadar County	320	1,552	1,458	3,010
Vukovar – Srijem County	219	1,903	1,735	3,638
Split – Dalmatia County	909	2,109	1,558	3,667
<b>Total Croatia</b>	<b>10,859</b>	<b>1,683</b>	<b>1,524</b>	<b>3,207</b>

Note: \* Average expenditures do not take account of outlays for non-financial assets and emergency intervention.

Source: The Ministry of Health and Welfare, 2008: *Unit Cost per Beneficiary in Social Welfare Homes*, internal documentation, page 23, Zagreb: The Ministry of Health and Welfare.

The cost of care in private homes can vary tremendously depending on State subsidy (see Table 2.17). Beneficiaries who do not receive State subsidy can pay as much as HRK 5,000.

The MoHSW and the Ministry of Finance need to initiate a system of unit costing for long-term social care services in private homes as well as in NGO homes. Few organizations are currently able to provide a unit cost for services. Cost for care was given as a total and not an itemized breakdown. A consistent unit of measurement was lacking. Overall, there is a lot of inconsistency and variation in the way costs is calculated, making it difficult to identify the basis and breakdown of totals.

**Table 2.17: Cost of Care in Private Homes for the Elderly/Infirm (2007)**

	Total cost per beneficiary (HRK)
Croatian avg. with State subsidy	3,200
Croatian avg. without State subsidy	5,000

Source: Bejakovic (2009)

A guideline for cost needs to be developed using a systematic approach. Although costs cannot be uniform across counties and facilities, cost needs to be calculated using a reliable and uniform methodology. The Ministry should consider conducting pilot tests on unit costing which would help in developing sample unit costs and comparisons for a range of services.

Determining unit costs for long-term social care services is essential for determining current expenditure and for future projections. Successful future policy making for a growing elderly population will depend on an accurate and reliable costing system. Recent external demands for more public accountability have also fueled the need for reliable cost system. An increased number of beneficiaries, increasing unit costs per beneficiary, and limited budget revenues contribute to need for a consistent and reliable system.

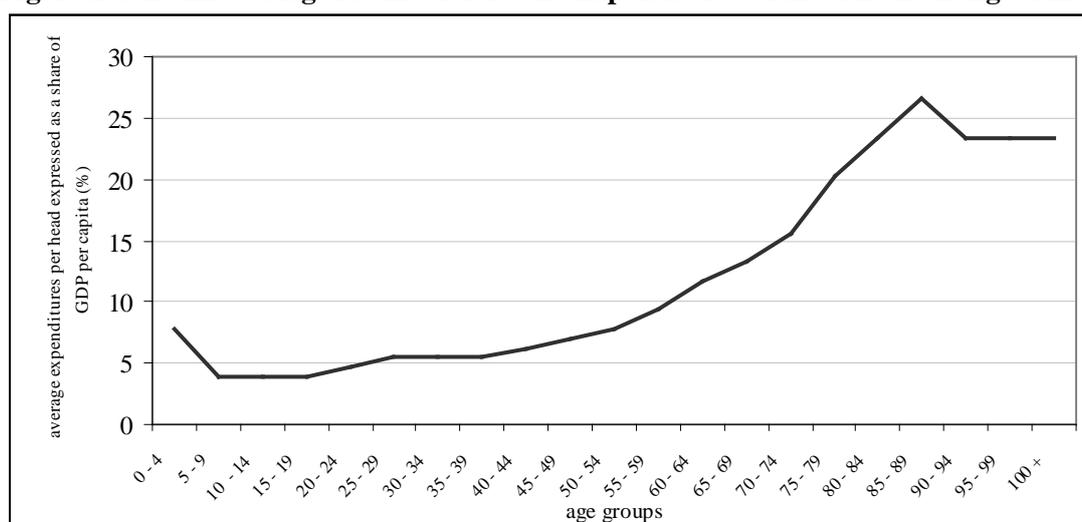
## **2.7 Demographic Change on Public Expenditures**

The expenditures on health and long-term care are considered to be highly related to age and therefore are projected within the assessments of long-term fiscal implications of ageing. According to the standard methodology, public expenditures on health and long-term care should be separated. In the case of Croatia, however, it is not possible to disentangle long-term care expenditures from healthcare expenditures. Therefore, long-term care expenditures include social care and health care expenditures. For the sake of simplicity, we will assume the age profiles for public expenditures on long-term care correspond to public expenditures on healthcare.

Based on the lack of data on the age profile for public expenditures on healthcare in Croatia, this exercise will be based on the assumption that average expenditures per capita on healthcare for different age groups (expressed as a share of GDP per capita) correspond to the typical age distribution of healthcare expenditures in EU member countries. Justification for such an assumption can be found in the fact that average expenditures per capita on healthcare for different age groups are quite similar across EU countries, so it is likely that the age distribution for healthcare expenditures in Croatia do not significantly differ from the European pattern. Since projections were based on estimation of the age profiles for public expenditures on health and long-term care, and not from the exact data, in order to avoid the stacking of miscalculations, we assume that there are no significant differences between the age profiles of males and females.

In a paper by Svaljek (2007), the distribution of average expenditures per head on healthcare in Croatia is estimated on the basis of the average distribution in EU countries, but applying this distribution to total expenditures on health and long-term care in Croatia. The figure for the total expenditures on healthcare refers to 2001, since this is the most recent year for which official data on healthcare expenditures are available. In 2001, the total expenditures on health and long-term care in Croatia were as high as 8.2 percent of GDP, which is rather high compared to the European weighted average of 6.6 percent of GDP in 2000. The estimated age profiles for public expenditures on health and long-term care in Croatia are presented on Figure 2.4. The projection of public expenditures on health and long-term care in Croatia is carried out using the assumption that expenditures per capita on health and long-term care grow at exactly the same rate as GDP per capita. The relative magnitudes of expenditures per capita across age groups are considered to be the same in all projection years, and to be the same as in the base year profiles.

**Figure 2.4: Estimated Age Profiles for Public Expenditures on Health and Long-term Care**



Source: Bejakovic (2009)

**Table 2.18: Projected Public Expenditures on Health and Long-Term Care for all Demographic Projection Variants (as % of GDP)**

	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050	Change
Medium variant	8.2	8.4	8.7	8.7	8.8	8.9	9.2	9.3	9.4	9.5	1.3
High variant	8.2	8.4	8.5	8.6	8.7	8.9	9.0	9.1	9.1	9.0	0.8
Low variant	8.2	8.4	8.6	8.8	8.9	9.2	9.4	9.7	9.8	10.0	1.8
Constant-fertility variant	8.2	8.4	8.6	8.7	8.9	9.1	9.3	9.5	9.7	9.8	1.6

Source: Bejakovic (2009)

According to the results obtained, based on assuming demographic changes alone, expenditure is projected at approximately 1.3 percentage points of GDP in the medium variant, with a range between 0.8 and 1.8 percentage points in other demographic projection variants. This projected outcome is somewhat more optimistic compared to projections for other EU countries, where ageing is projected to raise health and long-term care expenditures from 1.7 to 3.2 percentage points of GDP or 2.2 percentage points on average, between 2000 and 2050, using a similar projection approach (European Policy Committee, 2003).

### Limitations

The approach used in this exercise is relatively simple, but has at least one drawback. It ignores the concentration of health expenditures at the end of life irrespective of age at death, and tends to overestimate the impact of demographic changes on overall expenditure level. Therefore, the Economic Policy Committee working group on ageing populations suggests producing the optional scenario that takes account of the concentration of health expenditures towards the end of life. Such a scenario implies running projections which include estimates of so-called death-related costs. Although the results of such projections would be informative, the limited availability of expenditure data makes it difficult to make the estimates.

It should be stressed that projections for health and long-term care costs should be taken with caution because they are based on assumptions. Projections and analysis would be enhanced and more accurate with reliable and consistent data. It is important that involved ministries and institutions in Croatia (e.g. the Croatian Institute for Health Insurance, The Ministry of Health

and Social Welfare) collect better data. Particularly important is data on health and long-term care expenditure by age group.

## **2.8 Future Policy Directions**

### *Improve Coordination of LTC System*

The need for coordination and a cohesive LTC policy is critical in the current context of a limited and already burdened long term care services centers, the rising needs of a rapidly ageing population, and already stretched public budgets for social welfare and health spending. In Croatia, there is no comprehensive policy approach for integrating the health and social care components of long-term care. An integrated network of institutional and non-institutional services, provided by a range of formal and informal actors, by both state and private organizations is necessary. A needs and capacity assessment will be needed for developing an integrated network. A network can effectively organize and allocate long term care services in a consistent and fair way. This type of network requires close coordination among ministries who are already involved in providing long term care. A likely outcomes of an integrated network is complementary policies that do not are not duplicated across sectors. This level of coordination is essential for an overall cost-effective national strategy.

Long-term care provision seems to be organized into numerous, specialized services with weak links between benefits. The system of benefits and allowances for long-term care is fragmented into a various benefits, all of which are of very small amount. These benefits are targeted to two specific beneficiaries; foster families housing the elderly and to persons with disability and parents of children with disability. Formal and informal caregivers are not supported by the allowance system. In the area of social care for the elderly, there are duplicated services by different key institutions, which do not necessarily ensure greater coverage or quality of services.

Institutional capacities for long-term healthcare are decreasing, in line with the general trend of reduction of hospital facilities and beds since 1990, which is one of the central components of a lengthy healthcare reform. According to the Committee on Geriatrics of MoHSW, actual needs for geriatric treatment are three times higher than what the system can provide, while most long-term care, across categories of chronic conditions (geriatric, psychiatric and various chronic diseases) is almost fully utilized. The need for closer coordination of social welfare and healthcare institutions is evident, in order to relieve the pressure from hospital facilities, in cases where stationary accommodation (combining intensive provision social and health services), may can act as adequate substitute for hospitalization, the costs of which are much higher. This issue needs to be explored in greater detail, both regarding the current level of coordination and costs.

The role division between institutional care (through social welfare homes) and non-institutional care through NGOs can be a potential way to guarantee continuity of care provision among long-term beneficiaries as institutions rely on more predictable funding for operating costs while NGOs are usually funded on short-term project basis. Bridging the gap between informal and professional caregivers and responding to specific needs of beneficiaries is probably far better addressed by less formal organizational structures, such as NGOs who are led by members of local communities and social networks of target beneficiaries.

A weakness of the social care system as a whole and in individual institutions as well is the lack of managerial skills among managers. Almost the entire system is managed by leaders who often lack adequate training in strategic management, financial planning and other skills necessary for

institutional management in a competitive market environment. This deficiency needs to be addressed over the medium term.

### *Improving Market Incentives*

The overriding goal of recent public sector reforms in developed market economies is to ensure more effective use of public funds. One approach to this goal is to introduce more competition into social care markets. In Croatia, the role of the private sector as a provider remains limited. One reason for this is the weak administrative capacity in the MoHSW.

This can be improved by strengthening internal institutional management and by addressing public policy needs. Within institutions, the primary goal of cost measurement should be to address program cost and cost drivers and to inform future decisions about internal reallocation of resources. Projects that encourage the use of cost measurement and benchmarking with comparable institutions will be particularly helpful for these purposes.

Adequate incentives for community-based social care provision can be ensured through social policy reform, and by development of a specific framework for the classification, standardization and sub-contracting of non-institutional social services provided by various non-state actors including NGOs. Despite several international support programs, this reform has not been adequately and consistently carried out over the past five years.

### *Monitoring*

The functions of monitoring and auditing financial operations of social care institutions are apparently absent. Countries worldwide are working harder to get better value for the money by monitoring progress based on resource input in publically funded institutions. In Croatia, there is a lack of comprehensive monitoring and reporting on the scope and types of non-institutional long-term care services, especially in respect to non-state providers and informal caregivers.

Inconsistent and partial integration of NGOs and other private providers into the social welfare and healthcare system results in a lack of official data on the total coverage and outreach, a lack of quality assurance and risks the sustainability of publically funded long-term care services. Annual reports from MoHSW shows that tracking of daycare and home care services in privately owned long-term care institutions is poor. NGOs collect and provide data on provided services however they do so through project reports they submit to different grant-making agencies. Even still, data for projects that are directly funded from state budgets are often limited and not complete.

Further improvements should focus on strengthening the roles and functions of the line Ministry. With the increase in the number of service providers, the Ministry should direct and strengthen its functions for monitoring service quality, training personnel, and controlling expenditure as well as addressing the needs of the elderly.

### *Improve Quality*

Ensuring adequate scope and quality of long-term care for the elderly should be a clear priority for further policy planning as they represent the fastest growing group of beneficiaries. Institutional capacities for long-term care for the elderly lag behind the European average of five percent coverage of the entire elderly population, while coverage in Croatia is two percent. The

institutional capacities of key social and health care providers for the elderly are stretched to the maximum, with particular strain on services of residential accommodation and geriatric hospitals.

The identified differences in the beneficiary structure and turn-over (departure) rate between county and private homes for the elderly require further inquiry, in order to assess the specific factors that affect stay. Efforts have been made to deinstitutionalize long-term care. This is evident by the range of non-institutional services that social welfare homes provide for the elderly. However, strengthening the role and functions of NGOs and other community-based providers can improve the availability and access to non-institutional care. This can be done by providing public funding for non-state providers of non-institutional care.

### *Strengthen Informal Sector and Non-institutional sector*

Long-term care services for the disabled and the elderly are beginning to be deinstitutionalized. Social welfare homes which typically provide institutional care are now providing various non-institutional care services. This trend is a likely result of recent government agenda to deinstitutionalize care over time. If this trend continues, there are good prospects for development support services for informal caregivers. Currently, it appears that informal caregivers are not recognized in the expenditure system for long-term care. It is commendable that NGOs are integrated in the system of social and healthcare provision for people with disability, to a much greater degree than NGOs providing long-term care services for the elderly and mentally ill. Successful projects, such as the MoFVIS personal assistance project should be implemented on a wide scale.

This analysis suggests there is a smaller range of services available for persons with mental illness. Non-institutional care services are underdeveloped both as part of additional services provided by social welfare homes and through private and community initiatives. A larger proportion of beneficiaries in homes for the mentally self-finance their care. There appears to be no support services for informal caregivers, while, overall, both social and health care institutional capacities are insufficient.

Non-institutional health services seem to be more structured than non-institutional social services due to the long tradition of public health in Croatia which includes outreach work. Even still, there is a lack of standards and adequate financial support for private initiative (e.g. centers for nursing and care) for long-term healthcare services. The slow development of palliative care is an indication of this.

The overview of long-term care in Croatia suggests that infrastructure for long term care is in place however a comprehensive framework for long-term care needs to be developed. Within the framework, the following needs to be addressed: coordination of services between separate ministries and agencies, market incentives to support growth of the private sector that seek to provide long-term social care at the community level, improve accountability of public funding by developing a reliable cost system, and institutionalizing a monitoring strategy for long-term care social services. A comprehensive framework will need to address the current and changing needs of the elderly and other recipients of LTC.

### *Further Recommendations*

- There is a need to determine beneficiaries that are entitled to some rights for services in the system as well as clear criteria for these rights;
- Furthermore there is a need to initiate and coordinate the activities related to residence for the old and infirm persons that includes the development of various models of residence for older and infirm persons like apartments, villages, special houses with adequate assistance and condominiums (special communities for older and infirm persons);
- There is a need to stimulate the activities of the units of local government and self-government to organise and provide services of social care for older and infirm persons;
- There is a need to provide pre-conditions for activities of geronto housewife that are specialised in the care for older and in firm persons;
- It is important to enable and educate older people in self-help and self-reliance to help them in overcoming existing problems in everyday life;
- There is a need to improve cooperation and coordination between governments on various levels like central, local and regional states and in the system of health care and protection, education and non-governmental organisation, religion and other organisations in and out of institution;
- It is important to improve active participation of older and infirm persons in the life of the broader community and prevent their social exclusion; and
- Finally, it is crucial to informing and educating the local community and broader public in the importance of helping and caring for the old and infirm persons.

### 3. LATVIA

#### INTRODUCTION

Latvia is a medium-sized country located in Eastern Europe. It is situated between Estonia and Lithuania and bordered by Belarus and Russia. Lithuania covers 64,589 square kilometers of territory. The country is divided into 26 districts and seven large cities<sup>14</sup>. The population of Latvia is 2,217,969. The life expectancy for the population is 72.42 years with a higher life expectancy for females compared to males<sup>15</sup>.

Latvia is a former Soviet republic, re-gaining independence in 1991. Latvia became a member of the World Trade Organization in 1999 and joined the EU and the North Atlantic Treaty Organization (NATO) in 2004<sup>16</sup>. Following membership into the EU, Latvia went from the poorest of the new EU countries to among the fastest growing EU countries in 2006 with annual GDP growth rates of over 10 percent. In 2008 however, Latvia faced economic recession and its annual GDP growth dropped from 10 percent to -4.6 percent<sup>17</sup>. This decline was 5 percent lower than the average percent GDP growth for the Euro area. In 2009, their GDP growth dropped even lower to nearly -18 percent, making it one of the most severely affected countries by the economic recession. A financial stabilization package was introduced as a response to the recession. The package aims to reduce the deficit and to preserve the country's currency. Other economic indicators for Latvia include a GDP of \$34 billion (2008), a GNI of \$27 billion (Atlas method, 2008)<sup>18</sup>, an inflation rate of 3.3 percent in 2009, a 17.1 percent unemployment rate and a per capita income of \$17,105 (2008, PPP)<sup>19</sup>. Currently, the nation's labor force is estimated at 1,205,000 people or more than 54 percent of the population<sup>20</sup>.

Latvia, like other European countries, faces a significant aging of its population over the coming decades. Although Latvia is in a relatively early stage of its demographic transition compared to other Western European countries, the elderly population above the age of 65 is still projected to increase considerably over the next 50 years. This increase in the elderly population will have serious consequences for the demand of certain publicly financed services, like for example health care services. Although there is some uncertainty about the exact impact of aging on health care expenditures, there is consensus among researchers that the demand for long-term care (LTC) services is bound to increase strongly. The number of dependent people who are in need of LTC services will undoubtedly increase in the future, while at the same time, the number of potential care givers in the population will decrease. This raises the question, who will take care of the elderly in the future? At the same time, the working age population will also decrease significantly, raising the next question, who will pay for future LTC needs?

This section will explore some of these issues by looking at the demographic transition in Latvia and draw some conclusions on the long-term impact of aging on the dependent population. The section also explores current public expenditures on LTC in Latvia, and discusses important potential efficiency gains in the health sector by shifting services to the LTC sector. The main finding is that Latvia has to prepare for the demographic changes ahead by adjusting its health and social policy towards more community-based LTC services and by strengthening the

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<sup>14</sup> Statoids: Municipalities of Latvia (2010)

<sup>15</sup> CIA World Factbook (2010)

<sup>16</sup> World Bank Country Brief (2010)

<sup>17</sup> World Bank Country Brief (2010)

<sup>18</sup> World Bank Country Brief (2010)

<sup>19</sup> U.S. Department of State (2010)

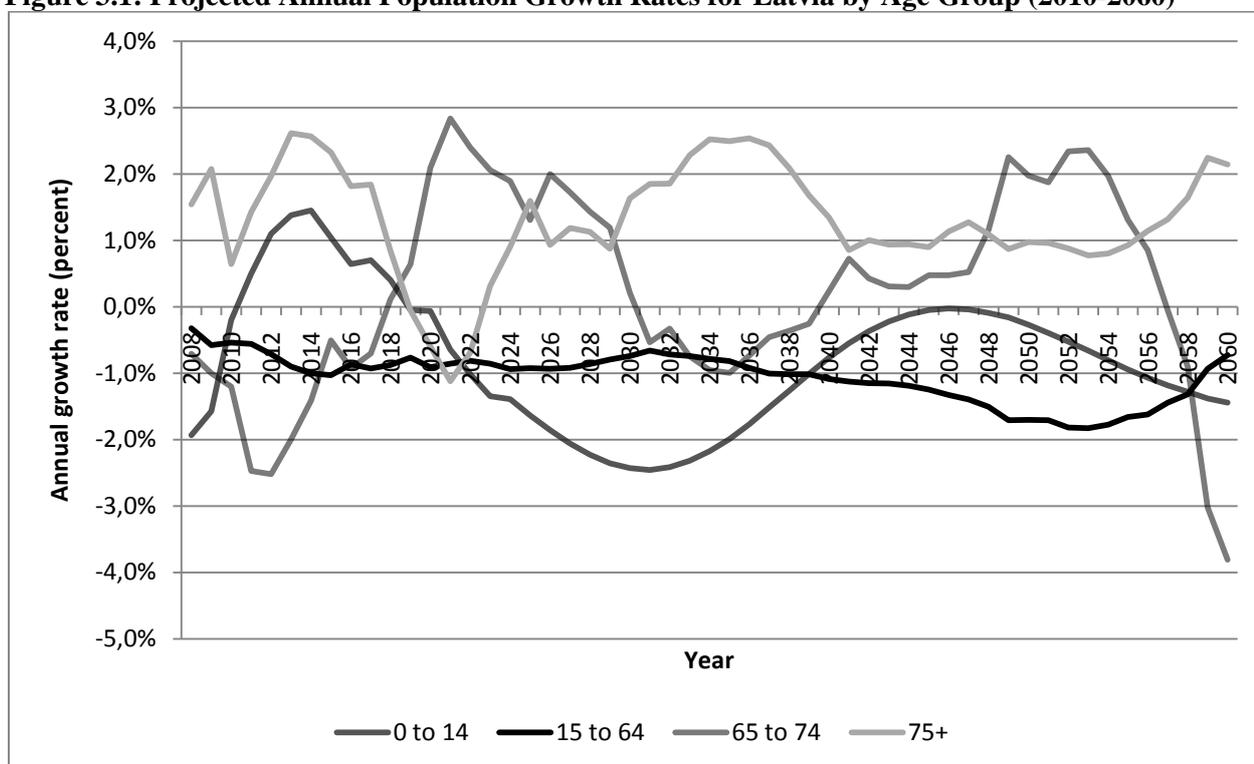
<sup>20</sup> CIA World Factbook (2010)

linkages and the coordination between the health and the social sector. Latvia currently spends relatively little on LTC, so in the medium term, increased investments in community-based LTC services could lead to important efficiency gains in the health sector.

