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Few remarks on constructing a system to cover the risk of long-term care in Poland

Kilka uwag o konstruowaniu systemu zabezpieczającego ryzyko potrzeby długoterminowej opieki

Abstract
The subject of this study is to present selected issues concerning the constructing of the service system covering the risk of the need of long-term care. Author discusses the questions of: defining the risk of the need of long-term care seen in the context of demographic situation, scope and character of the system services and as well as its organization and financing.

Keywords
risk of the need of long-term care, dependency, long-term care system

JEL: K39

Streszczenie
Celem artykułu jest przedstawienie wybranych zagadnień dotyczących konstruowania systemu świadczeniowego zabezpieczającego ryzyko potrzeby opieki długoterminowej. Autor omawia następujące zagadnienia: zdefiniowanie ryzyka potrzeby opieki długoterminowej w kontekście sytuacji demograficznej, zakres i charakter świadczeń, organizację systemu oraz jego finansowanie.

Słowa kluczowe
potrzeba opieki długoterminowej, niesamodzielność, system opieki długoterminowej

Introduction

The issues concerning the challenges of social policy relating to long-term care as well as medical, psychological, sociological and economic issues have been raised in Polish literature many times (Augustyn, 2010; Bakalarczyk, 2013, 2016; Więckowska 2010, Mossakowska *et al.*, 2012). Over the last few years its legal aspects have finally been presented (Przybyłowicz, 2013; 2017, Lach, 2018a). All available data and studies show that appropriate legislative action is urgently needed. The legislator's obligations arising from the judgments of the Constitutional Tribunal in cases: K 27/13 (of 5 December 2013) and K 38/13 (of 21 October 2014) regarding the differentiation of the legal situation of informal caregivers of dependent persons have to be taken into the consideration too (Bakalarczyk, 2016).

The aim of this study is to present some selected, recently discussed legal problems concerning the construction of the service system related to the risk of dependency (the need of long-term care) against demographical changes, and challenges resulting from an increasing need for long-term care. This accords to the author's recent research and following publications, illustrating not only the importance and contemporaneity of the issue, but also its complexity and multifaceted nature.

First of all, there is the issue of defining the "dependency" — also concerning an age-related dependency of children and youth — as a social risk. Closely related to this problem is the question of the subjective scope of the system (universality) and its financing (taxes vs. contribution). It is also necessary to highlight the basic issues concerning the structure and nature of benefits / services within the long-term care system securing the effects of the risk of dependence, as well as the problem of their recipients (benefits in cash vs. in kind, for dependent persons and/or informal caregivers). Findings in this regard influence considerations regarding the organization of the long-term care system.

Demographical challenges and the need of the long-term care

The meaning of the demographical changes and challenges for the need of the long-term care are obvious and have been reported before (Jończyk, 2009; Augustyn, 2010; Becker, 2013; Lach 2018a). However, it is worthwhile — basing on current statistical data and forecasts — to recall the importance of the problem. The statistical "Forecast for years 2014–2050" shows that the share of the population aged 65+ in the total population, currently at the level of c. 18%, will exceed 32% by 2050. As a consequence, the number of people aged 65 and more, compared to that of people aged 0–14, at present roughly at 1:1 ratio, by 2050 will increase to almost 2.7:1. Importantly, after 2025, the percentage of people in their 80s and older will drastically increase too: in 2040, people over eighty years old will constitute as much as 36% of the group of elderly (*i.e.* 65+) people (GUS, 2014, p. 125 onwards).

The eldering of the society and a significant increase in life expectancy will result in a growing demand for long-term care. It concerns not only the assistance and support for persons with reduced abilities in terms of daily living activities (ADLs) (bathing and showering, personal hygiene and grooming, dressing, toilet hygiene, functional mobility ["transferring"], self-feeding). Very important, also from the point of view of appropriate care, is the growing number of people with age-related cognitive impairment. In the group of people aged 65 and over, only 31.6% revealed normal cognitive functions, while the remaining 68.4% showed disorders of varying severity (36.3% mild cognitive impairment; 32.1% various degrees of dementia). Age has been confirmed to be a factor that strongly influences abnormalities in cognitive functions (Siuda *et al.*, 2012, pp. 112–114). It is important not only concerning the instrumental activities of daily living (IADLs) (cleaning and maintaining the house, money management, moving within the community, preparing meals, shopping for groceries and necessities, taking prescribed medications, using the telephone or other form of communication), but also the character of care services. Care over older persons with dementia is very burdensome — physically and psychically. It becomes more intensive and extends into actual maintenance, such intensive caring having negative impact on mental health of the caregiver (Grochmal-Bach, 2007, pp. 224–227; Pyszkowska & Naczyński, 2015, p. 267; Colombo *et al.*, 2011, p. 97 onwards).