### 3.1 Aging and Its Long-Term Impact on the Dependent Population

Since 1990, the share of the elderly population aged 65 and over has been rapidly increasing. The share of the elderly has increased from 11.8 percent in 1990 to almost 17 percent in 2006. This trend resembles the aging trend in EU-27 countries. Moreover, the share of the elderly is projected to increase to over 22 percent in 2030 when nearly one in every four Latvians will be 65 and over. Projections over the next 50 years, point to continued aging of the Latvian population. Latvia is at a relatively early stage of its demographic transition when compared with Western European countries. Its largest cohort—in a Western European context called Generation X—is currently 26 years old.<sup>21</sup> The children of this bulge generation, which will be born over the next 10 years, will help to keep the growth of the youngest age group positive for some time, but will be negative after 2020 (see Figure 3.1). The all important working age group—aged 15 to 64—is projected to continuously decrease over the next 50 years. The older age groups, in contrast, are projected to grow strongly. As the parent generation of Generation X—the so-called baby boomers—start to retire over the next 20 years, the annual growth of the 65 to 74 age group will increase by up to 3 percent in 2022. This is followed by a significant and continuous expansion of the very old—the population aged 75 and older. This age group will also expand strongly between now and 2018.

**Figure 3.1: Projected Annual Population Growth Rates for Latvia by Age Group (2010-2060)**



Source: Eurostat (2010) and author's calculations

Of particular concern are the growth rates of the old and the very old because they are the main demanders of LTC services. People who are in need of LTC services have restrictions in

<sup>21</sup> In France, in comparison, the largest cohort is currently around 35, in Italy around 40, and in Germany and the United Kingdom around 45.

performing activities of daily living (ADLs). In other words, they are hampered in their mobility, which affects their ability to perform routine activities like cooking, cleaning, personal hygiene, shopping, eating, and so on. They are therefore dependent on others to support them in these activities. The reason for their dependency could be a mental or physical disability—in particular dementia—but in the case of elderly people it is not necessarily disability, but frailty in general. In any case, the share of the dependent population increases strongly with age. In Latvia, only 1.4 percent of the population aged 15 to 24 is considered severely dependent (or severely hampered), while 27.2 percent for the population aged 75 to 84, and 41 percent for the population aged 85 and older (see Table 3.1) are severely dependent. These shares are more or less in tune with other EU countries. The share of the population with dementia also increases strongly with age (see Table 3.2). Another contributing factor to the growing dependency rates is the increasing life expectancy rate for the elderly in Latvia. From 1990, life expectancy for the population aged 65 and over increased from 15.9 years in 1990 to 17.3 years in 2006 (see Table 3.3).

**Table 3.1: Share of Severely Hampered People by Age Group in 2008 (percent)**

	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
<b>Latvia</b>	1.4	1.9	4.0	5.9	11.2	15.9	27.2	41.0
<b>EU-average</b>	1.5	2.3	3.8	6.9	10.9	14.6	25.0	39.5

Source: Eurostat (2010)

**Table 3.2: Share of people with Dementia by Age Group in Latvia (percent, 2005)**

	60-64	65-69	70-74	75-79	80+
<b>Women</b>	0.5%	1.1%	3.9%	6.7%	17.7%
<b>Men</b>	1.6%	2.2%	4.7%	4.9%	15.7%

Source: Alzheimer Europe (2006)

**Table 3.3: Life expectancy at the age of 65**

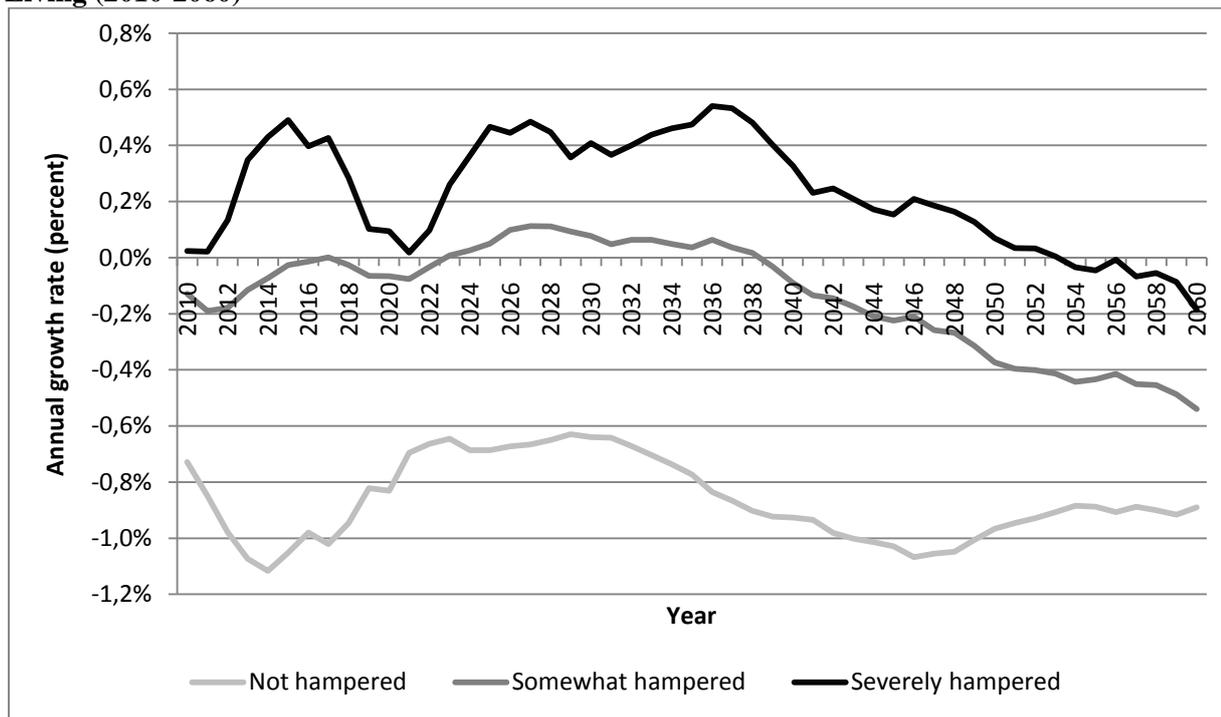
	1990	1995	2000	2006
Latvia				
Women	15.9	15.9	17.0	17.3
Men	12.2	11.4	12.5	12.7
EU-27 average				
Women	17.4	17.9	18.5	19.5
Men	13.9	14.2	14.9	15.9
EU-10 average				
Women	15.9	16.2	17.0	17.8
Men	12.5	12.6	13.3	13.8

Source: Eurostat

The increase in the older age groups will result in a strong growth of the severely hampered population. Combining the age-specific shares of the hampered population with population projections allows for an estimation of how the dependent population will develop over the next 50 years.<sup>22</sup> For Latvia, the severely hampered population is projected to constantly grow over the next 40 years, at a rate of up to 0.5 percent annually (see Figure 3.2). At the same time, the healthy, non-hampered population will strongly decrease over the next 50 years, sometimes as much as 1.1 percent annually. This means that the aging of the Latvian population will also mean a shift to a much more dependent population.

<sup>22</sup> The age-specific shares of the hampered population used in the projections are an average of the shares between 2004 and 2008. The projections do not take into account any eventual improvement in the health status of elder populations over time. The limited data available from between 2004 and 2008, though, seems to suggest an *increase* in the share of the severely hampered population, and therefore deterioration and not an improvement in the health status of elder populations. This is not only true in Latvia, but also in other European countries.

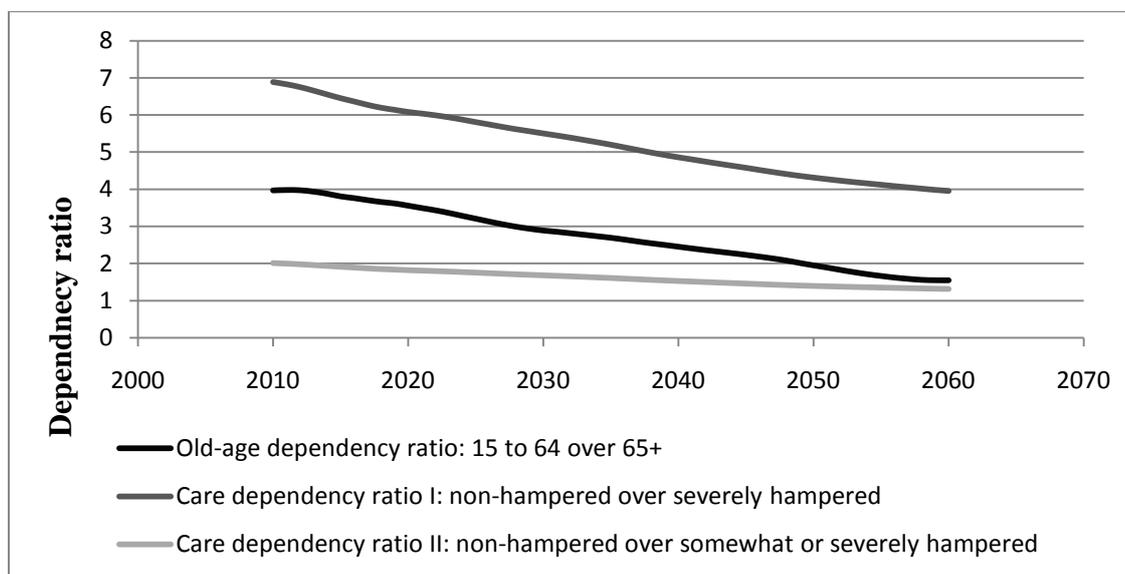
**Figure 3.2: Projected Annual Population Growth Rates by Level of Restriction in Activities of Daily Living (2010-2060)**



Source: Eurostat (2010) and author's calculations

These profound changes in the Latvian population are also reflected in the projected development of the inverse old-age and care dependency ratios. While today, there are about 7 non-hampered Latvians for one severely hampered Latvian, by 2060, there will only be 4 non-hampered per severely hampered person. In other words, while today there are 7 potential care givers for one dependent person, in 2060 there will be only 4 potential care givers. The ratio of the working age population to the elderly population is also expected to decrease over time. Currently, there are 4 working age persons per retired person, while by 2060, it will be less than 2. In other words, today there are 4 persons who can potentially pay for one retired person but by 2060, there will be less than 2 person to support the elderly.

**Figure 3.3: Projected Inverse Dependency Ratios for Latvia (2010-2060)**



Source: Eurostat (2010) and author's calculations

The questions then are: Who will care of the elderly population of Latvia in the future? Who will pay for this care? The next section will start investigating this question by looking at current public expenditures on LTC in Latvia.

### 3.2 Description of Long-term Care: Provision and Financing

#### Provisioning

Long-term care is provided through the social long-term care system (SLTC) and through the health care system. Beneficiaries of LTC services include the elderly, disabled, mentally ill, children with learning difficulties, and people suffering from addictions. Long-term care through the SLTC system is regulated by the Law on Social Services and Social Assistance. Care through this system is provided in nursing home institutions, outside of institutions and in beneficiary's home, and as social rehabilitation care. Informal providers are supported through in-kind benefits and less frequently with cash benefits. Long-term care is also provided through healthcare system in hospitals.

#### *Long-term Care in the Social Long-term Care System*

As of 2007, the SLTC system was made up of 82 institutions providing care to 5,723 elderly beneficiaries (see Table 3.4). In the same year, LTC home-care services were provided to 7,553 elderly beneficiaries. In 1995, legislation was approved to deinstitutionalize LTC through the development of alternative types of LTC services. Since this legislation, Latvia is now providing a large share of the elderly with LTC services in the homes of the elderly (see Figure 3.4). Since 1995, the number of elderly receiving home-care services through the SLTC system grew nearly nine-fold while the number of elderly receiving institutional care has increased at a much slower rate. The average number of beneficiaries in SLTC institutions has also decreased from 1995 to 2007 from 98 to 70, respectively. The deinstitutionalization of LTC was re-emphasized in the Law on Social Services and Social Assistance of 2006. This legislation was intended to allow the creation of additional care alternatives to institutional care. These alternatives are a part of social rehabilitation care.

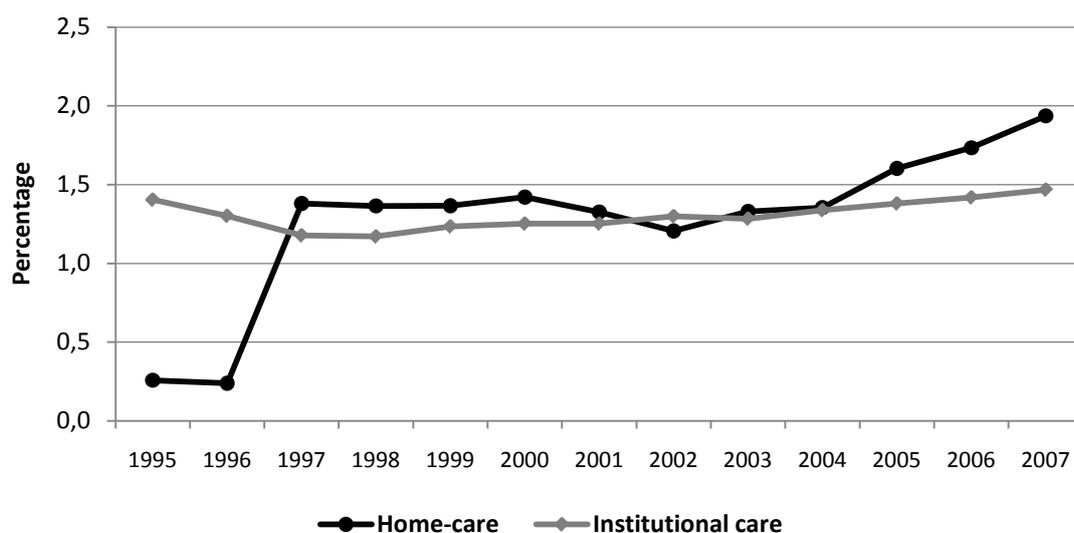
**Table 3.4: Trends in Beneficiaries of SLTC (Old-Age)**

	1995	2000	2005	2007
Home-care				
Beneficiaries	869	5019	6113	7553
Institutions				
Beneficiaries	4722	4424	5261	5723
No. of institutions	48	61	75	82

*Notes:* Beneficiaries and institutions refer only to old-age persons and are therefore not directly comparable with the 114 institutions for disabled and old-age (2007) mentioned in the text.

*Source:* Statistics Latvia

**Figure 3.4: Share of Elderly Population (65+) Receiving Institutional and Non-Institutional Care**



Source: Statistics Latvia and Eurostat

Social rehabilitative facilities serve as a place of transition. Halfway homes or group homes for persons with mental disorders are an example of this. Halfway homes are designed as a transition place for persons with severe mental disorders who have been living in special social care centers but whose functional condition has since improved. These homes allow people to move out of institutional care settings and adapt to independent life within a social rehabilitation program. The number of such homes and beneficiaries accessing these homes is not available. If a person adapts well to independent living in a halfway home, they can then move into group housing. Another alternative to institutional care are service apartments adapted to the needs of severely dependent people. The growth of both group houses and service apartments has been relatively slow; in 2007, there were 15 group houses and 57 people using service apartments<sup>23</sup>.

Currently, it appears that cash allowances are based on disability. As of 2006, 10,803 beneficiaries received disability allowances; however the share of the elderly receiving these benefits is not available.

Private organizations also provide LTC services. Non-governmental organizations<sup>24</sup> and other private providers can register to become providers of social services. However, there are only a small number of private institutions. In fact, of the 114 institutions providing long-term care and rehabilitation to adults (both disabled and old-age) in 2007, 78 were municipal providers, 27 were state-owned and only 9 were private. Private providers who receive public funding must agree to comply with the minimum quality standards.

### *Long-term Care in the Healthcare System*

Long-term care in Latvia is also provided in hospitals. Extended long-term care in hospitals is often based on need for additional social support and not based on need for additional medical treatment. This is particularly true for patients with dementia. Over 25 percent of people with dementia stay in hospital for over a year just to receive social care services<sup>25</sup>.

<sup>23</sup> Ministry of Welfare (2008)

<sup>24</sup> Contrary to other countries, religious organizations don't seem to play a very important role in the provision of care in Latvia.

<sup>25</sup> Alzheimer Europe (2007)

### *Entitlement to benefits*

Entitlement to LTC services in Latvia is based on an assessment of individual needs and is carried out by a specialized social worker and the patient's doctor. The assessment considers the person's functional ability and resources and also the availability of family support. Following the assessment, a decision is made regarding the type and duration of services that can be provided within services available in that particular municipality. A change in the patient's health or living condition can be communicated to the social worker or the patient's doctor, triggering an update of the assessment. All individuals receiving LTC (inside or outside of institutions) are registered with a primary care physician and receive primary health and ambulatory care services similar to what is provisioned for the rest of the Latvian population. Even after an assessment, primary care physicians are responsible for following their patients who are in LTC institutions. For example, institutions for mentally ill or disabled persons may have a resident physician but the patient's doctor continues to follow the patient.

### **Financing**

In Latvia, the main sources of financing for LTC are State and municipality expenditures and fees paid by beneficiaries. Health (primary and palliative) care provided for those receiving long-term care is financed by the health care system.

Public financing of SLTC services is divided between the State (central government) and municipal governments according to type of LTC service. The State government is responsible for provisioning and financing social rehabilitation services while municipal governments are responsible for the provision and financing of institutional care, and non-institutional care services and benefits (in-kind and cash benefits for informal care providers). Nursing home (institutional) care for the elderly is financed jointly by municipal governments and by the beneficiary. Elderly beneficiaries are required to contribute based on a co-payment from their pension. The State is responsible for financing social rehabilitation benefits for people with impaired vision and hearing, services for the disabled and for those with functional disorders. Benefits for other beneficiaries of the SLTC and social rehabilitation system are outlined by level of government in Table 3.5. In Latvia, State and municipal level funding for LTC programs are financed by general taxation revenue. Long-term care services provided through the health care system (in hospitals) are also financed from tax revenue.

Since 2003, Latvia has been moving towards a decentralized approach to financing LTC. This approach began by making municipalities responsible for the provision and financing of the LTC services. This decentralized approach was reinforced by the 2006 Law on Social Services and Social Assistance. This law is characterized by minimum state support, increased responsibility for municipalities, and a selective approach for the provision of services. This means that provided LTC services should reflect the most pressing social issues in a given area and that the municipality must finance this level of care. This shift in financing responsibility has led to varied LTC services and benefits across municipalities. Wealthier municipalities, like the city of Riga, have a reasonable supply of LTC services, while rural municipalities are believed to be worse off now than during the Soviet era. Also, Latvia recently underwent an administrative reform that drastically reduced the number of municipalities (from around 500 to 109). This will likely impact LTC services.

**Table 3.5: LTC Services by Level of Government**

Central Government	LTC institution	Working age individual with mental illness Children with learning impairment Orphans and children who are victims of violence
	Social rehabilitation	People with impaired vision or hearing People suffering from addiction People with functional disorders and vocational training for disabled Provision of technical aids to disabled
Municipal Government	LTC (at home and in institutions)	Frail elderly people at pensionable age
	In-kind and cash benefit	Informal care providers

Source: Ministry of Welfare

As previously mentioned, the elderly and their relatives are expected to pay for the cost of long-term social care services according to their financial resources.<sup>26</sup> In case they cannot meet the cost themselves, municipalities will provide social assistance to those in need. In municipal institutions beneficiaries must be able to keep at least 15 per cent of their pension<sup>27</sup>. Within these guidelines, municipalities have an incentive to charge higher “market prices” for LTC services. Old-age pensions in Latvia are relatively low and this makes the elderly who rely on their pensions vulnerable to poverty. According to figures from the Central Statistical Bureau of Latvia, in 2007, 30 percent of those aged 65 or older were living in poverty (an increase of 9 percentage points from 2006).<sup>28</sup> Women are particularly at risk of being poor (36 percent of women aged 65 and older were poor compared to 17 percent of men).

Private providers may have their services purchased by municipal governments or sold directly to patients in the market. Private providers who rely on pensions from the elderly to cover their costs find it difficult to cope with the quality requirements for providing care and still be able to have a profitable activity. The recent announcement by the Latvian government to reduce pensions by 10 percent due to budgetary constraints arising from the financial crisis may result in even greater financial difficulties for the elderly.<sup>29</sup>

### 3.3 Current Public Expenditures on Long-term Care

Unfortunately, there is limited available data on current public expenditures for LTC. This is the case in other countries as well, making it difficult to compare LTC expenditures across countries. The lack of data on LTC expenditure is largely due to LTC services provided under both the health and the social sector, making it difficult to calculate LTC expenditure.

According to the System of Health Accounts (SHA) methodology developed by the Organisation for Economic Development and Co-operation (OECD), LTC comprises the following categories of services: (i) in the health sector, palliative care, long-term nursing care (including accommodation in nursing homes), personal care services to assist with ADLs, and services and

<sup>26</sup> Given their target population, state institutions don't usually require the payment of fees.

<sup>27</sup> NOSOSCO (2000)

<sup>28</sup> Using Eurostat's definition of “at risk of poverty”, that is, those whose equivalized income is below the threshold of 60% of the national equivalized median income.

<sup>29</sup> European Older People's Platform (AGE), see [http://www.age-platform.org/EN/spip.php?article772&var\\_recherche=Latvia](http://www.age-platform.org/EN/spip.php?article772&var_recherche=Latvia).

financing in support of informal (family) care; and (ii) in the social sector, home help and care assistance, residential care services other than nursing homes, and other services like daycare and transportation.<sup>30</sup>

Available data on LTC expenditure through the SHA database varies across countries. This makes the data hardly comparable across countries. In the case of Latvia, expenditure data on LTC is only available for two years, 2005 and 2006. According to this data, Latvia spent 1.4 percent of GDP on LTC in 2005 and only 0.2 percent of GDP in 2006.<sup>31</sup> This large variation already shows that even for the same country, the data does not seem comparable across time. For Latvia, the large variation is explained by recorded expenditures on LTC of LAT 111.04 million in the social sector in 2005, while in 2006 this expenditure category is missing. Overall, the SHA data on LTC has a strong bias towards health sector expenditure, with data on expenditures in the social sector largely absent, especially for EU-10 countries.