In this context one should also mention the impact of demographical changes on the old-age dependency ratio (which increases from about 25 now to over 50 in 2050), as well as the parent support ratio (which increases from about 15 now to approx. 38 in 2050) (GUS, 2014, p. 134 onwards). This means not only a growing financial burden upon people in working age, but will also significantly affect the possibility of providing care for dependent relatives. Then, informal caregivers are predominantly women, which is important considering that high-intensity caring can lead to reduced rates of employment and hours of work. Caring is associated with a higher risk of poverty (Colombo *et al.*, 2011, p. 85 onwards). In effect, social security of such informal caregivers becomes endangered as well (Bakalarczyk, 2016; 2017; Lach, 2018b).

Last but not least, we should observe that an increase in life expectancy influences the individual ability to organize and finance the necessary long-term care services on the free-market. The statutory old age pension scheme is a defined contribution scheme, which means that life expectancy is of fundamental importance in determining the amount of the pension: the longer the life expectancy, the lower the benefit.

Summing up, it can be concluded that demographic changes make the issue of long-term care a social issue: various life situations, requiring the organization or financing of long-term care, occur on a mass scale, and their effects — also in the absence of adequate forms of protection (Jończyk, 2009, p. 2) — not only affect individuals, but also influence the functioning of the entire society, threatening the social exclusion of whole groups of entities.

Dependency as a social risk

It is nowadays beyond discussion that the long-term care dependency constitutes a model example of a new social risk (Schulte, 2013, p. 213; Becker, 2018, p. 5). Nonetheless, it is still problematic to define the dependency as a social risk understood as legal qualification of numerous and diverse situations where the need of long-term care occurs and certain services are to be granted.

This issue was noticed in the ECJ judgment of 5th March 1998 in case C-160/96, Molenaar. In it ECJ states that the German Care Insurance Law "is designed to cover the costs entailed if insured persons should become reliant on care, that is to say, if a permanent need were to arise for those insured to resort, in large measure, to assistance from other persons in the performance of their daily routine (bodily hygiene, nutrition, moving around, housework, and so on)." The occurring problems concerning the transfer of the long-term care services which were not implemented into the regulation (EC) No 883/2004 of 29 April 2004 on the coordination of social security systems gave impulse for the European Commission and the Administrative Commission to complete this regulation and set e definition of long-term care benefit. Independent experts of the trESS network[1] tried to develop a common understanding of and a definition of the concept of long-term care. Basing on the OECD definition, definitions adopted in the member states and the *Molenaar* case, the experts distinguished several elements common to all the definitions, which might be used as minimum common criteria to identify long-term care benefits. These criteria include: (1) reduced or lost or never (fully) acquired (physical,

mental, intellectual or sensorial) autonomy, due to old-age, disease or incapacity, (2) ailments or disabilities that require a significant assistance of another person, (3) those that occur over an extended period of time (as opposed to, for instance, nursing in a hospital which is as a rule of short duration), (4) efforts that aim at enabling the performance of the essential daily living activities (Jorens *et al.*, 2011, pp. 13–14).

On this basis the European Commission made a proposal for the amendment of the Regulation (EC) No 883/2004, recommending to supplement Article 1 with a definition of the long-term care benefit as "any benefit in kind, cash or a combination of both for persons who, over an extended period of time, on account of old-age, disability, illness or impairment, require considerable assistance from another person or persons to carry out essential daily activities, including to support their personal autonomy; this includes benefits granted to or for the person providing such assistance". After Amendments of the European Parliament, this definition is: "long-term care benefit means a benefit in kind or in cash, the purpose of which is to address the care or support needs of a person who, on account of old age, disability, illness or impairment, requires assistance from another person or persons to carry out their essential activities of daily living for an extended period of time in order to support their personal autonomy, including in a workplace; this includes benefits granted for the same purpose to the person or persons providing such assistance"[2] .

Against this background, and according to the International Classification of Functioning, Disability and Health (ICF)[3] the following definition of dependency as a social risk was proposed in Polish literature: it is the need (but not the necessity) for significant support from other people resulting from the impairment of the body's functions, including nursing, caring and assistant benefits for a longer period of time (Lach, 2018a, p. 113).