Nevertheless, data from the SHA database that is available, suggests that Latvia—along with other EU-10 countries—spends relatively little on LTC. Table 3.6 lists total expenditures on LTC (as a percentage of GDP) *only* for countries where expenditures are relatively constant over time, which suggest at least consistency of data collection within countries. The data imply that high-income countries currently spend as much as 3.7 percent of their GDP on LTC (Sweden). The EU-10 countries, in contrast, all report much lower numbers, generally spending less than 1 percent of GDP on LTC. Ignoring the outlier for 2005, the data suggest that Latvia spends as little as 0.2 percent of GDP on LTC, which would certainly rank it among the countries with lowest LTC expenditure.

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<sup>30</sup> See OECD (2008)

<sup>31</sup> These numbers refer to total expenditures, that is, including public and private expenditures.

**Table 3.6: Total LTC Expenditures as a Share of GDP in Select Countries  
(According to System of Health Accounts, 2003-2007)**

	2003	2004	2005	2006	2007	Average 2003-2007
<b>Sweden</b>	3.8	3.8	3.7	3.7	3.6	3.7
<b>Norway</b>	2.4	2.3	2.2	2.1	--	2.3
<b>Switzerland</b>	2.2	2.2	2.2	2.1	2.1	2.1
<b>Finland</b>	2.0	2.1	2.2	2.1	2.1	2.1
<b>Denmark</b>	2.0	2.0	2.1	2.1	2.0	2.0
<b>Germany</b>	2.0	2.0	2.0	1.9	1.9	1.9
<b>Iceland</b>	1.9	1.9	1.9	1.9	--	1.9
<b>Japan</b>	1.6	1.7	1.7	--	--	1.7
<b>Belgium</b>	--	--	1.6	1.6	1.7	1.6
<b>France</b>	1.4	1.5	1.5	1.6	1.6	1.5
<b>Austria</b>	--	1.3	1.3	1.3	--	1.3
<b>Netherlands</b>	1.3	1.3	1.3	1.3	1.2	1.3
<b>Slovenia</b>	1.1	1.1	1.2	1.2	1.1	1.1
<b>United States</b>	1.0	1.0	1.0	1.0	--	1.0
<b>Spain</b>	0.7	0.7	0.7	0.7	0.8	0.7
<b>Lithuania</b>	--	0.4	0.4	0.4	0.5	0.4
<b>Poland</b>	--	0.4	0.4	0.4	0.4	0.4
<b>Hungary<sup>1</sup></b>	0.3	0.3	--	0.2	0.2	0.3
<b>Czech Republic</b>	0.3	0.2	0.2	0.3	0.3	0.3
<b>Cyprus</b>	0.2	0.2	0.2	0.2	0.2	0.2
<b>Estonia</b>	0.1	0.1	0.2	0.2	0.2	0.2
<b>Portugal</b>	0.1	0.1	0.1	0.1	--	0.1
<b>Bulgaria</b>	0.0	0.1	0.2	0.0	0.0	0.1
<b>Romania</b>	0.0	0.0	0.0	0.0	0.0	0.0
<b>Average</b>	1.2	1.2	1.2	1.1	1.1	1.2
<b>Latvia</b>	--	--	1.4	0.2	--	0.8

Note 1: The 2005 value for Hungary (8.23 percent of GDP) was dismissed as an outlier.

Source: Eurostat (2010)

An alternative—more limited, but also more reliable approach—is to focus on public expenditures instead of total expenditures on LTC. As already mentioned, the main gap in the SHA data is expenditures in the social sector. In most countries, the largest share of public expenditures for LTC in the social sector—in particular for the elderly—occurs on the local government level. This decentralized financing of LTC services makes it difficult to obtain consolidated expenditure data for a whole country. A recent initiative by the World Bank, though, aims at developing consolidated government expenditures databases that reports expenditure on all levels of government. This allows also for the first time, to obtain detailed public expenditure data on LTC on local level. A first detailed analysis of such data was recently conducted in Poland (see Chapter 4), and resulted in estimated public expenditures on LTC in the health and social sector of 1.0 percent of GDP in 2007 (as opposed to estimated *total* expenditures, including private expenditures, of 0.4 percent according to SHA).

A similar analysis in Latvia results in estimated public expenditures on LTC in the social sector to about 0.44 percent of GDP in 2008 (see Table 3.7). Expenditures increased strongly from LAT 59 million in 2007 (0.4 percent of GDP) to LAT 72 million in 2008. Note that this excludes any spending on LTC in the health sector or any private spending on LTC. Rather, these are

expenditures in the social sector for incapacity, temporary incapacity, disability, and support for the elderly. It excludes any cash benefits or social security benefits that are not specifically labeled to support care or care givers. Most importantly, it excludes any old-age or disability pensions. Rather, these expenditures truly focus on LTC services provided by the social sector—that is, in-kind LTC benefits and some limited cash benefits for care. Accordingly, the main expenditure items are remuneration, goods and services, subsidies and grants (mainly to NGOs, public providers, and charity organizations), and capital investments. Detailed lists of all budget lines and expenditure from 2006 – 2009 in central and local government can be found in Table 3.8 and 3.9.

**Table 3.7: Total Government Expenditure on LTC According to Government Expenditure Data (LAT, 2007/08)**

<b>Code</b>	<b>Description</b>	<b>2007</b>	<b>2008</b>
<b>10.100</b>	<b>Social protection in case of incapacity</b>	<b>2,985,554</b>	<b>3,894,635</b>
	Central government	255,944	3,618
	Local government	2,729,610	3,891,017
<b>10.110</b>	<b>Social protection in case of temporary incapacity</b>	<b>0</b>	<b>83,828</b>
	Central government	0	83,828
	Local government	0	0
<b>10.120</b>	<b>Social protection in case of disability</b>	<b>34,790,221</b>	<b>40,951,782</b>
	Central government	34,790,221	40,951,782
	Local government	0	0
<b>10.200</b>	<b>Support for the elderly</b>	<b>21,304,872</b>	<b>27,343,030</b>
	Central government	0	0
	Local government	21,304,872	27,343,030
	<b>Total</b>	<b>59,080,647</b>	<b>72,273,275</b>
	<i>as share of GDP</i>	<i>0.40%</i>	<i>0.44%</i>
	<b>Central government</b>	<b>35,046,165</b>	<b>41,039,228</b>
	<i>as share of GDP</i>	<i>0.24%</i>	<i>0.25%</i>
	<b>Local government</b>	<b>24,034,482</b>	<b>31,234,047</b>
	<i>as share of GDP</i>	<i>0.16 %</i>	<i>0.19%</i>

Source: Latvia Ministry of Finance

**Table 3.8: Central Government Expenditure on LTC According to Government Expenditure Data (LAT, 2006-2009)**

<i>Code</i>	<i>Description</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>
<b>10.100</b>	<b>Social protection in case of incapacity</b>	<b>28,348,039</b>	<b>255,944</b>	<b>3,618</b>	<b>0</b>
1000	Remuneration	21,893,489	79,215		
3000	Subsidies and grants	5,460,241			
4000	Interest payments		176,729	0	
5000	Fixed capital formation	994,309			
6000	Social benefits			1,809	
6400	Other benefits compensations in kind, nec			1,809	
<b>10.110</b>	<b>Social protection in case of temporary incapacity</b>	<b>0</b>	<b>0</b>	<b>83,828</b>	<b>97,652</b>
1000	Remuneration			83,828	
3000	Subsidies and grants				97,652
<b>10.120</b>	<b>Social protection in case of disability</b>	<b>5,708,766</b>	<b>34,790,221</b>	<b>40,951,782</b>	<b>34,062,487</b>
1000	Remuneration		17,976,478	21,624,985	17,258,005
2000	Goods and services		9,385,656	10,524,515	9,058,074
3000	Subsidies and grants	5,708,766	5,953,280	7,703,361	5,370,036
5000	Fixed capital formation		1,474,247	1,097,083	2,376,372
6000	Social benefits	0	560	1,838	
6237	<i>Benefit and remuneration for custodian and foster family</i>			1,838	
6238	<i>Benefits to disabled person who needs special care</i>		560		
	<b>TOTAL Central Government</b>	<b>34,056,805</b>	<b>35,046,165</b>	<b>41,039,228</b>	<b>34,160,139</b>

Source: Latvia Ministry of Finance

On the central government level, expenditures on LTC increased strongly during 2008 (+17.1 percent nominally) and contracted significantly during the crisis year of 2009 (-16.8 percent). In nominal terms, expenditures were below 2007 levels in 2009 (LAT 34 million versus LAT 35 million). The Central Government's responsibility in provisioning LTC is strictly limited to the population with disabilities. The strongest increases during 2008 and decreases during 2009 were recorded for expenditures on remuneration and the purchase of goods and services. The only exception is fixed capital formation, which increased significantly during 2009 (+117 percent). This suggests that spending cuts focused on salaries while investments in infrastructure were expanded.

On the local government level, unfortunately data is not available for 2006 and 2009. Local governments' responsibilities focus on support for the elderly and the population with incapacity to work. During 2008, expenditure at the level of local government increased at a much higher rate (+30 percent) than on the central government level (from LAT 24 million to LAT 31 million). As on the central government level, this increase was driven by increases in remuneration and purchases of goods and services. Interestingly, expenditures on subsidies and grants went down considerably, while fixed capital formation increased strongly. This could suggest a shift from buying LTC services from private organizations (like NGOs and charities) to the production of LTC services by municipalities themselves. This raises some concerns about crowding out private and non-profit sector production and should be investigated further.

**Table 3.9: Local Government Expenditure on LTC According to Government Expenditure Data (LAT, 2007/08)**

<i>Code</i>	<i>Description</i>	<i>2007</i>	<i>2008</i>
<b>10.100</b>	<b>Social protection in case of incapacity</b>	<b>2,729,610</b>	<b>3,891,017</b>
1000	Remuneration	692,952	901,031
2000	Goods and services	373,056	1,619,950
3000	Subsidies and grants	1,306,082	581,816
5000	Fixed capital formation	247,129	683,798
6000	Social benefits	110,391	104,422
6252	<i>Benefits for health care in cash</i>	38,388	35,853
6253	<i>Benefits for feeding in cash</i>	32,916	29,603
6300	<i>Social benefits in kind</i>	12,372	24,720
6400	<i>Other benefits compensations in kind, nec</i>	26,715	14,246
<b>10.200</b>	<b>Support for the elderly</b>	<b>21,304,872</b>	<b>27,343,030</b>
1000	Remuneration	8,934,708	11,912,908
2000	Goods and services	6,935,823	9,208,046
3000	Subsidies and grants	1,720,197	1,616,145
4000	Interest payments	89	1,557
5000	Fixed capital formation	3,493,015	4,285,872
6000	Social benefits	221,040	318,502
6233	<i>Additional payment to family benefit for disabled child</i>	210	180
6237	<i>Benefit and remuneration for custodian and foster family</i>	.	.
6238	<i>Benefits to disabled person who needs special care</i>	.	2,665
6252	<i>Benefits for health care in cash</i>	52,186	53,826
6253	<i>Benefits for feeding in cash</i>	18,421	24,479
6300	<i>Social benefits in kind</i>	72,423	157,982
6400	<i>Other benefits compensations in kind, nec</i>	77,800	79,370
	<b>TOTAL Local Government</b>	<b>24,034,482</b>	<b>31,234,047</b>

Source: Latvia Ministry of Finance

### 3.4 Future Policy Directions

LTC is a crucial policy area, with important fiscal implications in the medium and in the long-term. It is essential that Latvia improves its data collection and recording practices on LTC services in order to be able to develop good and fiscally responsible policy in this area. The OECD SHA methodology gives good guidance on how to record public (and private) expenditures, and it is important that Latvia strengthens its efforts along these lines on both the central and the local government level.

What can be said with certainty at this point is that Latvia spends relatively little on LTC and that increased investments in LTC services could lead to important efficiency gains in the health sector. Due to inefficient overcapacities in the hospital sector, it is conceivable that a large part of LTC is currently provided in hospitals. Long-term care through hospitals is both expensive and puts the elderly at risk for of receiving the wrong type of care and for contracting hospital infections.

The relatively high average length of stay in hospitals suggests that improved patient discharge management could decrease expenditures in the hospital sector. Patient discharge management

aims at reducing length of stay in hospitals by transfer patients to more cost-efficient outpatient services like post-surgical treatments and rehabilitation. Latvia currently spends only 0.8 percent of total health expenditures on rehabilitation, hinting a lack of rehabilitative services (see Table 3.10). In contrast, for other EU countries where such data is available, expenditures on rehabilitative services as a share of total health expenditure is around 2.9 percent (this is true for many EU-10 countries).

**Table 3.10: Total Expenditures on Rehabilitative Care as a Share of Total Health Expenditures in Select Countries (2003-2007)**

	2003	2004	2005	2006	2007	Average 2003-2007
<b>Cyprus</b>	10.7	10.6	10.7	10.8	10.7	10.7
<b>Iceland</b>	5.2	5.1	5.3	5.2	--	5.2
<b>Netherlands</b>	4.5	4.3	4.4	4.7	4.8	4.5
<b>Austria</b>	--	4.1	4.2	4.4	--	4.2
<b>Lithuania</b>	--	4.2	4.2	4.3	4.1	4.2
<b>Belgium</b>	--	--	3.3	3.8	4.1	3.7
<b>Czech Republic</b>	3.8	3.6	3.7	3.4	3.5	3.6
<b>Germany</b>	3.6	3.5	3.3	3.3	3.3	3.4
<b>Finland</b>	3.2	3.2	3.0	3.1	3.0	3.1
<b>France</b>	3.0	3.0	3.0	3.0	3.0	3.0
<b>Hungary</b>	2.9	3.0	3.1	2.6	2.8	2.9
<b>Poland</b>	--	2.2	3.0	3.0	3.1	2.8
<b>Estonia</b>	2.0	2.5	3.1	2.6	3.2	2.7
<b>Luxemburg</b>	--	--	2.5	--	--	2.5
<b>Slovenia</b>	2.2	2.2	2.3	2.2	2.3	2.3
<b>Switzerland</b>	1.6	1.6	1.5	1.6	1.7	1.6
<b>Norway</b>	1.4	1.5	1.5	1.5	--	1.5
<b>Bulgaria</b>	0.9	1.3	1.4	1.3	1.3	1.2
<b>Japan</b>	0.9	1.0	1.0	--	--	1.0
<b>Romania</b>	0.7	0.6	0.6	0.6	0.7	0.7
<b>Slovakia</b>	--	--	0.5	0.6	--	0.6
<b>Spain</b>	0.0	0.0	0.0	0.0	0.0	0.0
<b>Average</b>	2.9	3.0	2.9	3.0	3.2	2.9
<b>Latvia</b>	--	--	0.8	0.8	--	0.8

Source: Eurostat (2010)

In the case of elderly patients, patient discharge management also requires social workers to help organize temporary (or permanent) assistance with ADLs after discharge. For older patients who live on their own and lack family support, even a minor injury—like a broken leg—can leave them temporarily dependent on outside support. Based on the tendency of hospital beds to operate at overcapacity, hospital management would keep such a patient hospitalized until they are fully recovered, although the patient needs social not medical care. A more cost-efficient solution would be to discharge the patient when further medical care is not necessary and provide the needed social care through community-based LTC services. This could either happen through home-based services or through temporary residential LTC services. The city of Riga has already successfully implemented such an approach. A careful evaluation of the experience in Riga could form the basis for a countrywide rollout of discharge management.

Any publicly funded investments in building up more LTC (and also rehabilitative) service facilities, though, have to be carefully evaluated against other policy objectives. Various potential policy objectives come into mind. First, reforms should be cost-effective and have the wellbeing of patients in mind. This implies a focus on community-based services like home care and daycare. Institutional care is also an important component of any LTC system, but it results in higher-intensity care, is therefore more expensive, and is not the preferred form of care by patients. Second, cost shifting between the health and the social sector should be avoided as much as possible. This implies that coordination of care services has to focus on the needs of patients rather than cost implication for either the health or the social sector. The current LTC patient needs assessment involves both a social worker and a general practitioner. This is an excellent starting point for building a patient-focused care coordination system. Third, provider payment rules and capital investments have to ensure a leveled playing field between the public and the private sector. If public providers are subsidized—either directly from the budget through staff salaries or through capital investment subsidies—private sector providers are unfairly disadvantaged and private sector responses in the provisioning of LTC services might be dampened.

The conversion of small municipal hospitals into institutional LTC facilities is a good example of how LTC reform can run counter some of these policy objectives. International experience shows that many countries at some point in their history have converted redundant municipal hospitals into LTC institutions. The risk that is created by such reforms is that it introduces a bias towards expensive institutional care in a country's LTC system. Poland is a good recent example. Some years ago, Poland started to convert small hospitals into medical nursing homes that were operated and financed by the health sector. These medical nursing homes were intended to provide post-surgical care at a lower cost than in regular hospitals. The unintended consequences were that—given the general shortage of LTC services in Poland—patients and their families continued to use the medical sector as a substitute for social LTC services, at a much higher price than this could be done in the social sector. The medical nursing homes were largely financed from the health insurance fund and came at a much lower price for patients than private or social sector LTC services. Private sector response was dampened because for-profit and even non-profit organizations could not compete with the lower user fees in medical nursing homes. Municipalities, who finance most of the social LTC services, also found it cheaper to shift patients to medical nursing homes rather than provide their own social services.

A better approach would be to convert redundant municipal hospitals into community centers—either privately or publicly owned—that provide a whole range of LTC and rehabilitative services. Such community centers would be at the center of care coordination for patients. They could serve as daycare centers for the elderly and the disabled (or even childcare), and provide outpatient services like physical therapy. They could also function as the central facility for home-based services like care assistants or community nurses who support dependent people in their homes. To the extent necessary, these community centers could also provide temporary residential care and respite care. The exact setup of such community centers would depend on local needs and circumstances and also on other costs. Transportation cost can be especially important in remote, rural areas of Latvia. High transportation costs could in fact justify more residential care facilities with low levels of care intensity.



## 4. POLAND

### INTRODUCTION

Poland is located in Central Europe. It is bordered by Belarus, Czech Republic, Germany, Lithuania, Russia, Slovakia, Ukraine and the Baltic Sea to the north. Poland is a relatively large country with 312,685 square kilometers of territory. The country is administratively divided into 16 provinces. The country's current population is estimated at 38,463,689. Life expectancy at birth for the entire population is 75.85 years; with 71.88 years for a male 80.06 years for a female. The currency in Poland is the zloty (PLZ)<sup>32</sup>.

Poland is a former Soviet satellite state. In 1990, a democratically elected government replaced the communism led government. Around this time, the centrally planned economy was altered into a free-market economy, and the constitution was re-designed. The current government is made up of a President who is the head of State (country) and the Prime Minister who is head of the government. The legislative branch is made up a bicameral house with a lower and upper house<sup>33</sup>. In 1999, Poland became a member of NATO. Five years later in 2004, Poland joined the European Union. From 1996 through 2007, Poland had continuous economic growth with an average annual real GDP growth of 4.6 percent. Upon joining the EU, Poland has maintained its growth. In fact, in 2009, Poland was the only EU country to sustain positive growth despite the recent Global Financial Crisis. Poland's resiliency to withstand the Global Financial Crisis has been attributed to its stable initial macroeconomic situation, the large size of its domestic market, a flexible exchange rate, and appropriate policy measures. Economic indicators as of 2008 include a GDP of \$528 billion, GDP growth of 4.89 percent, a GNI of 447 billion (Atlas method), and an inflation rate of 4 percent. The unemployment rate as of 2008 was 7 percent<sup>34</sup>. The labor force is estimated at 16.99 million people or approximately 44 percent of the population<sup>35</sup>.

Currently, Poland spends less on long-term care (LTC) benefits compared to other OECD countries, but recent increases in public spending raise concerns about the fiscal implications of future spending.<sup>36</sup> When compared to high-income OECD countries, Poland currently spends considerably less of its GDP on LTC services. As in many other countries, LTC benefits in Poland are fragmented across various parts of the social protection and health system. Overall, benefits reach only a relatively small fraction of the Polish population, with the notable exception of cash benefits, which are paid to everyone above the age of 75.<sup>37</sup> In-kind formal LTC services, on the other hand, are not readily available in Poland, and a large share of Poland's dependent population receives no or only informal LTC. Recent increases in public expenditure for in-kind LTC benefits, though, suggest that Poland might quickly catch up with its Western European peers and substantially increase the availability and quality of formal LTC services.

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<sup>32</sup> CIA World Factbook (2010)

<sup>33</sup> U.S. Department of State (2010)

<sup>34</sup> World Bank Country Brief (2010)

<sup>35</sup> CIA World Factbook (2010)

<sup>36</sup>For the purpose of this paper, long-term care benefits are defined as benefit (cash and in-kind) provided to dependent persons who are unable to perform activities of daily living (ADLs).

<sup>37</sup> See, Więckowska (2008).

The question that then arises is if Poland—given that it is a middle-income country—can afford the same breadth and depth of LTC services that high-income countries provide to their populations? In answering this question, one has to keep in mind that Poland—although an emerging economy—is aging quickly, and, as various literatures have pointed out, will grow old before it grows rich.<sup>38</sup>

The objective of this chapter is to investigate the potential fiscal implications of future public spending on LTC benefits in the context of an aging society. Like other Eastern European countries, Poland's population will age considerably over the next 50 years. This demographic trend will challenge the fiscal sustainability of the LTC sector; on the one hand, the contribution base of the tax and social security system will decrease over the coming years while the demand for LTC services is bound to increase due to a growing number of dependent, elderly population and a decreasing number of potential informal care providers.

This chapter finds that Poland faces a considerable fiscal challenge if it wants to provide appropriate LTC services for its aging population. If Poland continues its current pattern of strong annual expenditure growth, combined with a pronounced increase in the number of expected beneficiaries, public expenditures on LTC will quickly become fiscally unsustainable. The increasing old-age dependency ratio raises serious concerns about the financing of LTC through pay-as-you-go mechanisms.<sup>39</sup> A disproportionate care dependency ratio could lead to further increases in demand for formal LTC. At the same time, substantially increased wages for formal LTC due to labor shortages can put public LTC expenditures under considerable upward pressure.<sup>40</sup> It is therefore critical for the Polish government to think about ways i) to finance future LTC expenditures through means other than a pay-as-you-go mechanism, like for example, through private savings; (ii) to control demand for formal LTC services and channel demand into the right types of LTC services, like outpatient care; and (iii) to control costs of in-kind benefits and reform the cash benefit.