To explain the meaning of this definition some remarks have to be done. First, this definition refers to ICF definitions of body functions (the physiological functions of body systems, including psychological functions) and impairments (problems in body function or structure, such as a significant deviation or loss). Importantly, the impairments of structure can involve an anomaly, defect, loss or other significant deviation in body structures; it should be observed that impairments are not the same as the underlying pathology — instead, they are manifestations of that pathology. They represent a deviation from certain generally accepted population standards in the biomedical status of the body and its functions, and can be temporary or permanent; progressive, regressive or static; intermittent or continuous. Deviation from the population norm may be slight or severe and may fluctuate over time. For the recognition of the impairments contextual factors are important, which represent the complete background of an individual's life and living. They include two components: Environmental Factors and Personal Factors, which may have an impact on the individual with a health condition and that individual's health and health-related states[4]. In consequence, the concept of formulation "Impairment of body functions" refers to all possible restrictions on independence, regardless of their source or nature.

Talking about "support" it should be pointed out that this formulation refers not only to nursing services or help in the undertaking of the activities (also instrumental) of the daily living. It ought to be understood wider, including "assist services" for the dependent person: intellectual, psychical and emotional support by performance of different tasks or actions (to overcome the activity limitations) or by involvement in life situations (to overcome the participation restrictions) (Lach, 2018a, pp. 24–27).

According to Molenaar EJC judgement, foreign definitions, and proposal of a think tank tress, it should be also suggested to abandon the ultimate term "necessity" (of) care / assistance used in Polish literature (Augustyn, 2010, p. 9; Szweda-Lewandowska, 2014, p. 215), in favor of the term "need" or "require" (Lach, 2018a, p. 108). This way it is emphasized that the risk of dependency is not limited to people for whom the provision of long-term care benefits / services is (unconditionally) necessary, (indispensable, crucial), but also applies to people who would find it difficult to function without such support.

Another, separate problem is that of adjudication of dependence as the "need for the support", which refers to open clauses such like a significant support and medical finding of the impairment of the one's body's functions. This is closely related to the problem of the grading of the risk of dependency. The point is to allocate limited funds to finance services as adequately to the needs of a given person as possible. It is actually about differentiation of the legal situation of groups of recipients of certain benefits (Lach, 2018a, p. 92). It could be done by evaluating the time needed for the long-time care services (*e.g.* Austria, Pfeil, 2018) or by scoring the points in different areas according to physical and psychical body's functions (*e.g.* Germany and a very complex system of *Begutachtungsinstrument*, Gansweid *et al.*, 2010, pp. 54–55; Rothgang, 2016, p. 20)[5]. The points-scoring system seems to be better, not only because it allows multi-faceted assessment of the degree of impairment of the one's body's functions, but also because of high flexibility it offers. Appreciation or devaluation of certain criteria enables a quick change of the adjudication system without the need to reconstruct the entire system, *e.g.* when the priorities of social policy change or when such a need arises due to the results of the analysis of the effects of the functioning of the system (Lach, 2018a, p. 113).

The adjudication of dependence meets special problems where it concerns children (including infants) and youth. Admittedly, that in their case a certain and decreasing degree of dependence in relation to activities

of daily living (especially regarding small children), as well as mental immaturity (also in relation to teenagers) is related to their age. For this reason, there is a problem of objectifying individual development of children and youth what influences the adjudication of their dependence and its gradation (Gansweid *et al.*, 2010, pp. 57–59). In this case it is worth paying attention to the German solutions, in which the points-scoring system was significantly redesigned, creating a separate regulation taking into account specificities of this group (Lach, 2018a, pp. 100–107).

Subjective scope and the financing of the long-term care system

Dependency defined as a social risk has universal character. It may apply to everyone, regardless of age, sex, etc., and — importantly — is not related to professional activity. Therefore, the subjective scope of recommended system meant to protect citizens form the consequences of fulfillment of this risk should also be universal, as the health-care system is.