Five sections present these findings in more detail. Section 4.1 discusses the demographic prospect of Poland, with a focus on the dependent population. Section 4.2 presents an overview of the LTC system. Section 4.3 follows with findings on expenditures of the various types of LTC benefits over the last three years. Section 4.4 presents various projections on how current public expenditures might evolve in the future. Section 4.5 offers policy implications.

## 4.1 The Demographic Prospects of the Polish Population

The Polish population is facing the double challenge of an increasingly older and more dependent society. The population aged 65 and older will continuously increase over the next 50 years, while the working age population will shrink by over a third. This will cause the dependent population (with severe restrictions in their activities of daily living, ADLs) to increase significantly while the number of potential care providers—in particular potential providers of informal care—will decrease sharply. In other words, the old-age dependency ratio and the care dependency ratio will increase considerably.

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<sup>38</sup> See, for example, Chawla, Betcherman, and Banerji (2007).

<sup>39</sup> The old-age dependency ratio is defined as the ratio of the population in elderly age over the population in working age (see EUROSTAT QUALITY PROFILE, <http://epp.eurostat.ec.europa.eu>). Its inverse, therefore, measures how many people aged 15 to 64 there are for one person aged 65 and above—in other words, how many potential workers have to support one potential retiree.

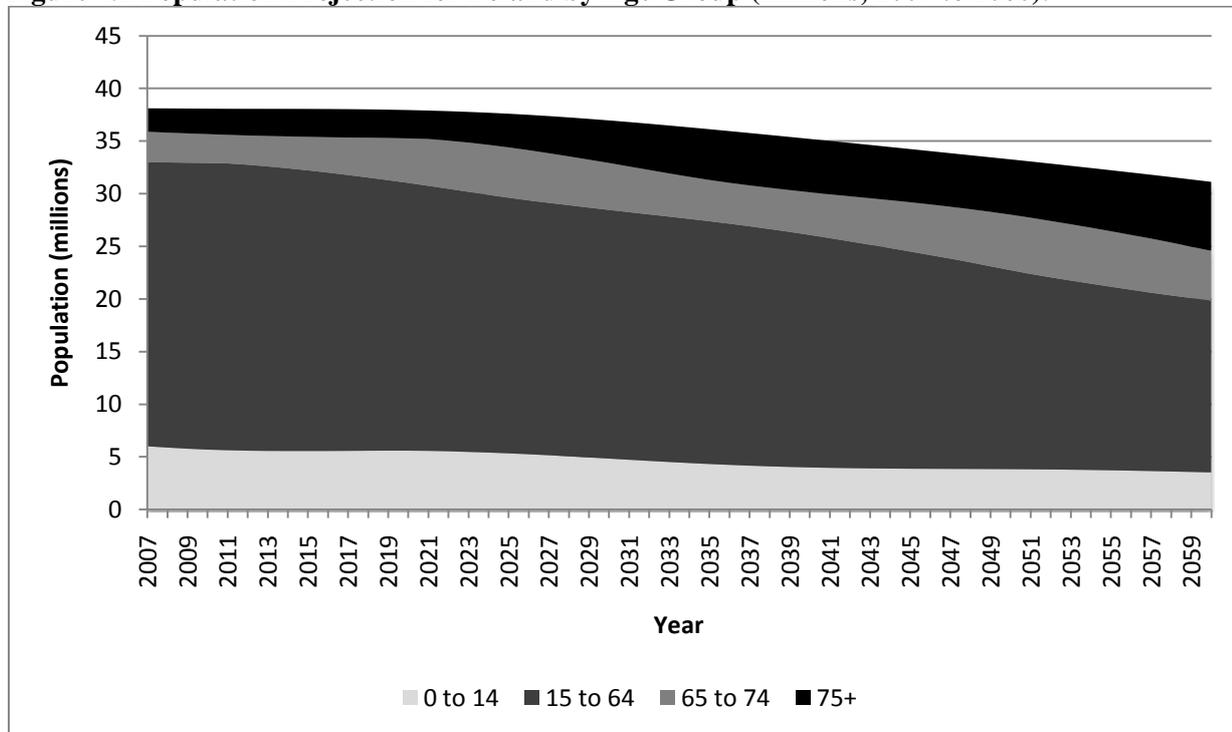
<sup>40</sup> The care dependency ratio is defined as the ratio of the population that needs support with activities of daily living over the rest of the population (source: authors' definition). Its inverse, therefore, measures how many non-hampered people there are for one (somewhat or severely) hampered person—in other words, the number of potential caregivers to one dependent person.

## The Aging of the General Population

Like in other European countries, a sharp drop of the working age population and a continuous increase in the population aged 65 and older drive the demographic changes in Poland. Over the next 50 years, the Polish population will decline from 38.1 million in 2009 to 31.1 million in 2060 (see Figure 4.1).<sup>41</sup> The working age population—aged 15 to 64—will decrease by almost 40 percent, from 27.2 million to 16.3 million. At the same time, the population aged 65 and above will increase from 5.2 million today to 11.3 million in 2060. Most notably, the very old population—aged 75 and above—will increase by 178 percent, from 2.4 million to 6.6 million.<sup>42</sup>

The dynamics of the demographic transition are driven by the aging of the two largest cohorts the Polish population will ever see, those born between 1950 and 1965 and their children, who were born between 1975 and 1990 (see Figure 4.3 for an illustration of the Polish population dynamics over the next 50 years). Usually, these generations would be called the “baby boomer” generation and “Generation X”, respectively, although in the case of Poland, the time between the peak years of these two generations is about 10 to 15 years. The demographic transition is not a gradual one but one that occurs in waves, with sudden strong increases of certain groups. The first considerable increase in the older age groups will happen soon, as the first Polish baby boomers reach retirement age. The annual growth rate of the 65 to 74 age group will sharply increase over the next five to ten years, from a currently negative growth rate to over 6.3 percent in 2018 (see Figure 4.2). This will subsequently lead to a similar growth spurt of the 75+ age group during the 2020s. The largest generation that Poland will ever see—Generation X—will start to retire beginning in the mid-2030s. This will lead to a second growth spurt in the 75+ age group during the 2040s and 2050s. The growth spurts for the mentioned generations will occur in the context of a continuously declining growth rate in the working age population and in the cohort aged 0 to 14 years.

**Figure 4.1 Population Projection for Poland by Age Group (millions, 2007 to 2060).**

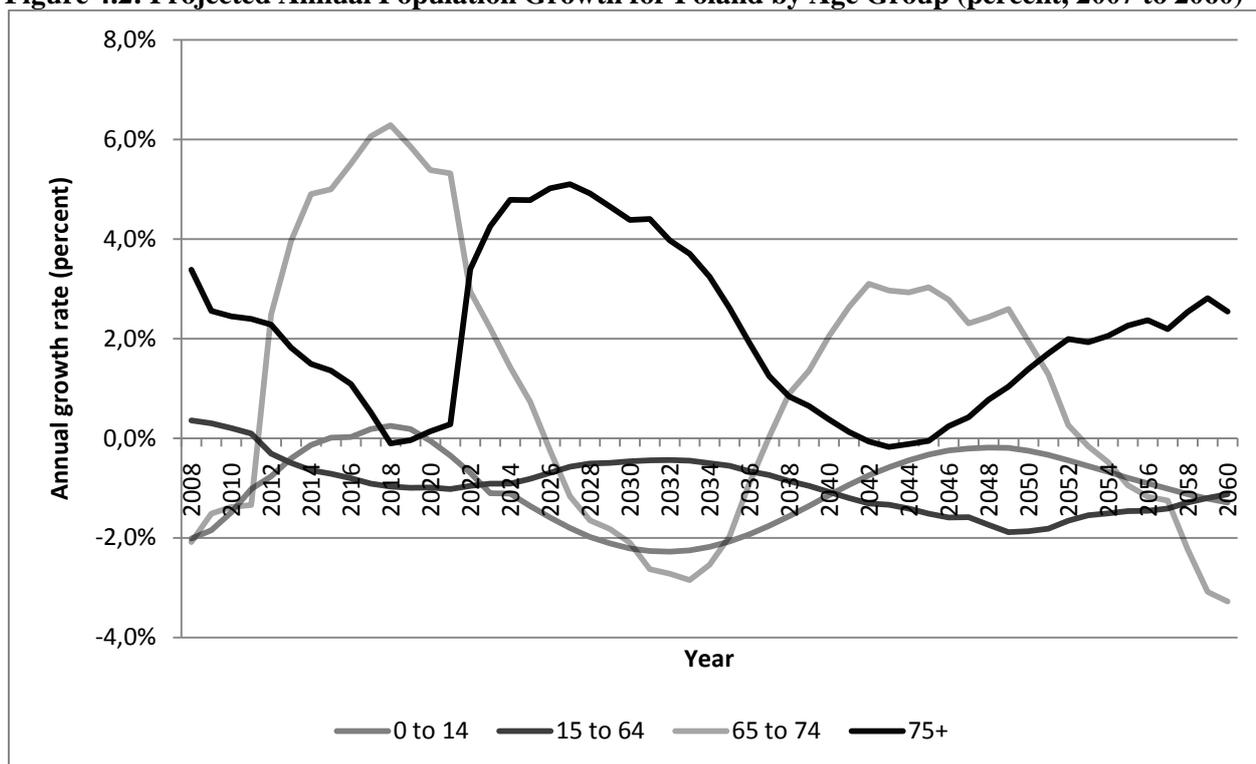


Source: Eurostat (2009a and c)

<sup>41</sup> The population projections are taken from Eurostat (2009c)

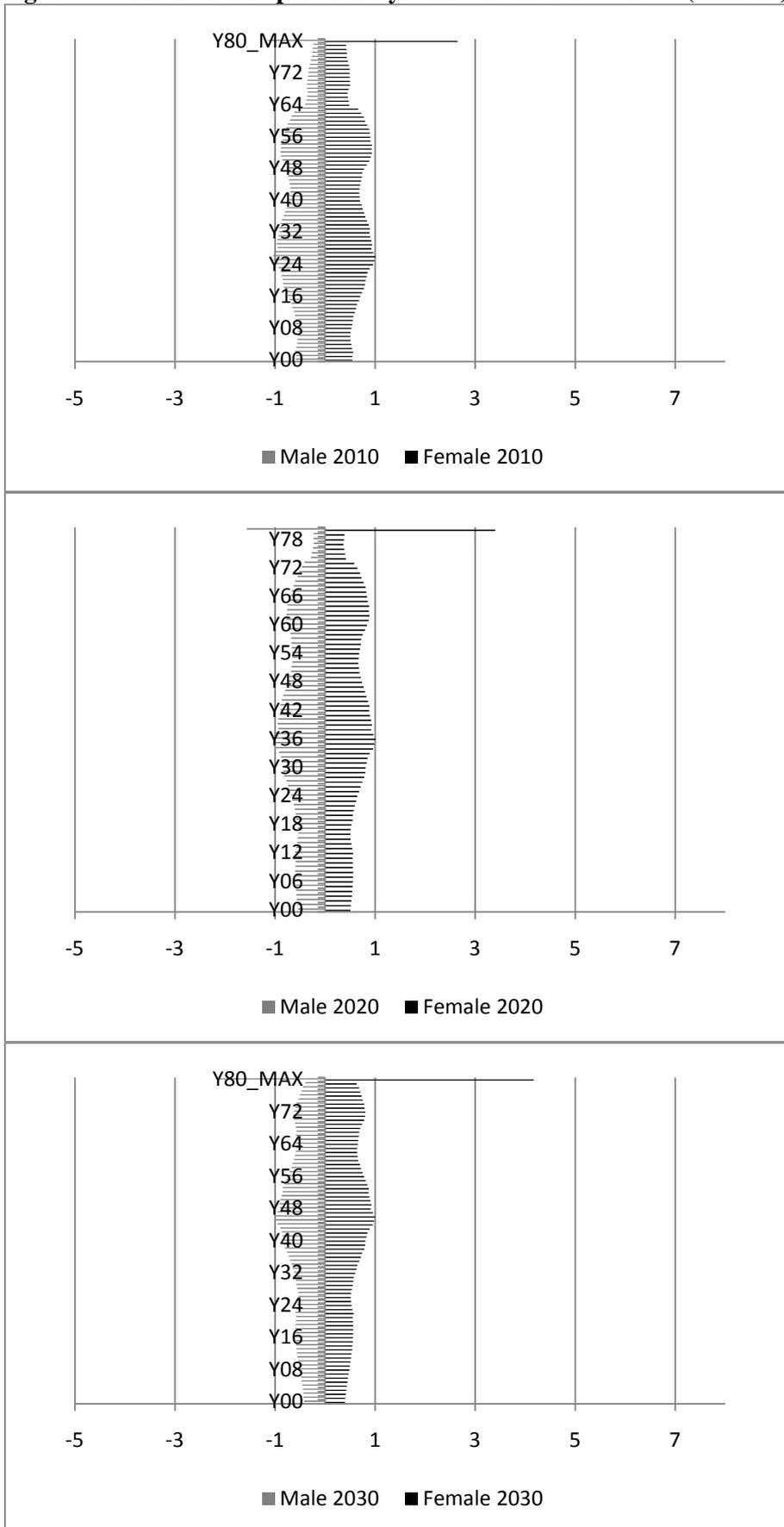
<sup>42</sup> This is called the double ageing process, that is, an increase in the overall elderly age group, with a concurrent increase in the share of the very old. See J. Kurkiewicz (2008).

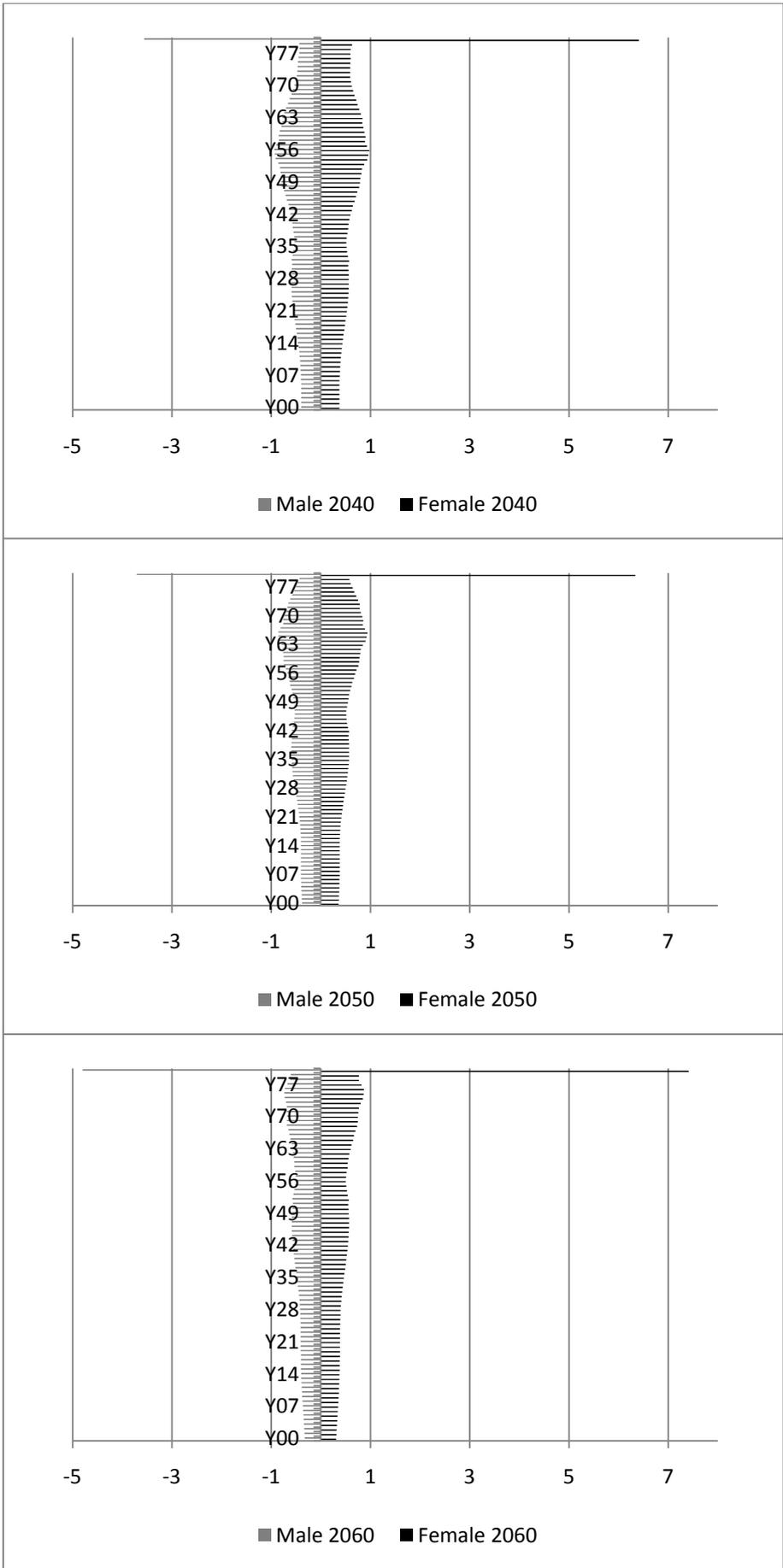
**Figure 4.2: Projected Annual Population Growth for Poland by Age Group (percent, 2007 to 2060)**



Source: World Bank staff calculations, based on Eurostat (2009a and c)

**Figure 4.3: The Polish Population Pyramids from 2010 to 2060 (millions)**





Note: The large and strongly increasing age group at the top of each pyramid represents the population aged 80 and above.  
 Source: Eurostat (2009a and c).

The question then arises of how this marked increase in the elderly population—in particular of the 75+ population—translates into future demand for LTC services. LTC services are provided to people who have difficulties performing activities of daily living on their own. In other words, the target population for LTC services is people who have lost the ability to live independently. Hence, the dependent population is the key variable that determines demand for LTC services.

### The Dependent Population

The size of the dependent population crucially depends on the general population's age structure. The share of the population that is either somewhat or severely hampered in their activities of daily living increases with age. For Poland, the share of the severely hampered population ranged by age group. In the 15 to 24 age group, 1.1 percent of the population was severely hampered while in the 85 and over age group, 45 percent of the population was severely hampered in 2007 (see Table 4.1).<sup>43</sup> As cohorts age, so does their share of dependents.

A purely demographic projection reveals that the Polish population will become much more dependent on care over the next 50 years. Assuming that dependency rates by age group remain at the 2007 level, the severely hampered population is projected to increase by almost 60 percent, from currently 2.2 million to 3.6 million in 2060 (see Figure 4.4). In addition, the somewhat hampered population will increase from 5.2 million to 6.3 million. Even more concerning is the strong decline of the non-hampered population. The increase of the dependent population contrasts with a dramatic decline of the non-hampered population, which is projected to decline by 7.1 million people (-28.5 percent). Given that a large share of the Polish dependent population relies on informal care, these projections raise serious concerns about who will provide care for the increasing dependent population in the future.

**Table 4.1: Share of Polish population by Dependency Level and Age Group (percent, 2006 and 2007)**

Dependency level	Year	Age group								
		15+	15 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 to 74	75 to 84	85+
Not hampered	2006	78.8	94.1	93.3	89.3	77.9	65.4	54.6	36.8	31.3
	2007	77.1	93.8	92.6	88.2	77.4	63.9	48.5	33.4	21.9
Somewhat hampered	2006	15	4.9	5.2	8.2	16.9	25.7	31.5	36.5	28.8
	2007	16.1	5.1	5.7	9.2	17.3	27.3	34.7	37.4	33.1
Severely hampered	2006	6.2	1.0	1.5	2.5	5.2	8.9	13.9	26.7	39.9
	2007	6.9	1.1	1.7	2.7	5.3	8.7	16.8	29.2	45.0

Source: Eurostat (2009b)

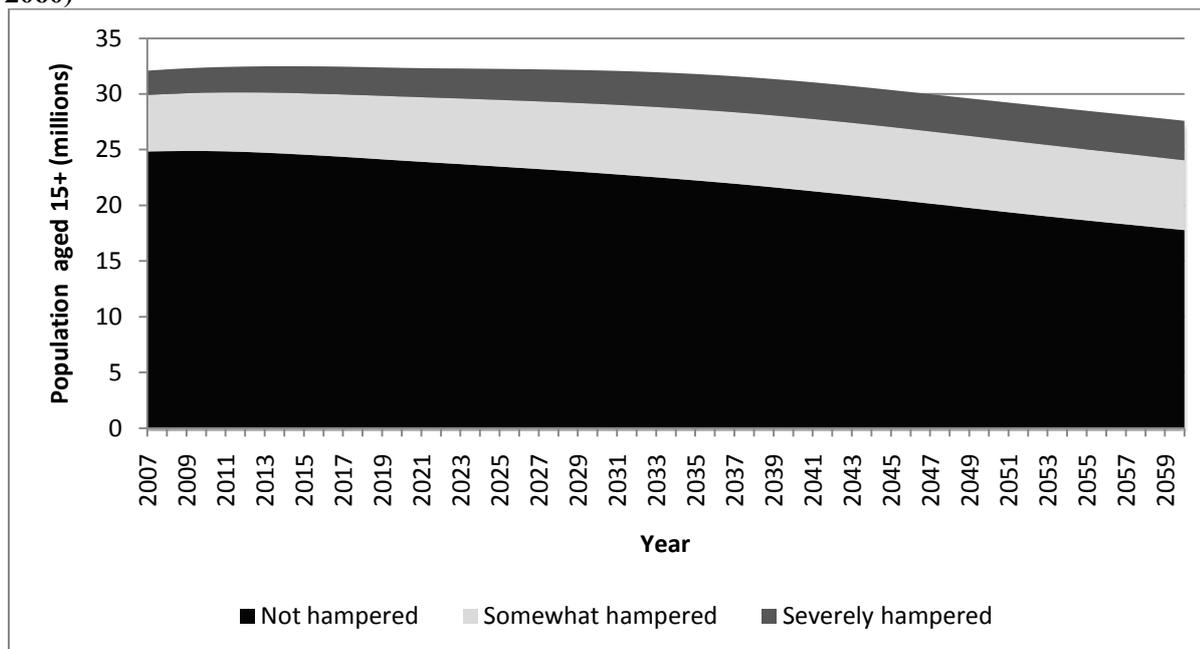
The projected growth dynamics of the dependent population are driven by the same demographic developments that were discussed above. Because the share of dependent peoples is much higher among the older age groups, the sudden increases of elderly age groups translate into equally sudden increases of the dependent population. The severely hampered population is projected to expand significantly over the next 50 years; the first wave setting in during the mid-2010s, followed by a second wave during the mid-2020s (see Figure 4.5). Growth spurts in the 65 to 74 age group in the 2010s and in the 75 and older age group in the 2020s lead to projected annual growth rates of the severely hampered population above 1.5 percent around 2013 and 2024. Thereafter, the annual growth rate of the severely hampered population is projected to decline, but will remain positive, stabilizing around 0.5 percent after 2050. The somewhat hampered

<sup>43</sup> See Eurostat (2009b). Other surveys estimating the number of dependent people in Poland can be found in *Polska starość* (2002), Synak B. (red), Wydawnictwo Uniwersytetu Gdańskiego, *Social Diagnosis* (2009), raporty: Czapiński J., Panek T. (red.), <http://www.diagnoza.com>.

population is projected to grow until the 2040s, yet at a lower level than the severely hampered population. After 2045, the somewhat hampered population is projected to decline. The non-hampered population, on the other hand, is projected to decline at an increasing rate from 2010 onwards. The rate of decline is expected to stabilize at -1 percent annually in the late 2040s.