A question that arises in this context is that about financing of the long-term care system. *Prima facie* it should be financed from taxes, as a social assistance scheme. The budget financing allows not only for taking into account various social contexts shaping the tax system, but also for covering people remaining outside the social insurance system. On the other hand, one has to be aware that such a system could be susceptible to budgetary and political manipulation, also because — according to demographical changes — the cost of benefits for the growing number of dependent people would occur a serious burden on public finances (Augustyn, 2010, p. 164). In this context we should mention the issue of making the right to services / benefits conditional on the financial situation of a dependent person by applying the income criterion (or even more broadly: by referring to the resources possessed). In view of budget financing, this would be justified (Naegele, 1984, p. 335). Then, it also should be taken into account that, in the light of the Article 68(2) and (3) of the Constitution of the Republic of Poland, it is forbidden to differentiate between citizens with regard to access to health-care services, according to the criterion of their material condition (Jończyk, 2004, p. 130 onwards). Apart from the resolution of the issue, if the nursing services for the long-term care dependent persons involve the same services as delivered in the health-care system, then the use of the income criterion as an instrument differentiating access to (all or some) long-term care services could raise doubts as to the constitutionality of such a solution. However, it should be borne in mind that the same could be justified by other constitutional values, *e.g.* maintaining budget balance and the proper condition of public finances (Lach, 2018a, p. 179).

Therefore, the contribution-based financing of the long-term care system seems to be a better solution. The contribution not only provides a solid financial foundation for the system, but also strengthens the position of beneficiaries: application to the system and payment of the premium would lead to the start of the guarantee phase and the acquisition of the right to benefits guaranteed in the system, realized as a result of fulfillment of the risk of dependency. As rightly pointed out in the literature, the benefit system "degrades" the risk of dependency, reducing it to the premise of the payment of benefits for a specific group of people (Rothgang, 2004, p. 596, 611), while the universal long-term care insurance in the first place protects the community (the lack of a system would mean the necessity to finance long-term care benefits from budget funds) whereas it is only secondly about protecting individuals and guaranteeing their right to benefits in the event of meeting the risk of dependency (Schulin, 1994, p. 436). One should also agree with the statements of the German doctrine which, in view of the nature of the risk of dependence, postulates that the system should be shaped as universal (*Bürgerversicherung*) and that all sources of income should be charged with contribution[6] (Hajen & König, 2011, p. 391; Rothgang, 2004, p. 614). In this context it might be discussed whether such a contribution is still a social insurance contribution, or does it become a *sui generis* provision (premium), kind of a specific tax[7]. Due to the lack of connection with professional activity, it seems justified to say it shouldn't be a "pure" social insurance contribution. Last but not least: the universal premium makes also possible the contribution-free incorporation into the system the family members of insured (first of all, children).

A separate issue is to determine the amount of the contribution/premium. It was observed that in Germany the contribution rate corresponds to roughly 0.6 of the share of dependent people in society (Lach, 2018a, p. 184). Due to the common and personal nature of the risk of dependency, it should only be borne by the beneficiaries.

Long-term care services and their recipients

Afterward, it is necessary to highlight the basic issues concerning the structure and nature of benefits/services within the system securing the effects of the risk of dependence, understood as the need for long-term care and support, necessary not only due to physical limitations, but also in relation to mental and cognitive disorders.

First, the nature of the benefits guaranteed should be decided. Referring to other social security systems, we can distinguish cash benefits addressed to a person who was touched by the risk of dependency and intended for independent organization / payment of necessary care at home or in a specialized care center, as well as benefits in kind (services), including the provision of care and assistant services at home or in a specialized care center, organized and paid by the system organizer (Skuban,

2004; Stöckl, 2011; Jorens *et al.*, 2011; Becker & Reinhard 2018). Both solutions are controversial.

The fulfillment of benefits in kind (long-term care services) requires the employment of an appropriate number of caregivers/assistants and the management of their services by a specialized state agency (as in the case of public health service), or contracting appropriate services (out- or inpatient) with external providers (as in the case of health-care insurance). Therefore, there is the issue of organizing the market of appropriate services (setting standards of care, certification and defining the principles of the functioning of service providers, co-financing the creation of public service providers, *etc.*), and the creation of organizational structures and regulation of their activities in this area (procedures for valuation of services and contracting them, *etc.*). On the other hand, the cash benefits are based on the assumption that the recipient is able to find out information and details about the services offered by the market, and make — on his/her own — optimal decision, which is rather unlikely for people with mental and cognitive deficits (Przybyłowicz, 2017, p. 130). Therefore, the payment of benefits in cash should be paid only when the necessary care is provided by relatives or volunteer caregivers. The problem is such allowance becomes, then, a benefit addressed to caregivers rather than to dependent people.