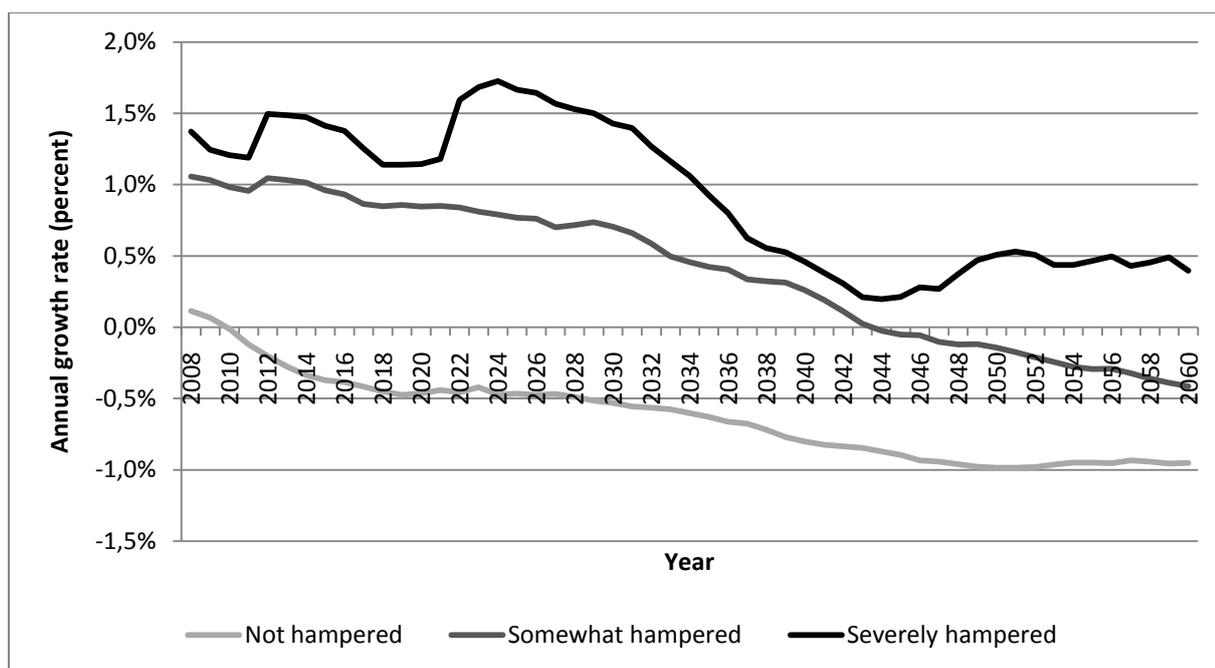
The increase in the severely hampered population is almost entirely driven by an increase in the population aged 75 and above. Among the severely hampered, this age group will increase from currently 750,000 to 2 million people by 2060 (+173 percent, see Figure 4.6). The combined growth rate of all the other severely hampered age groups remains relatively constant because the growth of the 65 to 74 age group is absorbed by the decrease in the 15 to 64 age group.

**Figure 4.4: Population Projections for People aged 15+ by Dependency Level (millions, 2007 to 2060)**



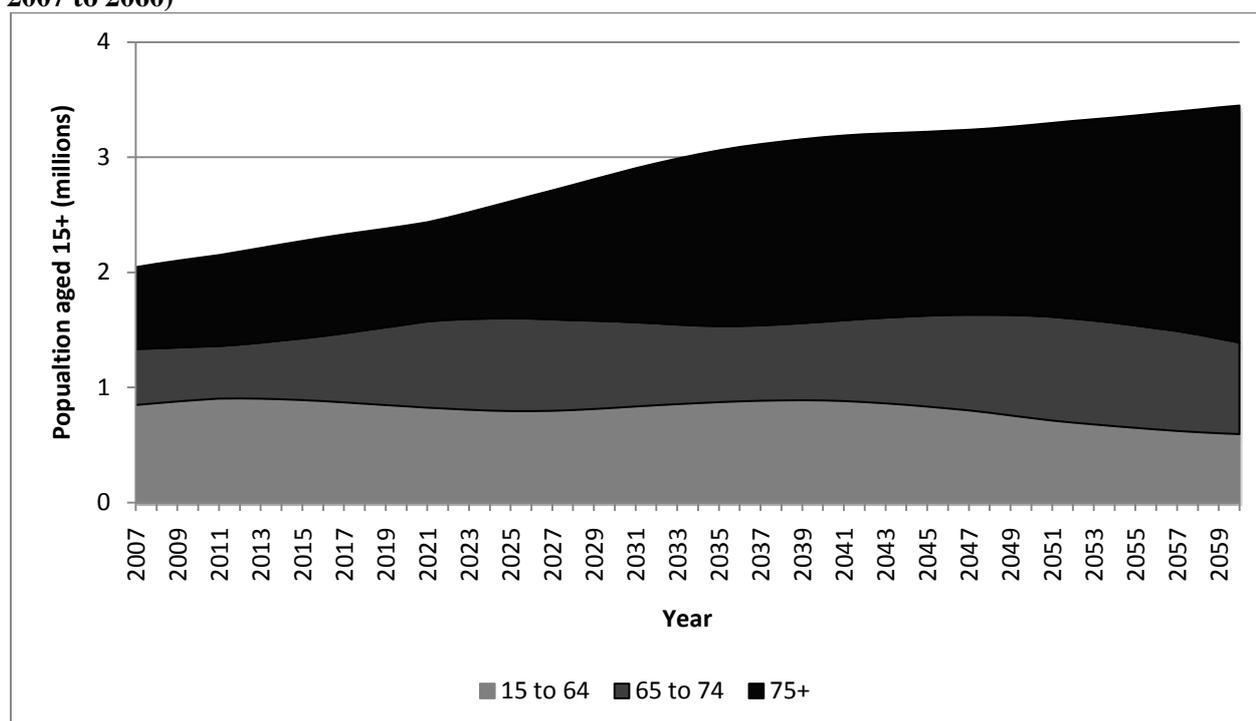
Source: World Bank staff calculations, based on Eurostat (2009a, b, and c)

**Figure 4.5: Projected Annual Population Growth for Poland by Dependency Level (Percent, 2007 to 2060)**



Source: World Bank staff calculations, based on Eurostat (2009a, b, and c)

**Figure 4.6: Projection of the Severely Hampered Population in Poland by Age Group (millions, 2007 to 2060)**



Source: World Bank staff calculations, based on Eurostat (2009a, b, and c)

Some of the projected increases in the severely hampered population could be reduced if the health status of the elderly population improves in the future. The projections presented above assume constant dependency levels over age groups for the next 50 years. If the health status of the population improves over time, elderly populations in the future might display lower care dependency rates. In other words, the share of the 75+ population who can live independently might increase, leading to a less pronounced increase in the severely hampered population. Healthy life styles during younger ages, with a focus on preventive health care and a reduction of unhealthy behavior like tobacco consumption and obesity, can reduce morbidity among the elderly in the future. Medical progress—in particular with regard to neurological diseases like Alzheimer—is another important, yet difficult to predict determinant of future dependency levels.

The share of the dependent elderly population in Poland is clearly above EU average, which suggests that there might indeed be potential to improve the health status of the elderly population. In 2007, 45 percent of the 85+ population in Poland was severely hampered, compared to an EU average of only 37.5 percent (see Table 4.2). The proportions vary widely from 27.9 in the Netherlands to 58.9 in Estonia, and they also show considerable variation over time, even from year to year, raising questions about the accuracy of the data on dependency levels.

Nevertheless, even if current dependency levels are not measured accurately or if they improve over time, the underlying demographic dynamics that drive the projections are highly reliable. Demographic projections are highly reliable because their main determinates are contained in today's population structure, in particular the number of women in childbearing age. Although some uncertainties exist about future fertility and migration rates, demographic projections have proven relatively accurate, even in the very long run. Hence, even if dependency rates improve over time, the marked increase in the 75+ age group will certainly lead to a strong increase in the dependent population.

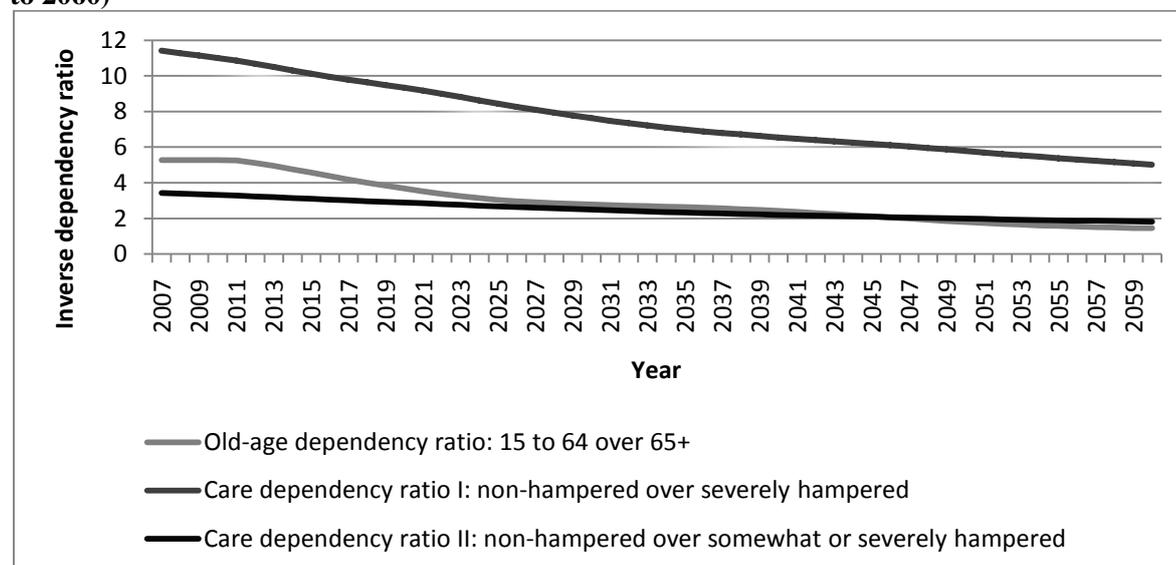
**Table 4.2: Share of Severely Hampered Population among Those aged 85 or older in Selected European Countries (percent, 2004 to 2007)**

	2004	2005	2006	2007
AT	48.1	48.5	52.6	43.5
CZ		32.0	41.5	32.9
DE		46.8	46.6	43.4
EE	62.9	69.1	56.6	58.9
ES	30.8	34.8	35.3	33.0
EU average		36.1	38.3	37.5
FI	35.5	40.2	40.0	38.7
FR	36.9	39.5	34.0	40.3
GR	26.4	32.6	28.7	35.7
HU		50.7	53.6	47.3
IE	33.9	23.2	32.0	29.8
IT	34.1	39.7	42.6	42.0
LT		61.9	55.7	52.7
LV		47.1	46.9	39.7
NL		22.8	32.9	27.9
NO	23.5	20.9	32.7	28.2
PL			39.9	45.0
PT	48.1	52.1	51.7	54.7
RO				47.4
SI		30.5	32.4	33.2
SK		46.7	56.4	51.0
UK		27.9	36.9	31.3

Source: Eurostat (2009b)

These projected demographic changes will lead to skewed dependency ratios. The inverse old-age dependency ratio is projected to decrease from currently 5.28 people in working age per elderly to only 1.45 in 2060 (see Figure 4.7). In other words, there will be less than two workers per retiree by 2060. The decline of the inverse care-dependency ratio for the severely hampered is even steeper. While currently there are 11 non-hampered persons per one severely hampered individual, by 2060, this ratio will decrease to 5 to 1. Taking into account also the somewhat hampered population, the inverse care-dependency ratio will decline from 3.4 today to 1.8 by 2060.

**Figure 4.7: Projected Inverse Old-age and Care Dependency Ratios of the Polish Population (2007 to 2060)**



Source: Authors' calculations, based on Eurostat (2009a, b, and c)

In summary, the Polish population is projected to undergo a profound demographic transition over the next 50 years. The working age population and the non-hampered population will decline significantly, while the elderly and severely hampered populations will expand strongly. This leads to the crucial question: Who will care for the elderly and who will pay for their care? The next section will start investigating this question by looking at current expenditures on LTC.

## 4.2 Description of Long-term Care: Provision and Financing

### Provision

Long-term care benefits and services are spread across different parts of the social security system. The social security system is made up of the health care system, the social insurance system, and the social assistance system (see Scheme 1). Two types of LTC benefits are available across the social security system and they include cash benefits and in-kind benefits (see Scheme 2). The total number of beneficiaries receiving these benefits is outlined in Table 4.3. As of 2007, 3,281,870 people received cash benefits while 14,263 people received in-kind benefits. The following sections provide a more detailed description of each type of benefit under the systems that provide LTC.

**Scheme 1: Structure of LTC benefits in Polish social security system**

Healthcare system	Social insurance system			Social assistance system
Healthcare insurance	Social insurance	Social insurance for farmers	State funded social security	
<b>Long-term care benefits</b>				

Source: Więckowska's elaboration

**Scheme 2: Type of LTC benefits within Polish social security system**

Benefits in cash		Benefits in kind	
Social insurance system (insurance)	Social assistance system (budget)	Healthcare system (insurance)	Social assistance system (budget)

Source: Więckowska's elaboration

**Table 4.3: LTC beneficiaries in Poland**

	2005	2006	2007
<b>in thousands</b>			
Cash benefits	3,103.45	3,176.00	3,281.87
In-kind benefits	139.04	141.88	142.63
<b>TOTAL</b>	<b>3,242.49</b>	<b>3,317.88</b>	<b>3,424.50</b>
<b>as %</b>			
Cash benefits	95.7	95.7	95.8
In-kind benefits	4.3	4.3	4.2
<b>TOTAL</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

Source: Więckowska's calculation

### Cash benefits

Cash benefits are paid out either as care supplements to various pensions paid from social security or as care allowance paid from social assistance.<sup>44</sup> There are two eligibility criteria that entitle beneficiaries to cash benefits: (i) frailty; or (ii) age. In the former case, beneficiaries have to prove total incapacity to work (for care supplements) or a serious disability or care responsibility for a disabled child (for the care allowance). In the latter case, the only eligibility

<sup>44</sup> Social security in Poland comprises a general scheme (ZUS), a farmer's scheme (KRUS), and various state-funded schemes for specific occupations.

criterion is that the beneficiary is at the age of 75. Hence, by law, all beneficiaries of the social insurance system aged 75 and over are automatically entitled to the care supplement.

### *Social Insurance System*

The cash benefit under this system is provided as a care supplement. Although not explicitly stated in law, this cash benefit is intended to support informal care, home-based care and day care. The care supplement is suspended if stay in social welfare homes (SWHs) or nursing homes exceed two weeks in one month. The care allowance amount is equivalent under all components of the social insurance system. The amount is determined by the President of Social Insurance Institutional and is published through the official journal of Republic of Poland (*Monitor Polski*). As of January 2009, the care supplement was in the amount 173.10 PLZ (39.62 Euro).

### *Social Assistance System*

Care allowances under the social assistance system are based on a disability and age criteria. The benefit is provided regardless of family income. The care allowance amount is equivalent to the care supplement amount provided through the social insurance system.

The total number of beneficiaries receiving cash benefits from both the social insurance system and the social assistance system is presented in Table 4.4. As of 2008 3,777,460 beneficiaries received LTC cash benefits. More than half of these beneficiaries received these benefits based on the age eligibility criteria.

**Table 4.4: Number of beneficiaries of cash benefits by eligibility criteria (2005 to 2008)**

	2005	2006	2007	2008
<b>Total</b>	<b>3,103,450</b>	<b>3,176,000</b>	<b>3,281,860</b>	<b>3,377,460</b>
<i>due to frailty</i>	1,453,520	1,437,080	1,442,220	1,435,620
<i>due to age</i>	1,649,930	1,738,920	1,839,640	1,941,840

Source: Więckowska's calculation (for missing data concerning care allowances it was assumed split into categories (shares) is as in 2008).

### **In-kind benefits**

In-kind LTC benefits are provided either in an inpatient setting in LTC institutions or in outpatient settings as home-based care. Inpatient care in Poland is provided either within the health sector, in medical nursing homes and hospices; or within the social assistance sector, in SWHs. Medical nursing homes aim at rehabilitating and remobilizing patients so they can return to their homes and live independently. This includes post-surgery patients who have temporarily lost their ability to live independently until further rehabilitation. Accordingly, the maximum length of stay in medical nursing homes is set at six months. In the social assistance sector, inpatient care is provided in SWHs. These homes provide care for those who are unable to live independently.<sup>45</sup> These include the elderly, but also the disabled, the mentally ill, and the chronically ill. Unlike medical nursing homes, there is no maximum length of stay in SWHs.

### *Health care system*

Within the health care system in Poland two types of LTC services are provided: palliative (and hospice) care and nursing care (see The aim of outpatient nursing care at home is to provide services to chronically ill patients who stay at home (and are not qualified for hospitalization) but who, due to the existing healthcare conditions, need systematic and intensive nursing care. This

<sup>45</sup> This definition follows Kozierekiewicz and Szczerbinska (2007)

care is combined with patient's general practitioner care (please note: for home nursing care a patient needs a referral from general practitioner).

Scheme 3). Characteristics of the care services and types of institutions correlated with it are outlined in the National Health Fund Presidents' ordinance No. 61/2007/DSOZ (dated August 6<sup>th</sup> 2008).

The aim of outpatient nursing care at home is to provide services to chronically ill patients who stay at home (and are not qualified for hospitalization) but who, due to the existing healthcare conditions, need systematic and intensive nursing care. This care is combined with patient's general practitioner care (please note: for home nursing care a patient needs a referral from general practitioner).

**Scheme 3: Types of institutions within LTC financed from public healthcare sector**

	ambulatory care	palliative and hospice care	palliative medicine clinic
outpatient care	home care	nursing care	long-term care services for mechanically ventilated patients long-term care services for mechanically ventilated children nursing care at home
		palliative and hospice care	home hospices home hospices for children
inpatient care		nursing care	wards for chronically ill care home care home for youth and children medical home medical home for vegetative patient medical home for mechanically ventilated patients medical home for youth and children medical home for mechanically ventilated children
		palliative and hospice care	palliative care ward Hospice

Source: Więckowska's elaboration based on National Health Fund Presidents' ordinance No. 61/2007/DSOZ (from August 6th 2008).

In Poland two types of inpatient nursing homes, with historically different missions: care homes (zakład pielęgnacyjno-opiekuńczy ZPO) – which provide personal daily care and medical homes (zakład opiekuńczo-leczniczy ZOL) – which provide medical nursing care. Currently however, the mission and function of ZPOs and ZOLs are similar and for this reason, the number of these homes is combined.

The aim of nursing homes in Poland is to provide a 24-hour nursing and medical treatment for chronically ill patient and for patients recently discharged from hospitals, after successful treatment and/or surgery. These patients do not need further hospitalization but due to their frailty and inability to live independently in their home environment, they are in need of third party assistance, professional personal care, rehabilitation and nursing care.

The number of patients by age in nursing homes and hospices from 2005 through 2007 are presented in Table 4.5. In 2007, 76 percent of patients in nursing homes and in hospices were over the age of 60. Table 4.6 shows the capacity of the LTC hospital system and the number of patients utilizing those services. It is important to note that these totals are for all long term care recipients and not just for the elderly. Table 4.7 shows the total number of nursing home institutions and total number of patients for 2005 through 2007. As of 2007, there are a total of 407 nursing homes in Poland.

**Table 4.5: Patient structure in LTC institution in Poland, by age (2005 to 2007)**

	2005			2006			2007		
	Nursing homes	Hospices	Total*	Nursing homes	Hospices	Total*	Nursing homes	Hospices	Total*
<i>18 and less</i>	577	7	584	577	16	593	495	23	518
<i>19-40</i>	357	20	377	308	22	330	764	24	788
<i>41-60</i>	1,746	193	1,939	1,865	159	2,024	3,605	151	3,756
<i>61-74</i>	3,751	254	4,005	3,762	211	3,973	4,793	216	5,009
<i>75 and more</i>	9,102	267	9,369	9,712	284	9,996	10,832	253	11,085
<b>TOTAL</b>	<b>15,533</b>	<b>741</b>	<b>16,274</b>	<b>16,224</b>	<b>692</b>	<b>16,916</b>	<b>20,489</b>	<b>667</b>	<b>21,156</b>
	<b>as %</b>								
<i>18 and less</i>	4%	1%	4%	4%	2%	4%	2%	3%	2%
<i>19-40</i>	2%	3%	2%	2%	3%	2%	4%	4%	4%
<i>41-60</i>	11%	26%	12%	11%	23%	12%	18%	23%	18%
<i>61-74</i>	24%	34%	25%	23%	30%	23%	23%	32%	24%
<i>75 and more</i>	59%	36%	58%	60%	41%	59%	53%	38%	52%
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

\* Note: As of 31. December

Source: Więckowska's calculation based on: Basic data on health service and social welfare, Central Statistical Office, 2006, 2007, 2008.

**Table 4.6: Capacity of LTC services in Poland (2004 to 2007)**

Year	beds in inpatient care	places in daycare	patients in inpatient care	patients in home care	patients in daycare
2004	17,772	198	51,260	6,459	216
2005	19,965	385	57,231	22,310	443
2006	21,043	170	60,044	11,311	173
2007	21,559	170	60,444	7,772	150

Source: Więckowska's calculation based on: Statistical Bulletin of Ministry of Health 2005, 2006, 2007, 2008.

**Table 4.7: Nursing homes in Poland (2005 to 2007)**

	Institutions	Beds	patients (total)	average length of stay	patient-days per bed	ratio per 10000 population	
						Beds	Patients
2005	350	16,440	41,374	135.95	342	4.31	10.84
2006	373	17,291	43,249	135.88	340	4.54	11.34
2007	407	21,543	48,553	157.27	354	5.65	12.74

Source: Więckowska's calculation based on: Basic data on health service and social welfare, Central Statistical Office, 2006, 2007, 2008.

### *Social assistance system*

LTC services in social assistance comprise of:

- (1) home based care services and specialized care services,
- (2) services in family social welfare houses
- (3) services in support centers
- (4) services in social welfare houses
- (5) services in centers for disabled, chronically ill or elderly run as an enterprise.

Care services and specialized care services are provided to those who live alone and need assistance because of their age, illness or disability. They can also be provided to a person who lives with their family but needs help because his/her family cannot provide such help. Care services comprise of fulfilling activities of daily living "ADL" (cleaning, washing, doing shopping, cooking), hygienic care, and for maintaining social contact.

Care and specialized care services are provided by welfare centers and by other institution. Family welfare homes are designated for 3-8 inhabitants. Support centers provide semi-stationary LTC services mainly through: day centers, dosshouses and eating-houses. The aim of these institutions is to support informal care provided in the patient's home.

The most common form of stationary LTC institutions in Poland are SWHs. The classification of SWHs is presented in

Scheme 1. Social welfare homes vary by the type of beneficiary. Among others (see Scheme 4), there are SWHs for the elderly, the chronically ill and the disabled. As of 2007, there were 215 SWHs serving 14,043 elderly beneficiaries (see Table 4.8). The total number of beneficiary receiving any of the services provided by the social assistance system is outlined in Table 4.9, by age. In 2007, 15,158 elderly over the age of 60 received LTC benefits through the social assistance system.

### **Scheme 4: Types of social welfare homes in Poland**

<b>Social welfare home</b>	<b>social welfare home for the elderly</b>
	<b>social welfare home for chronically ill</b>
	<b>social welfare home for chronically mentally ill</b>
	<b>social welfare home for adults intellectually disabled</b>
	<b>social welfare home for children and youth intellectually disabled</b>
	<b>social welfare home for physically disabled</b>

Source: Więckowska's elaboration.

**Table 4.8: Social welfare homes by type (2005 to 2007)**

	Total	for the elderly		for the chronically ill		for the adults intellectually disabled		for the children and youth intellectually disabled		for the chronically mentally ill		for the physically disabled	
		N	%	N	%	N	%	N	%	N	%	N	%
<b>Institutions</b>													
2005	823	200	24.3%	219	26.6%	151	18.3%	99	12.0%	143	17.4%	11	1.3%
2006	821	203	24.7%	214	26.1%	152	18.5%	96	11.7%	145	17.7%	11	1.3%
2007	942	215	22.8%	244	25.9%	169	17.9%	110	11.7%	177	18.8%	27	2.9%
<b>Places</b>													
2005	81,246	14,877	18.3%	24,850	30.6%	15,042	18.5%	8,047	9.9%	17,320	21.3%	1,110	1.4%
2006	80,404	15,228	18.9%	23,679	29.5%	14,969	18.6%	7,804	9.7%	17,566	21.8%	1,158	1.4%
2007	<i>Nd</i>	<i>Nd</i>		<i>Nd</i>		<i>Nd</i>		<i>Nd</i>		<i>Nd</i>		<i>Nd</i>	
<b>Inhabitants</b>													
2005	78,887	14,027	17.8%	23,788	30.2%	14,824	18.8%	7,967	10.1%	17,178	21.8%	1,103	1.4%
2006	78,672	14,523	18.5%	22,912	29.1%	14,878	18.9%	7,750	9.9%	17,476	22.2%	1,133	1.4%
2007	78,407	14,043	17.9%	21,245	27.1%	14,324	18.3%	7,759	9.9%	19,248	24.5%	1,788	2.3%

Source: Więckowska's calculation based on: Basic data on health service and social welfare, Central Statistical Office, 2006, 2007, 2008

**Table 4.9: Inhabitants of social assistance institutions for the elderly (2005 to 2007)**

	Inhabitants		age groups				
	total	of which women	18 and less	19-40	41-60	61-74	75 and over
2005	15,720	10,243	22	145	1,309	3,854	10,390
2006	16,673	10,913	22	181	1,482	4,085	10,903
2007	16,617	10,675	-	112	1,347	3,890	11,268

Source: Basic data on health service and social welfare, Central Statistical Office, 2006, 2007, 2008.

## Financing

Public expenditure on LTC services is financed by social insurance, the National Health Fund and by state and local budget funds. Table 4.10 shows total spending on LTC by each entity. The social insurance system is financed mostly by contributions from the insured and by the State<sup>46</sup>. The National Health Fund is a national health insurance system that is intended to provide universal health coverage. The system is financed by payroll tax collected from employers, self pay and by the State for those who cannot afford self pay<sup>47</sup>. State and local budgets finance long-term care services from tax revenue.

**Table 4.10: Total public spending on LTC services in Poland, by financing source (millions, 2005-2008)**

	2005	2006	2007	2008
<i>social insurance</i>	4,259.19	4,595.50	4,695.00	5,102.31
<i>As %</i>	43	42	40	38
<i>health insurance</i>	537.16	598.56	717.52	988.40
<i>As %</i>	5	6	6	7
<i>budget funds</i>	5,139.73	5,642.22	6,182.30	7,182.25
<i>As %</i>	52	52	53	54
<b>TOTAL</b>	<b>9,936.09</b>	<b>10,836.28</b>	<b>11,594.82</b>	<b>13,272.96</b>

*Source:* World Bank staff calculation, based on expenditures data from Ministry of Finance.

### *Cash benefits*

Cash benefits are funded by the social insurance and the social assistance systems in Poland. As previously mentioned the social insurance systems are made up of the three different systems: social insurance, run by the Social Insurance Institution; social insurance for farmers (run by the Agricultural Social Insurance Fund; and the state funded social security for teachers, soldiers, policemen and public prosecutors. As of 2008, two-thirds of cash benefits provided by the social insurance were covered by the Social Insurance Institution (ZUS), and the rest was financed by the Agricultural Social Insurance fund (KRUS). Cash benefits provided by the social assistance system are financed by tax revenue. The State social security system for teachers, soldiers, policemen and public prosecutors is excluded from this analysis.

### *In-kind benefits*

Financing for in-kind services varies depending on the LTC service. For example, inpatient care is financed jointly by the health sector and by the social sector. In the health sector, the National Health Fund, the State budget and local governments contribute to cost of inpatient care. In the social sector, financial contributions come from the State budget and from local government budget. Similar cost divisions are made for other in-kind services. Overall costs for in-kind services come from local budgets (see Table 4.11). In 2008, 84 percent of in-kind services were financed by local budgets while 15 percent came from the National Health Fund and only 2 percent was financed from the State budget.

<sup>46</sup> Social Insurance Institution (2009)

<sup>47</sup> Berman (1998)

**Table 4.11: Annual expenditures on in-kind benefits by benefit type and funding source (current PLZ, millions, 2005 to 2008)**

	2005	2006	2007	2008
<b>Inpatient</b>	<b>2,044</b>	<b>2,242</b>	<b>2,445</b>	<b>3,022</b>
Health sector	537	599	718	988
<b>As %</b>	<b>26</b>	<b>27</b>	<b>29</b>	<b>33</b>
<i>HIF</i>	516	578	702	970
<i>State budget</i>	10	7	8	9
<i>Local governments</i>	11	13	7	10
Social sector	1,507	1,643	1,727	2,033
<b>As %</b>	<b>74</b>	<b>73</b>	<b>71</b>	<b>67</b>
<i>State budget</i>	21	42	37	46
<i>Local governments</i>	1,487	1,601	1,690	1,988
<b>Outpatient (social sector)</b>	<b>2,520</b>	<b>2,756</b>	<b>3,117</b>	<b>3,637</b>
<i>State budget</i>	36	41	48	57
<i>Local governments</i>	2,484	2,715	3,069	3,580
<b>Total public expenditure</b>	<b>4,564</b>	<b>4,998</b>	<b>5,562</b>	<b>6,659</b>
<i>Total HIF</i>	516	578	702	970
<b>As %</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>15</b>
<i>Total state budget</i>	66	90	93	111
<b>As %</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>2</b>
<i>Total local governments</i>	3,982	4,329	4,766	5,578
<b>As %</b>	<b>87</b>	<b>87</b>	<b>86</b>	<b>84</b>

Source: World Bank staff calculation, based on expenditures data from Ministry of Finance.

### 4.3 Current Public Expenditures on Long-term Care

Public expenditures on LTC care increased rapidly between 2005 and 2008. In 2005, the public costs of providing benefits for dependent people totaled to nearly PLZ 10 billion, and within three years, it increased by over 30 percent to PLZ 13 billion (see Table 4.12). Expenditures on in-kind services have increased at a much higher pace than expenditures on cash benefits (10.6 percent versus 4.5 percent, see Table 4.13). Among cash benefits, eligibility claims due to age expanding much faster than eligibility claims due to frailty.

The current eligibility criteria make the LTC cash benefits vulnerable to expenditure increases caused by an aging society. Because everyone older than 75 is eligible for cash benefits, the projected significant increase of the 75+ age group could pose particular challenges for this benefit in the future. As the proportion of the elderly population increases in the future, the number of potential beneficiaries eligible for cash benefits is expected to increase as well if the age based eligibility criterion remains in status quo. The policy objective of LTC cash benefits must be revisited: Are cash benefits intended to support those in need of LTC services, or is it meant as a tool to fight old-age poverty in general, or both? Currently, the latter seems to be the case; support is provided to the dependent population up to the age of 74, and to everyone above the age of 75. In this context it is important to note that of the 862,000 beneficiaries of the care supplement paid by ZUS aged between 75 and 79, only 97,000 received the benefit due to frailty.

That is, according to administrative data, only as little as 11 percent of the 75 to 79-year old beneficiaries might actually be dependent, which is well below of what is suggested by data derived from surveys (between 17 and 29 percent, see Table 4.12).<sup>48</sup>

**Table 4.12: Annual Expenditures on Benefits by Eligibility Criteria and Type of Service (Current PLZ, millions, 2005 to 2008)**

	2005	2006	2007	2008
<b>Cash benefits - total expenditure</b>	<b>5,372</b>	<b>5,838</b>	<b>6,033</b>	<b>6,614</b>
<i>due to frailty</i>	2,516	2,642	2,651	2,813
<i>due to age</i>	2,856	3,197	3,382	3,802
<b>In-kind benefits - total expenditure</b>	<b>4,564</b>	<b>4,998</b>	<b>5,562</b>	<b>6,659</b>
<i>Inpatient</i>	2,044	2,242	2,445	3,022
<i>Outpatient (social sector)</i>	2,520	2,756	3,117	3,637
<b>Total public expenditure</b>	<b>9,936</b>	<b>10,836</b>	<b>11,595</b>	<b>13,273</b>

Source: World Bank staff calculations (see Section 4.3).

**Table 4.13: Annual Real Growth Rates of Expenditures on Cash and in-kind Benefits by Benefit Type (percent, 2006 to 2008)**

	2006	2007	2008	Total	Average annual growth
<b>Cash benefits - total expenditure</b>	<b>7.60%</b>	<b>0.81%</b>	<b>5.22%</b>	<b>14.14%</b>	<b>4.51%</b>
<i>due to frailty</i>	3.96%	-2.09%	1.81%	3.63%	1.19%
<i>due to age</i>	10.82%	3.21%	7.89%	23.40%	7.26%
<b>In-kind benefits - total expenditure</b>	<b>8.42%</b>	<b>8.57%</b>	<b>14.89%</b>	<b>35.25%</b>	<b>10.59%</b>
<i>Inpatient</i>	8.57%	6.39%	18.63%	37.03%	11.07%
<i>Outpatient (social sector)</i>	8.30%	10.34%	11.96%	33.80%	10.19%

Source: World Bank staff calculations (see Section 4.3).

Total expenditures on in-kind benefits increased from PLZ 4.6 billion in 2005 to PLZ 6.7 billion in 2008. In real terms, this was an increase of over 35 percent within three years, or about 10.6 percent annually (see Table 4.2). The main increase occurred in the health sector, which almost doubled from PLZ 516 to 970 million (see Section 4.4). In addition, expenditures from the state budget for inpatient care in the social sector more than doubled, albeit from an initial low level. Expenditures for in-kind outpatient care increased from PLZ 2.5 billion in 2005 to PLZ 3.6 billion in 2008. Hence, for the last three years, real expenditures on outpatient care have been increasing on average by over 10 percent annually. Since outpatient care is provided exclusively by the social sector, these expenditures are almost entirely born by local governments. Expenditure on case benefits has increased by 14 percent.

Part of the significant growth in expenditures on in-kind benefits can be explained by an increase in beneficiaries. In particular, inpatients in the health sector have been increasing from 16,300 in

<sup>48</sup> Admittedly, the administrative data is biased because those beneficiaries above the age of 75 who initially receive the benefit due to age, but become dependent subsequently, are not re-registered as receiving the benefit due to frailty.

2005 to 21,500 in 2008, an increase of 32 percent. The number of inpatients in the social sector, however, has been relatively stable.

The largest increase in expenditure per beneficiary has been for inpatient beneficiaries in the health sector – where there is an average annual real increase of almost 9 percent (see Table 4.14). Expenditures per patient in the social sector are considerably lower at PLZ 24,400 per year in 2008, but the annual real expenditure increase per patient is almost as high as in the health sector (7 percent). Expenditures per (potential) beneficiary of outpatient LTC services are relatively low compared to inpatient expenditures, at only PLZ 1,731 in 2008. Although overall expenditure on outpatient LTC is high and growing fast, expenditures per beneficiary is low due to the high numbers of assumed beneficiaries.<sup>49</sup> The increasing expenditure on outpatient services in the LTC sector is due largely to an increasing number of beneficiaries and not due to increasing expenditure per beneficiary.

**Table 4.14: Annual Real Growth Rates of Expenditures per Beneficiary by Benefit Type and Sector (percent, 2006 to 2008)**

	2006	2007	2008	Total	Average annual
<b>Cash benefits</b>	5.15%	-2.44%	2.24%	4.88%	1.60%
<b>Inpatient benefits</b>	7.83%	1.67%	16.81%	28.06%	8.59%
<i>In health sector</i>	6.14%	-6.49%	30.17%	29.19%	8.91%
<i>In social sector</i>	7.91%	2.11%	11.26%	22.59%	7.02%
<b>Cash and inpatient benefits</b>	5.46%	-0.98%	6.04%	10.73%	3.46%
<b>Outpatient benefits</b>	n.a.	n.a.	10.46%	10.46%	10.46%
<b>Total</b>			7.39%	7.39%	7.39%

Note: n.a. for not available.

Source: World Bank staff calculation, based on expenditures data from Ministry of Finance.

Public expenditures on LTC per beneficiary, including expenditure for outpatient LTC services for the severely hampered, currently make up 7.1 percent of per capita income in Poland (see Table 4.15). This share varies widely, depending on benefit type. Public expenditure in the health sector, per beneficiary, reached 138 percent of per capita income in 2008. Since 2005, shares for cash benefits have been decreasing (-4.1 percent on average annually), but increasing for in-kind benefits (+2.5 percent). As before, 2008 displayed a particularly strong increase (+11.4 percent in the health sector).

<sup>49</sup> Due to lack of data on beneficiaries of outpatient LTC, it is assumed that the entire severely hampered population that does not benefit from other in-kind LTC services consumes outpatient LTC benefits.

**Table 4.15: Real Expenditures per Beneficiary by Benefit Type and Sector as share of real GDP per capita (percent, 2005 to 2008)**

	2005	2006	2007	2008
<b>Cash benefits</b>	<b>6.67%</b>	<b>6.60%</b>	<b>6.03%</b>	<b>5.88%</b>
<b>Inpatient benefits</b>	80.29%	81.49%	77.58%	86.44%
<i>In health sector</i>	<i>127.15%</i>	<i>127.02%</i>	<i>111.23%</i>	<i>138.12%</i>
<i>In social sector</i>	<i>70.96%</i>	<i>72.07%</i>	<i>68.91%</i>	<i>73.14%</i>
<b>Cash and inpatient benefits</b>	<b>8.92%</b>	<b>8.86%</b>	<b>8.21%</b>	<b>8.31%</b>
<b>Outpatient benefits</b>	n.a.	n.a.	<b>4.93%</b>	<b>5.20%</b>
<b>Total</b>			<b>6.97%</b>	<b>7.14%</b>

*Note:* n.a. for not available.

*Source:* World Bank staff calculation, based on expenditures data from Ministry of Finance.

#### 4.4 Fiscal Impact of Future Long-term Care Spending

As shown in the previous section, public expenditures on in-kind LTC benefits have grown substantially over the last three years. To some extent, these increases in public expenditures are certainly necessary investments in infrastructure and equipment. It is unclear, though, to what extent these increases, which largely occur on the local government level, are also driven by an increasing demand for formal LTC services. This section aims to project future LTC expenditure using current patterns of public expenditures on LTC while considering potential GDP growth. The projections will be used to discuss potential fiscal implications. The projections show that current expenditures patterns, based on expenditure growth over the past three years, are not fiscally sustainable. Further analysis leads to the following two main insights: first, cost control of in-kind benefits is crucial to avoid a rapid expansion of public expenditures on LTC; and second, cash benefits due to aging will lead to considerable fiscal pressures during the 2020s and again after 2050.

#### The Macroeconomic Environment: Projections on real GDP Growth

Poland's average real GDP growth is projected to fall significantly over the next 50 years. According to the International Monetary Fund (IMF), Poland's real GDP will decline by -0.7 percent in 2009, resume growth in 2010 (+1.3 percent), and return to its potential growth rate of 3.8 percent in 2011.<sup>50</sup> The European Commission, taking into account population aging, projects that Poland's economy will grow 3.8 percent on average in the 2010s.<sup>51</sup> Thereafter, though, Poland's potential growth rate will significantly decline. Between 2021 and 2040, the European Commission estimates an average growth rate of only 1.7 percent and from 2041 onwards a mere 0.4 percent. Applying a linear trend on these projections between 2011 and 2060, Poland's potential growth rate would actually be -0.42 percent by 2060.

<sup>50</sup> See IMF (2009)

<sup>51</sup> See European Commission (2009)

Nevertheless, taking into account the negative population growth over the same period, actual GDP per capita will continue to grow at a positive, yet diminishing rate. Combining the linear trend on GDP growth with the population projections from section 4.1 shows that GDP per capita growth will decrease from 3.6 percent in 2011 to 0.32 percent in 2060.

## **Expenditure Projections**

The projections presented below are based on a simple question: given today's LTC policy in Poland, what would happen with expenditures in the future? In other words, given today's expenditures per beneficiary and the age-specific coverage of benefits, how will aging impact total spending on LTC in the future?

## **Methodology**

The methodology applied for the projections is driven by certain assumptions on (i) the share of the population who receives benefits; and (ii) the amount of public expenditures per beneficiary. First, the share of beneficiaries over age groups is assumed to remain at the 2008 level. For example, in 2008, 5.32 percent of the 60 to 64 age group received a cash benefit due to frailty. The projections assume that this percentage stays constant. In other words, in 2060 as in 2008, 5.32 percent of the same age group is assumed to receive this particular benefit. Similar assumptions are made for (i) cash benefits due to age; (ii) in-kind benefits for inpatient care in the health sector; (iii) in-kind benefits for inpatient care in the social sector; and (iv) in-kind benefits for outpatient care in the social sector. Hence, changes in the total number of beneficiaries are entirely driven by the aging of the Polish population. Potential changes like shifting demand for different types of LTC benefits will not be considered in the projections.

Second, different scenarios are developed according to potential future changes in real expenditures per beneficiary for the different types of benefits. As the previous section has shown, the annual growth rates of real expenditures per beneficiary for the last three years vary from -2.4 to +5.2 percent for cash benefits and -6.5 to +30.2 percent for inpatient benefits (see Table 4.5). For outpatient benefits, on the other hand, expenditure growth data is only available for one year. This makes it very difficult to make prudent assumptions on the future development of expenditures per beneficiary, so different scenarios are provided to delimit potential developments.

Scenario 1 assumes that real expenditures per beneficiary will continue to grow at the average rate of the last three years.<sup>52</sup> Since even on average real expenditures have been growing at a comparatively high rate over the last years, the projections for this scenario result in very high, fiscally unsustainable expenditure levels.

Scenario 2, on the other hand, represents an opposite extreme, assuming that real expenditures per beneficiary will stay constant at 2008 levels for in-kind benefits. For cash benefits, Scenario 2 assumes a moderate annual increase of 20 percent of GDP per capita growth.<sup>53</sup> Accordingly,

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<sup>52</sup> In the case of outpatient benefits, expenditures are assumed to continue to grow at the same rate as in 2008.

<sup>53</sup> Polish law stipulates that the real value of cash benefits have to be increased by at least 20 percent of real wage growth every year.

public expenditures under this scenario are much lower. Even under this fiscally unfavorable scenario, and while assuming that the expected cost pressure in the care sector is very unlikely, overall public expenditure on LTC is still projected to increase.

Scenario 3, finally, tries to find a reasonable middle ground. As can be seen in Table 4.5, real expenditure per beneficiary was stronger during the years of economic expansion and less strong or decreased during years of weak economic growth. This suggests, not surprisingly, that public expenditures are connected to GDP growth. This connection seems reasonable from various perspectives. First, tax revenues are higher during economic boom years, so spending increases are easier to achieve during those years. Second, (real) GDP growth implies an increase in productivity, wages, wealth, and, ultimately, standards of living. In other words, as a country grows richer, it will also want to increase the quality and extent of LTC it provides to its citizens. A good case in point is a provision in Polish law on cash benefits, which links increases in the amount of cash benefits to wage growth.