Against this background a question arises about who should be the recipient of the benefits from the long-term care system: dependent persons only, or perhaps their (informal) caregivers, who, due to the need to care for and support family members, limit their economic activity or even give it up altogether. In this context one has to take into account that, with vast majority of dependent people, the appropriate support in the form of nursing, caring and assistant benefits is provided by informal caregivers, primarily family members, in the home environment of a dependent person. This situation is of course related with the fact that, in the case of most dependent people, the degree of impairment of their functions is insignificant and allows for satisfactory care by their relatives or refers to the functioning of intergenerational family support networks (Krzyżowski, 2012, pp. 133–134) — but not only with that. It is also partly due to insufficient access to professional services and the lack of qualified personnel (Błędowski, 2012, p. 451, 458; Iwański, 2016, p. 164; Trawkowska *et al.*, 2017, pp. 59–65). Nevertheless, it is recognized that informal home care is generally a desirable option and the best alternative to institutional care[8]. Question is whether the cash benefits are optimal benefits from the informal caregivers' point of view. In literature it was argued in this context that social security solutions for family members, being the largest group of informal caregivers, are often inadequate (Wallner, 2007, p. 54; Stöckl, 2011, pp. 75–81; Bakalarczyk, 2016; 2017) and so they may entail a risk of social exclusion of the informal caregivers (Reinhard, 2018, p. 589).

Taking into account the German solutions, one should propose, that under the long-term care system not only the cash benefits for dependent person should be granted, but benefits for their informal caregivers as well. First of all, the system should cover the costs of the social security contributions, not only for the pensions' schemes, but also for sickness, health and accident insurance (about diverse European solutions: Lach, 2019a). Also, very important are such benefits as financing and/or organizing of training, granting appropriated support, securing the possibilities of respite and also the measures to reconcile work with family life[9]. It should be emphasized that the fact that a third party (caregiver) assisting the person reliant on care derives personal advantages on that account does not alter the fact that it is the person whose reliance on care justified granting the whole benefit in the first place who becomes, this way, beneficiary of the scheme devised to help him/her to receive, in the most favorable conditions possible, the care adequate for particular health condition. The same may be said, moreover, with regard to the proper care allowance, where it is used in whole or in part to remunerate the third party assisting the person reliant on care[10] (Lach, 2018a, pp. 185–187).

A separate issue is that of determining the amount of cash benefits: whether they should be flat-rate and related to *e.g.* degrees of dependency, or perhaps individualized (if so, then basing on which criterion?) or even depending, for example, on the recipient's income.

Summing up, it seems justified to propose that the long-term care system should be a comprehensive one. It should include both: granting of benefits in cash and in kind (services), as well as the special benefits (aids) for informal caregivers (social security contributions, training, support, respite).

Organization of the long-term care system

Generally, three types of organization of long-term care systems may be distinguished. Chronologically first was the Holland's system, which is indeed a special part of the health-care system (Dijkhoff, 2018). In Austria a publicly financed system of cash benefits was implemented as a public assistance managed by the social insurance carrier or administration (Pfeil, 2018). Germany, after long years of discussions, followed the Bismarck's tradition and created the long-term care insurance, as the 5th pillar of the social insurance system[11] (Przybyłowicz, 2017; Udsching & Schütze, 2018).

These solutions show the existence of several variants of shaping the organizational (and financial) issues of the system guaranteeing long-term care services (Lach, 2019b). Therefore, referring to the Dutch experience, one could support the preservation of the status quo in Poland: the organization of benefits in kind under health-care system and the payment of cash benefits by institutions of social welfare and assistance. Such a solution was advocated — over a decade ago already — by J. Jończyk, who postulated "diversification of the risk of long-term care and wider application of the institution

of the law of social assistance (welfare), and limitation of the statutory regulation of this matter as universal and claim rights" (Jończyk, 2009, p. 2). It seems, however, that in view of the demographical changes and challenges resulting from the universality of phenomenon and risk of dependency, this would be not an optimal solution. The multiplicity and separation of entities organizing benefits in kind on the one hand, and paying cash benefits on the other hand, makes it difficult to manage funds and control their spending.

Looking at the Austrian experiences we see that the payment of long-term care benefits through social security institutions is a significant facilitation for the recipients of the allowances, and makes it possible to resign from creating a separate (and costly) organizational structure. However, one also has to notice that the costs of benefits for the growing number of dependent persons would be a heavy burden on public finances (see above 4., Augustyn, 2010, p. 164), and the liquidation of the existing benefits and tax reliefs might not compensate the costs of the newly created system (Lach, 2019b).