Linking expenditures per beneficiaries to GDP growth seems a reasonable assumption for capturing future public expenditure. Scenario 3 therefore assumes that real expenditures per beneficiary for the different types of benefits will grow at the same rate as real GDP per capita. Given that Poland currently has comparably low expenditures levels on LTC and has considerable backlog on the extent and quality of LTC services, this seems like a rather conservative, yet reasonable assumption for projecting future expenditure growth. It is important to note that for the last three years, such an assumption would have seriously under-estimated expenditure per beneficiary. Hence, at least for the short and medium-term, Scenario 3 should provide a reasonable, if not conservative, expenditure projection.

## **Results**

The number of beneficiaries of the various LTC benefits is expected to grow significantly over the next 50 years, especially during the 2020s and after 2050. The highest growth rates are for cash beneficiaries due to age, which—for obvious reason—is especially sensitive to aging. This category of beneficiaries is expected to grow by more than 5 percent annually in the late 2020s (see Figure 4.8). Overall, the number of cash beneficiaries due to age is expected to grow from 1.9 million in 2008 to 5.5 million in 2060. Cash beneficiaries due to frailty, on the other hand, will increase from 1.5 million to 2.6 million. The relatively small—but expensive—category of inpatient beneficiaries is expected to grow from 105,000 in 2008 to 170,000 in 2060, while outpatient beneficiaries will increase from 2.1 million to 3.4 million.

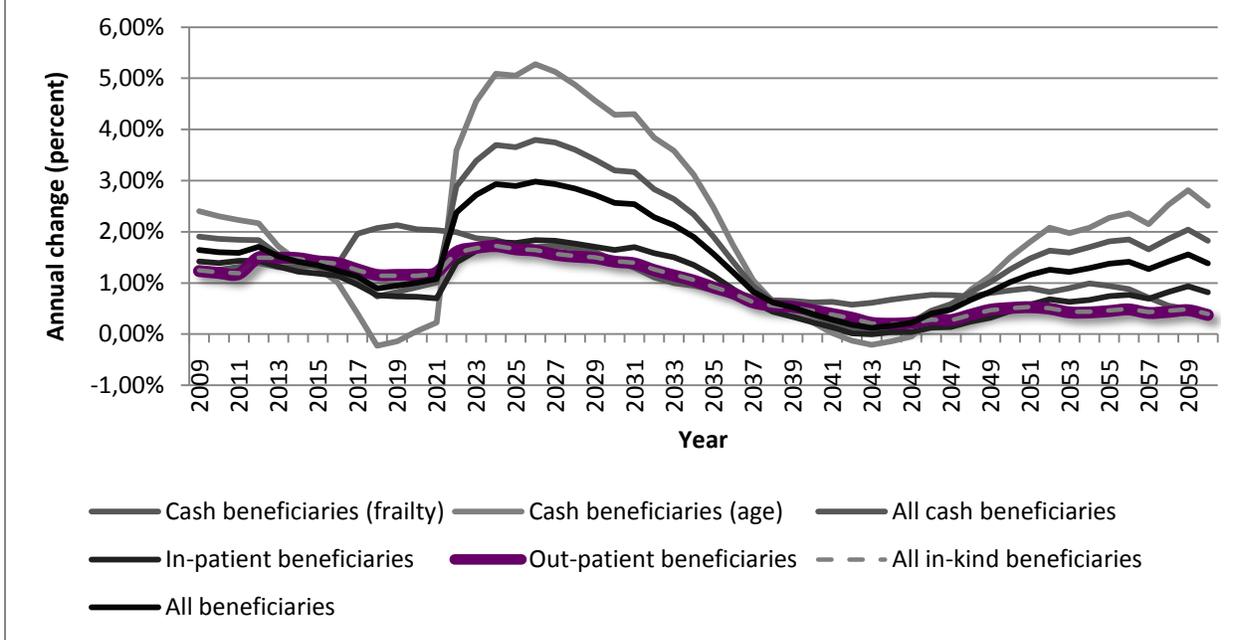
Combing these projections on beneficiaries with the various scenarios on expenditures per beneficiary reveals that the current expenditure patterns on LTC are clearly not fiscally sustainable in the long run. If real expenditures per beneficiary continue to grow as they have over the last three years, public expenditure on LTC care as a share of GDP will essentially double every 10 years and the Polish government would be spending nearly half of GDP on LTC by 2060 (Scenario 1, see Figure 4.9). The growth in public expenditures would be driven by a pronounced increase in expenditures on in-kind benefits, particularly for outpatient care. Total real expenditures on LTC would increase from currently PLZ 13 billion to PLZ 30.5 billion in 2020, to PLZ 77.9 billion in 2030, and to 1,294 billion in 2060. This translates into an average

annual growth rate of 9.4 percent. Expenditures on in-kind benefits as a share of GDP would grow in excess of 6 percent annually, gradually increasing to an annual growth rate of 10 percent by 2060 (see Figure 4.10). Expenditures on cash benefits as a share of GDP would grow at a more moderate rate.

Such an exponential increase in expenditures is of course unsustainable and relies on oversimplified assumptions of expenditures per beneficiary, but the underlying growth in the number of beneficiaries cannot be denied. Arguably, it is difficult to predict how much exactly the Polish government will spend on each beneficiary in the future. On the other hand, the number of future beneficiaries is easier to speculate because the underlying demographic trend is highly reliable. Assuming that the share of beneficiaries stays constant over age groups for the various benefits, a purely demographic projection shows that the number of LTC beneficiaries is expected to grow by around 1.5 percent annually over the next 10 years (see Figure 4.8). After 2020, though, there will be a very sudden, massive expansion of beneficiaries, with annual growth rates of up to 3 percent. The increase in the number of cash beneficiaries due to age is particularly pronounced (up to 5 percent annual growth rate). During the 2030s and the 2040s, the growth numbers are expected to decline somewhat, but will stay positive. After 2050, the growth rates will start to increase strongly again. In absolute numbers, the total number of beneficiaries will increase from 5.6 million in 2008 to 6.5 million in 2020, to 8.5 million in 2030, and to 11.6 million in 2060.

Since Scenario 1 is a pure extrapolation of past trends, the strong expenditure growth is driven by strong increases in expenditure per beneficiary on in-kind benefits over the past three years. Given that Poland is currently spending relatively little on in-kind benefits and therefore needs to invest heavily to build up infrastructure and equipment, it seems reasonable that at some point, these strong growth rates (on in-kind benefits) will decline considerably.

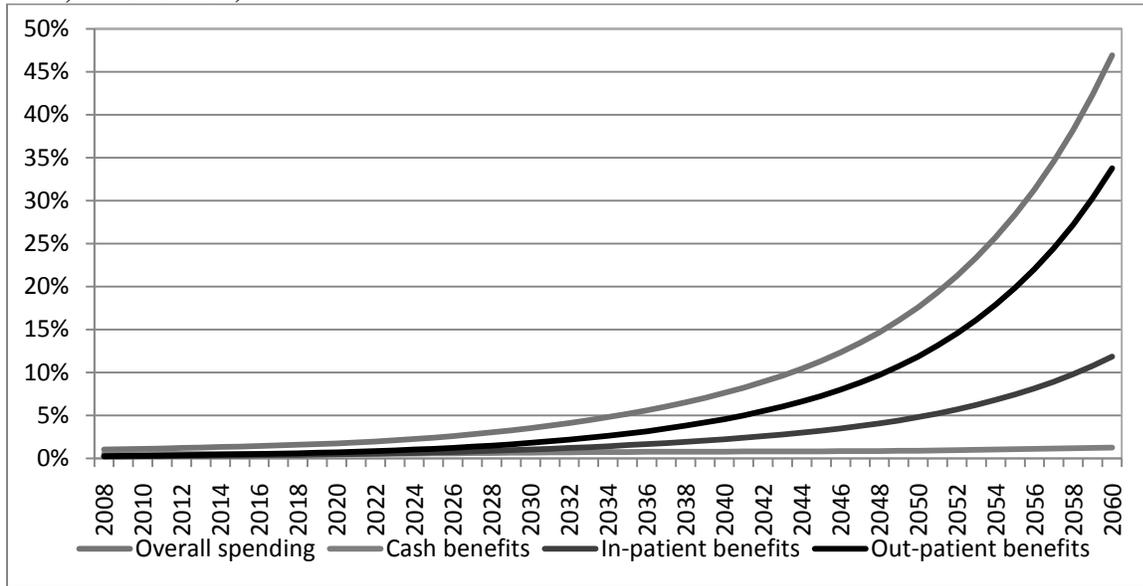
**Figure 4.8: Projected Annual Growth of Beneficiaries (percent, 2009 to 2060)**



Note: Outpatient beneficiaries and all in-kind beneficiaries grow at almost the same rate because inpatient beneficiaries only are a small part of all in-kind beneficiaries vis-à-vis outpatient beneficiaries.

Source: World Bank staff calculation, based on expenditures data from Ministry of Finance.

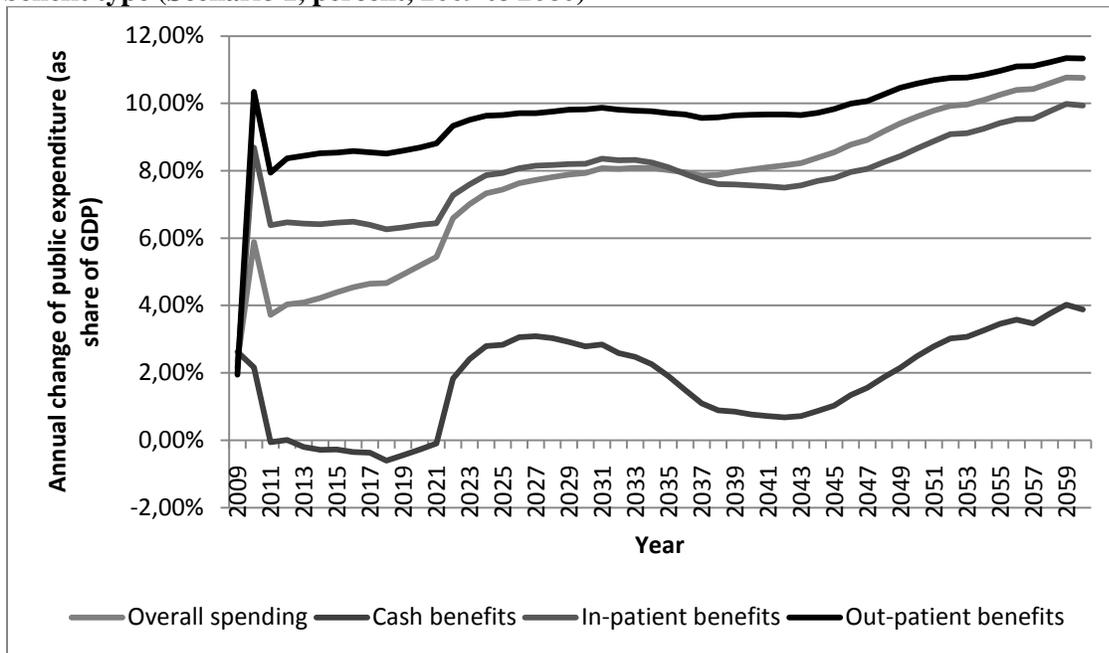
**Figure 4.9: Projected Public Expenditures on LTC by Benefit Type (Scenario 1, percent of real GDP, 2008 to 2060)**



Note: Scenario 1 assumes that real public expenditures per beneficiary continue to grow at the same rate as on average for the last one to three years.

Source: World Bank staff calculation, based on expenditures data from Ministry of Finance.

**Figure 4.10: Projected annual change of public expenditures (as share of real GDP) on LTC by benefit type (Scenario 1, percent, 2009 to 2060)**



Note: Scenario 1 assumes that real public expenditures per beneficiary continue to grow at the same rate as on average for the last one to three years.

Source: World Bank staff calculation, based on expenditures data from Ministry of Finance.

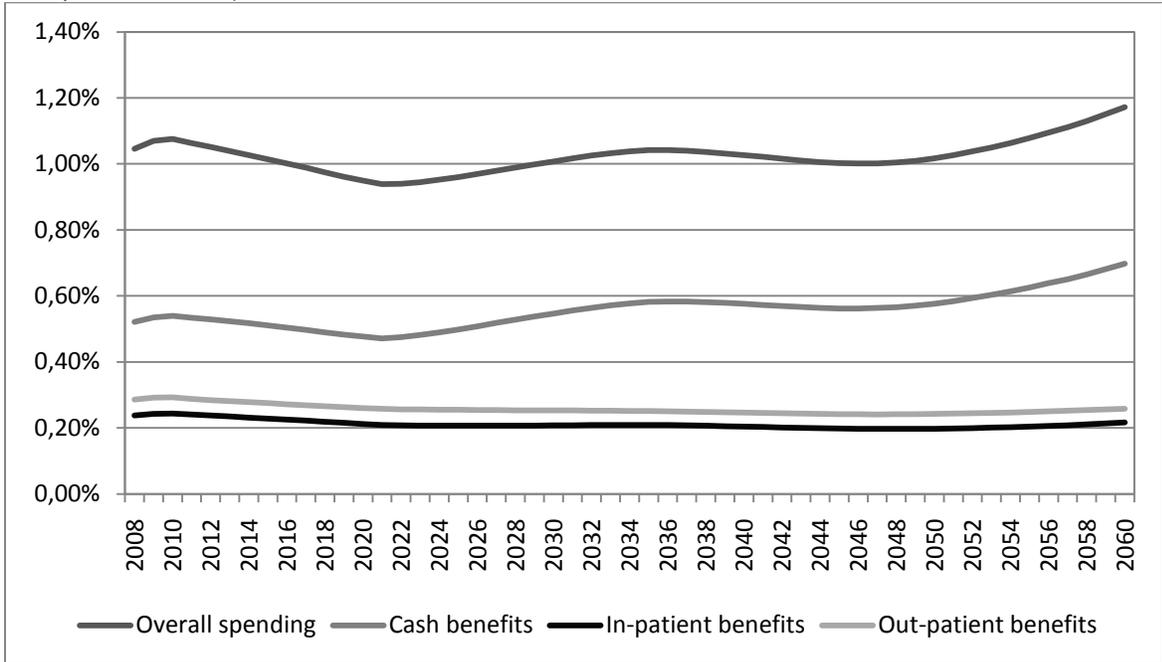
Given this strongly increasing trend in the number of beneficiaries, even under alternative, more conservative expenditure scenarios, real public expenditures on LTC are bound to increase. As already mentioned, the challenge is to combine the above mentioned trend in the number of

beneficiaries with reasonable assumptions on what the Polish government will spend *per* beneficiary. One scenario—based on extrapolation of past trends—has already been presented above and has showed the danger of continuing past expenditure patterns.

As a contrasting example, Scenario 2 presents the opposite extreme of constant expenditures per beneficiary on in-kind benefits, and moderate increases of cash benefits per beneficiary at 20 percent of real GDP growth per capita. Under this scenario, overall expenditure growth is mostly driven by aging—that is, an increase in the number of beneficiaries due to an aging population. Yet, even under this fiscally favorable but very unlikely scenario, total expenditure on LTC as a share of GDP is expected to increase from 2020 onwards (see Figure 4.11). In real terms, public expenditures would continuously increase and grow to PLZ 16.6 billion until 2020, to PLZ 22.2 billion until 2030, and to 32.3 billion until 2060. Public expenditure as a share of real GDP, would actually stay around 1 percent for the next 10 years, and then start to increase during the 2020s and again after 2050 (see Figure 4.12).

Under this scenario, expenditure increases are mainly driven by increases in expenditures on cash benefits, in particular during the 2020s (see Figure 4.12). A closer investigation shows that it is mainly cash benefits due to aging that will strongly increase and not so much cash benefits due to frailty (see Figure 4.13). This shows that this particular cash benefit is especially sensitive to aging, as already seen in the projections on the number of beneficiaries.

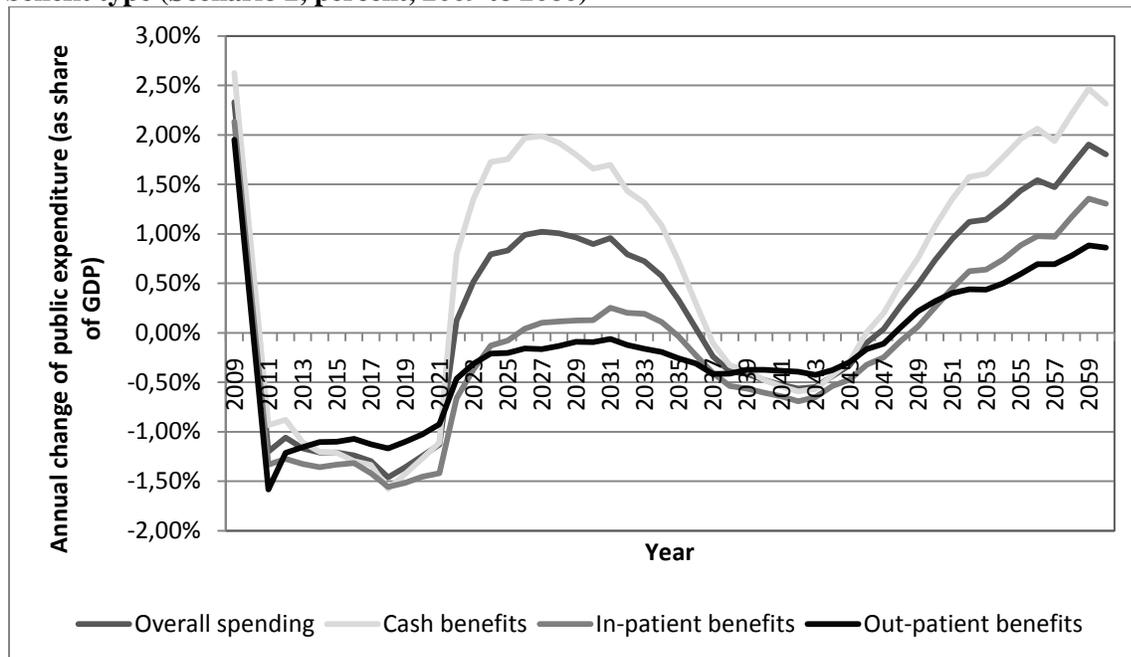
**Figure 4.11: Projected public expenditures on LTC by benefit type (Scenario 2, percent of real GDP, 2008 to 2060)**



Note: Scenario 2 assumes that real public expenditures per beneficiary stay constant at 2008 levels for in-kind benefits, and grow at 20 percent of annual GDP per capita growth for cash benefits.

Source: World Bank staff calculation, based on expenditures data from Ministry of Finance.

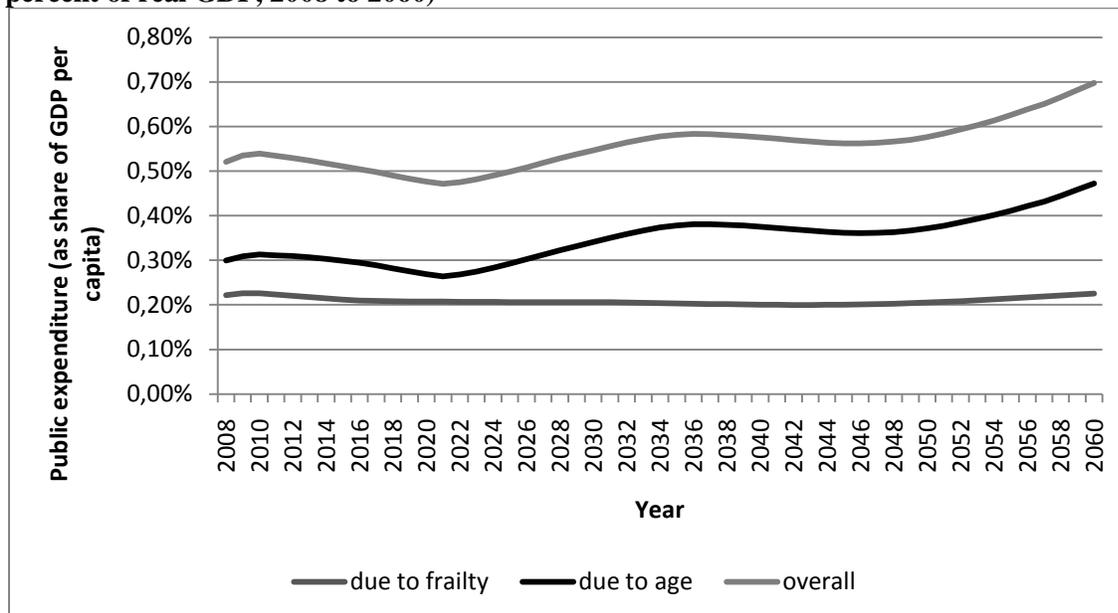
**Figure 4.12: Projected annual change of public expenditures (as share of real GDP) on LTC by benefit type (Scenario 2, percent, 2009 to 2060)**



*Note:* Scenario 2 assumes that real public expenditures per beneficiary stay constant at 2008 levels for in-kind benefits, and grow at 20 percent of annual GDP per capita growth for cash benefits.

*Source:* World Bank staff calculation, based on expenditures data from Ministry of Finance.