When referring to the long-term care insurance, it should be pointed out that the creation of the integrated system guaranteeing both cash and in-kind benefits (with the possibility of combining them) allows for a comprehensive solution of the issue of social securing of the need for long-term care resulting from the broadly understood dependence. Contribution-financing provides a solid financial foundation for the system and strengthens the position of beneficiaries (see above 4.). On the other hand, risk of dependency has no relation to professional activity and therefore the consequences of its fulfillment should not be secured under the social insurance system.

Summing up, one can argue that the optimal solution of the issue of securing long-term care needs seems to be the creation of a universal and compulsory, comprehensive long-term care system funded by contributions (premiums). Due to the common nature of the risk of dependency and the lack of its relation to professional activity, such a system should not become part of the social insurance system. Rather than that, it should be shaped as a system parallel to the health-care system, formally separate, and perhaps organizationally related in some ways: the National Health Fund has the resources and experience to organize benefits in kind, also in the field of long-term care. Moreover, nothing stands in the way of applying the concept of a trustee (Lach, 2009) also in relation to the newly created "long-term care system" (Lach, 2019b).

Conclusions

Demographic forecasts indicate beyond any doubt that the number of dependent people will increase. The Polish legislator will soon have to face the resulting challenges, especially considering that the existing legal solutions are fragmentary, far from sufficient and require legislative intervention (Lach, 2018a, pp.174–176). In view of the complexity of the issue and its social importance, the legislator's task is not easy.

In order to construct a coherent and functional system of benefits in the event of the fulfillment of the risk of dependency/the need for long-term care, the legislator must take into account and solve a number of issues. Most of them are substantive and should be based on research and findings made by experts; where possible, taking into account domestic and foreign experience to date. This does not change the fact that some issues — *e.g.* those relating to organizational and financial solutions — require political decisions: the legislator implements its program by making certain decisions also in the field of social policy. However, it is important to recognize the complexity and interconnectedness of the specific issues that need to be resolved.

It seems justified to propose a thorough construction of the long-term care system as a universal and compulsory, contribution (premium)-financed comprehensive system. There should be a wide variety of benefits granted: both in cash and in kind, as well as diverse aids for the informal caregivers (social security contributions, training, support, respite, *etc.*). Due to securing the benefits in kind (long-term care services, in- and outpatient) the system should be organized parallel to the health-care system: it is about similar tasks related to managing over public funds and concluding and settling contracts with service providers.

Notes/Przypisy

[1] http://www.tress-network.org/

[2] Report on the proposal for a regulation of the European Parliament and of the Council amending Regulation (EC) No 883/2004 on the coordination of social security systems and Regulation (EC) No 987/2009 laying down the procedure for implementing Regulation (EC) No 883/2004, (COM(2016)0815 — C8-0521/2016 — 2016/0397(COD)).

[3] ICF was officially endorsed by all 191 WHO Member States in the Fifty-fourth World Health Assembly on 22 May 2001(resolution WHA 54.21) as the international standard to describe and measure health and disability.

[4] Compare International Classification of Functioning, Disability and Health, Geneva 2001, p. 10–16, https://apps.who.int/iris/bitstream/handle/10665/42407/9241545429.pdf (access: 28.07.2020).

[5] The details are regulated by the extensive guidelines of the association of sickness funds: Richtlinien des GKV-Spitzenverbandes zur Feststellung der Pflegebedürftigkeit nach dem XI. Buch des Sozialgesetzbuches, http://www.mdk.de/media/pdf/Bri_Pflege_ab_01-2017.pdf

[6] As is the case in the Polish health insurance system.

[7] Concerning health-care system contribution: Lach, 2011, p. 335.

[8] European Parliament resolution of 9 September 2010 on long-term care for older people, 2011/C 308 E/13, point 7.

[9] European Parliament resolution of 9 September 2010 on long-term care for older people, 2011/C 308 E/13, point 5.

[10] ECJ judgement of 8 July 2004 in joined cases C-502/01 and C-31/02 (Gaumain-Cerii/Barth).

[11] However, it is characterized by a number of differences and solutions that differ from the model solutions of social insurance: only complementary role of long-term care insurance, flat-rate benefits, the possibility of choosing between cash and in-kind benefits and combining them (Landenberger, 1994; Evers, 1995; Rothgang, 1996; Schütze, 2016).

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