**Figure 4.13: Projected public expenditures on LTC cash benefits by eligibility criteria (Scenario 2, percent of real GDP, 2008 to 2060)**



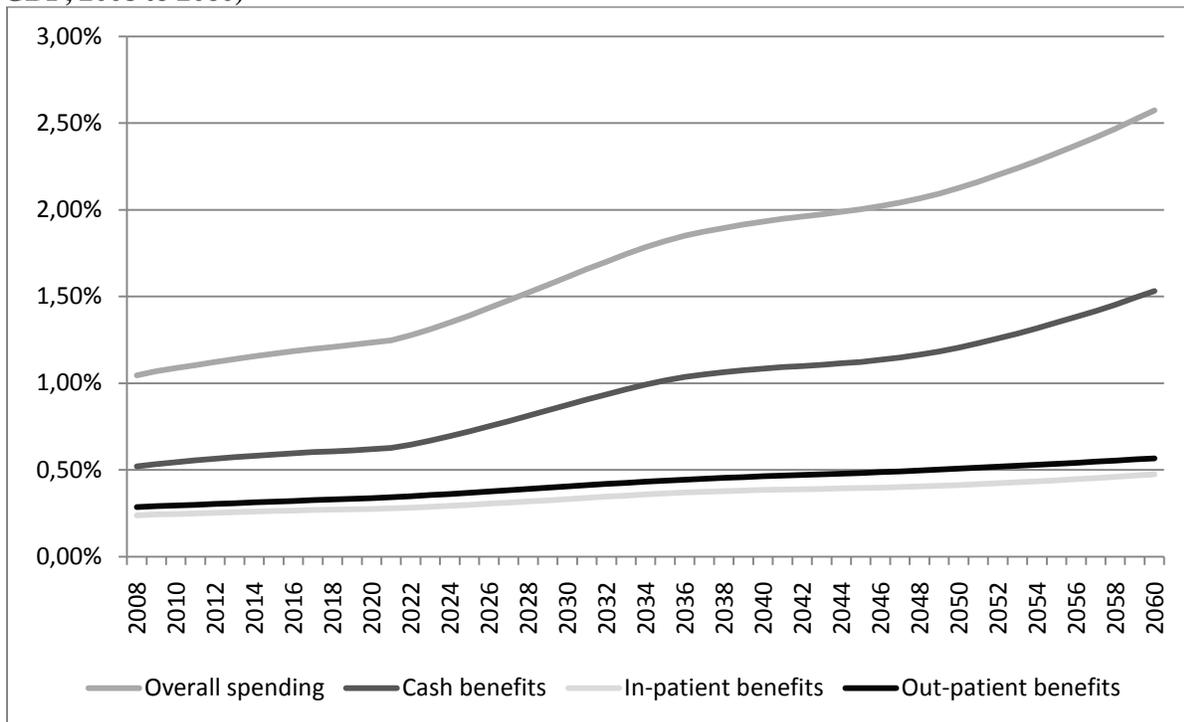
*Note:* Scenario 2 assumes that real public expenditures per beneficiary stay constant at 2008 levels for in-kind benefits, and grow at 20 percent of annual GDP per capita growth for cash benefits.

*Source:* World Bank staff calculation, based on expenditures data from Ministry of Finance.

Neither of the two scenarios—the extrapolation of past trends nor the assumption of constant expenditures per beneficiary—seem very likely, so a third scenario tries to find a reasonable middle ground.

Scenario 3, finally, links expenditure growth per beneficiary to GDP per capita growth over the next 50 years. Under this scenario, expenditure per beneficiary is assumed to grow at the same pace as the standard of living in Poland of Polish society. In other words, expenditure per beneficiary for the various benefit types stay at the exact same relation to GDP per capita as in 2008 (see Table 4.15), resulting in a continuous increase in public expenditures on LTC, from 1 percent of GDP in 2009 to over 2.5 percent in 2060 (see Figure 4.14). In real terms, public expenditures would increase to PLZ 21.5 billion in 2020, to PLZ 35.5 billion in 2030, and to PLZ 71 billion in 2060. As in Scenario 2, the increase is particularly pronounced during the 2020s and after 2050, mainly driven by the influx of cash beneficiaries due to age during those years (see Figure 4.15).

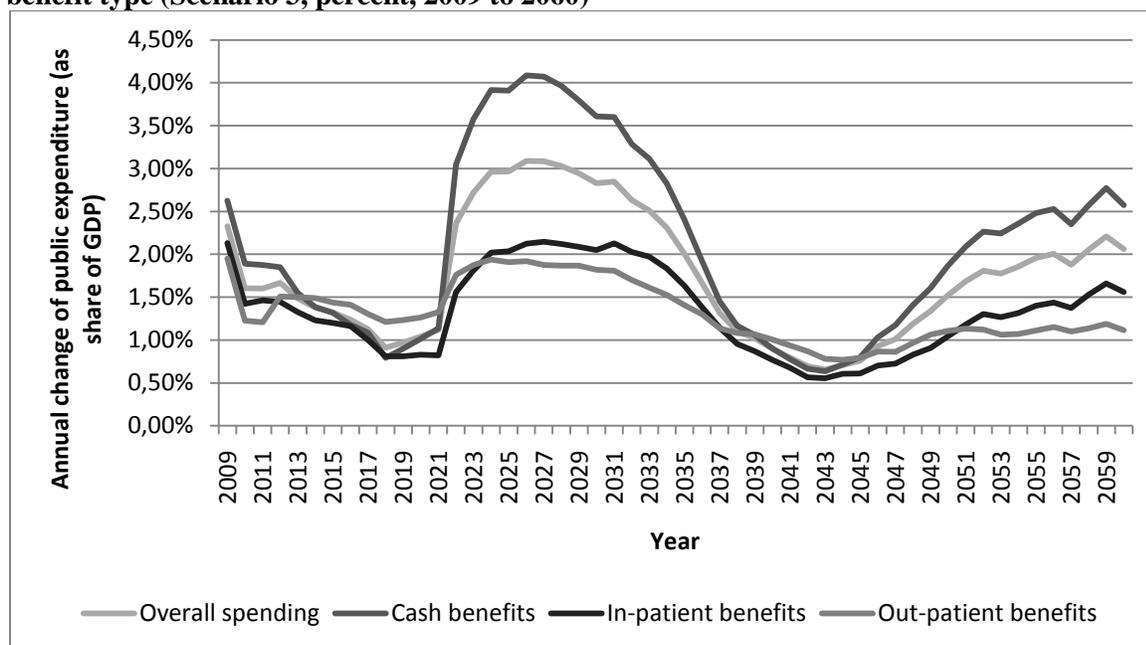
**Figure 4.14: Projected public expenditures on LTC by benefit type (Scenario 3, percent of real GDP, 2008 to 2060)**



Note: Scenario 3 assumes that real public expenditures per beneficiary grow at projected rate of GDP per capita.

Source: World Bank staff calculation, based on expenditures data from Ministry of Finance.

**Figure 4.15: Projected annual change of public expenditures (as share of real GDP) on LTC by benefit type (Scenario 3, percent, 2009 to 2060)**



*Note:* Scenario 3 assumes that real public expenditures per beneficiary grow at projected rate of GDP per capita.  
*Source:* World Bank staff calculation, based on expenditures data from Ministry of Finance.

In conclusion, Scenario 3 most likely underestimates expenditure growth in the near future, as heavy investments in infrastructure and equipment are needed to prepare for the future waves of sudden increase in demand for formal LTC services. At the same time, Scenario 1 clearly shows the dangers of maintaining current expenditure trends and points towards the fiscal dangers of failing to control costs of formal LTC services. The choices that the Polish government will make in the coming years on how much to invest in expensive inpatient, institutional LTC versus lower-cost outpatient, home-based and community LTC are of particular importance for the long-term fiscal outlook. In addition, cash benefits based on the age eligibility criterion are especially important for a large aging population and will lead to strong expenditure growth in the future. Since granting a cash benefit to everyone above the age of 75 seems more like a policy tool to manage old-age poverty risks rather than protection against dependency risks, it might make sense to abolish the age eligibility criterion and consider options on how to reform the cash benefit to be a true LTC benefit. This reform would need to strengthen the procedure on how to assess LTC needs and dependency levels and to introduce a scaled LTC cash benefit system.

### Analysis

The projections presented above lead to the following two main insights: first, cost control of in-kind benefits is crucial to avoid a rapid expansion of public expenditures on LTC; and second, cash benefits due to aging will lead to considerable fiscal pressure during the 2020s and after 2050.

On the former, cost control of in-kind benefits is key to keeping public expenditures on LTC fiscally sustainable. If current expenditure patterns of heavy investments into inpatient and outpatient care continue, overall costs could quickly get out of control. The problem, of course, is that the existing infrastructure for LTC in Poland requires considerable investments to meet current and future demand for formal LTC services. The question, then is, how current and future demand for LTC can be met; by investing in expensive inpatient care, or in cheaper outpatient care?

The number of severely hampered persons is bound to increase in the future, while at the same time, the number of potential care givers is decreasing (see discussion above and Figure 4.7). This means that the number of potential informal caregivers is decreasing, which in turn suggests that the demand for formal LTC services will strongly increase. In Poland, currently more than 80 percent of persons in need of LTC receive no or only informal care, and as the number of potential informal caregivers declines in the future, the demand for formal care services will increase.<sup>54</sup> This will lead to a profound change in the Polish care sector.

How will the Polish government respond to this increasing demand for formal care services? There is no doubt that a functioning LTC sector needs capacities for institutional, inpatient care, yet a fiscally responsible policy would aim at supporting informal care and providing as much outpatient care as possible. Outpatient care is a necessary complement to informal care and therefore supports it. It enables patients to stay at home for as long as possible and considerably delays institutionalization, leading to better outcome for patients, and also to lower public expenditures.

Given the importance of outpatient care in supporting overall LTC, it is encouraging to see that expenditures on outpatient care have been growing in recent years. In the future, one would expect important payoffs of such investments because outpatient care considerably minimizes expenditure on more expensive inpatient care.

Secondly, cash benefits due to aging could become a major driver of expenditure growth. The current eligibility criterion simply grants everyone at or above the age of 75 cash benefits. Since the age group of 75 and older will strongly increase in the future, expenditures on this particular benefit are very sensitive to aging and will increase as strongly in the future. As previously mentioned, though, current cash benefits are based on age and not necessarily based on LTC needs. The cash benefits serve more like an old-age pension supplement. It is therefore a measure to mitigate the risks of old-age poverty, and not a measure to mitigate the risks of dependency. This begs the relevance of such a benefit as a component of the Polish LTC policy.

Overall however, cash benefits can play a very important role in subsidizing demand for formal LTC services. The intriguing feature of the cash benefit is that it leads to consumer-directed demand for LTC services because patients are free to spend the money as they wish. It is therefore an important tool to direct supply toward the needs of patients. In particular, cash benefits can also be an important measure to support informal care, as the money can also be spent to pay informal caregivers. Therefore, it may not be advisable to abandon the cash benefit

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<sup>54</sup> See European Commission (2006)

altogether, but rather to reform the benefit in order to ensure that those in need of LTC are supported.

The concluding section will elaborate on these findings further and present implications for Polish LTC policy.

#### **4.5 Future Policy Directions**

Given the demographic context, current LTC programs and expenditures, and future projections of need and expenditure, what actions can the Polish government take to reform the Polish LTC sector in a fiscally sustainable way? Broadly speaking, the explored policy responses fall into three categories: (i) securing financing for future LTC expenditures; (ii) controlling demand for LTC services; and (iii) controlling costs of publicly provided LTC services and cash benefits.

##### **Securing Financing of Future LTC Expenditures**

First, on financing of LTC expenditure, the key will be to increase private savings for future LTC needs. This is not to say that the public sector should withdraw from financing LTC services. Costs for LTC services are catastrophically high and individuals who lose their ability to live independently are therefore at risk of being impoverished. Evidence from Austria suggests that the estimated income and assets of an average Austrian pensioner would finance only about four months of institutional LTC. This compares to an average length of stay of 35 months. Given this combination of low probability, yet high cost, economic efficiency requires some form of risk-pooling to allow people to protect themselves against the adverse financial impact of LTC needs. Hence, not only for reasons of equity, but also for reasons of economic efficiency, it is desirable that individuals pool their resources in order to protect themselves against the risk of becoming dependent—just as it is desirable in terms of equity and economic efficiency to protect against the risks of sickness or old age.<sup>55</sup> For various reasons related to asymmetric information, risk selection, adverse selection, and cost uncertainty, the potential for private LTC insurance to provide *in-kind services* is limited and in practice, has not been very successful.<sup>56</sup> This suggests that there is a need for the public sector to play a role in providing adequate instruments for pooling (old-age) dependency risks.

The most common forms of publicly provided risk pooling are contribution-financed social security and health benefits and tax-financed benefits like social safety nets. For LTC, most countries use both mechanisms to finance LTC expenditures. For example, in the United States, the contribution-financed, universal Medicare program provides limited LTC benefits for the elderly. Any LTC needs exceeding these limited benefits have to be paid by beneficiaries. If beneficiaries cannot afford these services, the tax-financed Medicaid program—a social safety net—provides at least a minimum level of LTC services. Austria has a tax-financed universal cash benefit that pays benefits based on dependency levels. Yet, these cash benefits are not sufficient to cover all formal LTC costs, in particular institutional care. Hence, the tax-financed

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<sup>55</sup> See Baeza and Packard (2006) for a discussion on risk-pooling in general, and Chakraborty, Hofmarcher, and Koettl (Forthcoming) on risk-pooling for LTC specifically.

<sup>56</sup> See Chakraborty, Hofmarcher, and Koettl (Forthcoming) for a more detailed discussion.

social assistance program pays all costs for institutional care that cannot be covered by beneficiaries. Germany has a universal, contribution-based social LTC insurance, but also uses its social assistance program to pay for LTC costs that cannot be covered by income and assets of beneficiaries.<sup>57</sup>

There is evidence that tax-financing, in particular via social safety nets and infrastructure investments, has been increasingly used to finance LTC services. Even in Germany, which has a social LTC insurance, 20 percent of total expenditures on LTC have been financed via general taxation between 2004 and 2007. In Austria, public LTC expenditures are almost entirely tax-financed, but within public LTC expenditures, the share of expenditures not related to the cash benefits—like social assistance and infrastructure investments—increased from about 25 percent in 1994 to over 40 percent in 2006.

Based on successful policies of its European counterparts, Poland should apply a mixture of instruments to finance LTC services. It seems that applying a mixture of instruments, from means-tested to universal entitlements, from privately paid or insured to tax and contribution-financed benefits, from defined contribution-type to non-defined contribution-type benefits, gives governments additional flexibility to adjust to changing conditions. Contribution-based benefits have the advantage of earmarked spending while tax-financed benefits put less of a burden on labor income. Universal entitlements might have the benefit of broad political support and fostering social cohesion while social safety nets act as benefits of last resort and an important measure to avoid old-age poverty. Supplemental and complementary private LTC financing instruments, in particular LTC insurance, finally, could serve those who are willing and able to pay more for better LTC services, and for better accommodation and services which are excluded from standard coverage.<sup>58</sup>

Whether LTC financing is done via contribution, a tax-financed systems, universal entitlements or through safety nets, nearly all of these instruments rely on pay-as-you-go financing mechanisms, which are highly unsustainable in the context of an aging society. The urgency of LTC reform comes from a need to convince Generation X—currently aged 20 to 35—to start saving for their own future LTC needs now—on top of having to pay for the LTC needs of their parent’s generation, the baby boomers. Generation X is the largest demographic cohort seen thus far and is followed by ever-smaller cohorts of younger people. Once Generation X begins to retire in 2040, any system relying on intergenerational solidarity will become increasingly unsustainable and will require large amounts of debt to be paid off by future generations.

If, on the other hand, private savings earmarked for LTC of Generation X from now until 2040—a time of high income growth—were increased, these savings could be used to support increased spending on LTC as this large cohort grows older. This implies a buildup of reserves—perhaps through a fully funded component—within social insurance or tax-financed funding systems.<sup>59</sup> If this does not happen, future generations will either face much higher contributions and tax rates, or benefits will have to be significantly decreased to ensure sustainability.

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<sup>57</sup> It should be stressed, though, that safety nets that support those in need for LTC usually have poverty reduction as their primary objective, and not providing LTC *per se*. For a detailed system classification, see Więckowska (2010).

<sup>58</sup> For private insurance classification, see Mossialos (2002).

<sup>59</sup> One option would be to investigate a link between private LTC savings and savings within the third pillar of the Polish pension system.

Yet, given the political and practical challenges of building up financial reserves within a public system, Poland should also consider the experience of France. In France, unlike in most other European countries, a small private insurance market for LTC provides supplementary LTC benefits. The market for private supplemental LTCI has been increasing by 15 percent annually between 2000 and 2007 and now covers 4 million people.<sup>60</sup> The key to the program's success appears to be based on a relatively simple design. Benefits are clearly defined in cash terms and based on disability levels. This makes the handling of claims much easier than insurance products, which are based on reimbursements of services (as in the United Kingdom or the United States). In fact, the French model is based more on financial products—like life insurance—than on health insurance products.<sup>61</sup> Monthly premiums are leveled, but not guaranteed, and are offered either as an individual or group rate. Eligibility for the benefit is based on total or partial irreversible loss of autonomy, upon which the insurance pays a lifetime annuity of EUR 300 to 2,500 per month (EUR 600 on average). Therefore, the uncertainty about future LTC costs is eliminated, and also other features that cripple private LTCI in many countries are reduced. In the future, though, as the market for these products matures in France, additional benefits, including in kind benefits, might be added.

### **Controlling Demand for LTC Services and Cash Benefits**

Second, on demand for LTC services, the key will be to promote healthy life styles and to support informal care. The aim is to decrease overall future demand for LTC by improving the health status of future elderly populations and to channel future demand into less expensive LTC services with higher benefits for patients. Promoting a healthy life style and healthy behavior is crucial for reducing not only morbidity but also the dependency of future elderly populations. Public health has a vital role to play in promoting healthy life styles, particularly with regard to tobacco consumption, obesity, and physical exercise.

The goal, though, is not only to reduce demand for LTC services in the future, but also to channel demand to the right types of services. For LTC, this means enabling the dependent population to continue living in their own home for as long as possible, and relying on outpatient care provided by the community and informal care provided by family members. Outpatient care is especially important because it provides social care to support dependent individuals in their activities of daily living, ranging from household chores, shopping, and personal hygiene to support with legal and financial matters and social activities. Most of this support is provided in the patient's home, but it can also be provided in daycare or half-daycare centers. These services not only support the dependent population, but also support their family members who might be the main providers for care, on an informal basis. Options for respite care, through which dependents receive inpatient care for a limited period of time when the main informal caregiver is not available, are another important way of supporting informal care.<sup>62</sup> Overall, LTC provided in outpatient settings is—either at home or in the community—is more cost efficient, is overwhelmingly preferred by patients, and leads to better outcomes.

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<sup>60</sup> See Le Corre (2008).

<sup>61</sup> This product is a typical LTC annuity. For other insurance products covering LTC risk, see Więckowska (2006).

<sup>62</sup> In the case of Poland, there is a continuing public discussion about abandoning elderly people in hospitals and social welfare homes as the result of a lack of respite care. See Mikulec (2009).

In this regard, it will also be important to build up capacities for patient-centered care coordination systems. Care coordination is necessary for assisting patients—many of whom might suffer from cognitive limitations—and their families to choose LTC services that are tailored to their needs while enabling patients to continue living in their homes for as long as possible. The coordination of care is particularly important for in-kind benefits provided by the health sector and the social sector. Because these services are funded from different sources—from the national health fund for health services, and from local government for social services—the incentives for costs shifting to the respective other sector are high. Such cost shifting usually occurs at the expense of the patients’ wellbeing because decisions are made on financial grounds, not medical or ethical grounds. Establishing a separate, independent fund to finance LTC benefits would positively complement reforms that aim at improving care coordination for patients. In this regard, it is also important to mention that increased competition between the acute healthcare sector and the LTC sector could in the future decrease financing for LTC services from the healthcare sector.

Finally, in an entirely different policy area, it will be useful to adjust building regulations to prepare Poland for its “Third Transition” towards an aging society. This means making public buildings and infrastructure accessible for the disabled and also providing incentives to make private homes more accessible and adequately built for an aging population.

### **Controlling Costs of Publicly Provided LTC Services**

Third, on cost control of publicly provided LTC benefits, the key will be to provide adequate in-kind benefits at good quality and at a reasonable cost. The costs for in-kind benefits will most likely increase significantly due to the increase in demand for LTC services and the concurrent decrease in the non-hampered, working-age population. The section on expenditure projections showed how significant cost increases could easily undermine fiscal sustainability.

One important step to providing adequate in-kind services at reasonable costs is to fully develop a provider market for LTC services, including private providers that are either for-profit or non-profit. Key to achieving this goal will be to develop adequate care standards, regulations and quality control, to harmonize the quality of LTC services across public and private providers, and to overcome the fragmentation of LTC financing. Regulatory instruments and bodies may take time to develop, and in the meantime, it may be worth considering public-private mix types of models where public provision is combined with outsourcing of selected items of provision (laundry, catering). Over time, as the financing for LTC matures, and the regulatory environment is in place, it should be possible to have more private sector provision.<sup>63</sup>

Next to consolidated financing, proper regulation, accreditation, standards of care, and quality control mechanisms are all crucial to further development of the provider market for LTC services in Poland. In order to stimulate competition in the market—assuming there will be competition to improve quality, the incentives must be equal for the different types of providers (public and private, for-profit and non-profit, rural and urban, large and small). This means that all providers will have to be subject to the same accreditation processes, regulations, care

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<sup>63</sup> For a more detailed discussion on important prerequisites for private provisioning of certain services, see Barr (2001).

standards, and quality controls. It will also mean that all providers will have to be paid the same for publicly financed LTC services, and maybe even investment costs. At the same time, it will be necessary to carefully balance incentives to ensure that providers are not unfairly pricing out competitors by taking advantage of economies of scale and scope, while at the same time providing incentives for service provisioning in disadvantaged regions. Such a balancing act might require substantial administrative capacities for regulation, monitoring, and evaluation as well as quality control.

Finally, cash benefits can also play an important role in Poland's LTC sector, as they are most effective in terms of controlling expenditures. Cash benefits do not automatically increase when costs in the LTC sector increase. Benefit levels are set annually, and as long as the government can resist political economy considerations, moderate benefit increases can help control public expenditure. However, overreliance on cash benefits can lead to unintended consequences; as the risk of significant cost increases for LTC services is shifted to individuals, individuals who cannot afford all LTC costs will end up in the public social safety net, thereby relying on public support.

Nevertheless, there is considerable potential for reform of the LTC cash benefit system in Poland. One very concrete option would be to reconsider the eligibility criterion of age for cash benefit. If cash benefits are truly meant to be a benefit for the dependent population, then access to the cash benefit should be based only on care needs. Eligibility for everyone older than 75 seems to be aimed at preventing old-age poverty and should therefore be part of the pension system, not the LTC system. In order to ensure that those in need of LTC receive the right amount of benefits, it is essential to have a strong needs assessment in place. In addition, most countries apply a scale on LTC cash benefit, granting higher benefits to those in more need. This is currently not the case in Poland, and reforming the cash benefit along these lines would require a scaled needs assessment, which again would require a strengthened capacity for need assessments. In addition, part of the cash benefit could be administered as a voucher in order to ensure that the benefit is indeed spent on LTC services.

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