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I HOME CARE CONCEPT AND SCOPE

In Poland, the most important role in the provision of long-term care is played by the family, and only in certain cases the obligation is taken over by public institutions.[1] The tasks needed to aid dependants in Poland are divided between:

- the health care system,
- the welfare system.

In addition, these tasks involve NGOs and the fast growing private sector. Despite this apparent multiplicity of entities, "a large group of dependants does not receive support or receive support inadequate to their needs".[2]

Benefits provided by the health care system are of inpatient and outpatient (home) character. Their cost is covered from the mandatory health insurance contributions, while the National Health Fund is their payer. Whereas, in the case of the social welfare system, the data from the reports of the Ministry of Family, Labour and Social Policy show that long-term or serious illness and disability are among the most common reasons for granting social assistance. Such assistance may be granted in the form of cash or in-kind benefits.[3]

Among cash benefits one may distinguish temporary and purpose benefits. A temporary benefit is granted due to a long-term illness to a person who meets the income criteria. Purpose benefits – also subject to income criteria – are granted to satisfy the basic living needs. This benefit may be granted, in particular, to cover all or part of the cost of the purchase of food, medicines and treatment. In specially justified cases, a person or a family with an income that exceeds the income criteria may receive a special purpose benefit. Granting special purpose benefits lies within the non-obligatory responsibilities of municipalities and their implementation is dictated by the financial abilities of the community and should respond to local needs.

An attendance allowance is another type of cash benefit granted by a municipality as part of its assigned tasks. It is granted in order to partially cover the expenses arising from the need to provide a disabled person with care and assistance from another person due to his or her

[1]Szweda-Lewandowska Z. Formy pomocy osobom starszym w wybranych krajach Unii Europejskiej. W: Kleer J., redaktor. Konsekwencje ekonomiczne i społeczne starzenia się społeczeństwa. Warszawa: PAN; 2008, 174.
[2]Szwałkiewicz E.: Niesamodzielni: niezbędny zakres pomocy, personel i finansowanie, 2010, 17. [online] Dostępny w: www.instytutobywatelski.pl/wpcontent/uploads/2010/09/niesamodzielni_raport.pdf.
[3] Błędowski P., Maciejasz M.: Rozwój opieki długoterminowej w Polsce – stan i rekomendacje. Nowiny Lekarskie 2013, 82 (1).s. 61–69.

inability to live independently and may be received e.g. by a person who has turned 75. A person who receives a carer's allowance or stays at a 24/7 care institution is not entitled to this type of allowance. The amounts of benefits are inadequate, and meet the needs of seniors only to a minor extent.

The second form of assistance are care services, which – like in the health care system – can be either of environmental or institutional character. The legal regulation determines a gradation of care services, which in the first place should be provided by the family, then as part of the community-based care, and only later by nursing homes. The care services are discussed in detail in the next section.[4]

The following table shows the long-term care in the health system and in the social welfare system in Poland.

	The health care system	***The social welfare system***
Legal act	Minister of Health Regulation on guaranteed benefits within the framework of attendance and care allowances in long-term care	Law on Social Assistance
Types of benefits	• Home Care • Health Care centre	• Home Care • Health Care centre • Financial support
Eligibility criteria	0-40 points on the Barthel Index	• Eligibility criterion (Article 5 of the Law on Social Assistance) • Difficult situation criterion (Article 2, Section 1, Article 7 of the Law on Social Assistance) • The income criterion in the case of cash benefits (Article 8, Section 1 of the Law on Social Assistance)

[4] Błędowski P., Maciejasz M.: Rozwój opieki długoterminowej w Polsce – stan i rekomendacje. Nowiny Lekarskie 2013, 82 (1).s. 61–69.

Residential care	• Care and Treatment Facility (ZOL) • Nursing and Care Facility (ZPO)	Social welfare homes for: - elderly people - people with chronic somatic diseases - chronically mentally ill people - adults with intellectual disabilities - children and young people with intellectual disabilities - physically disabled people

Source: Błędowski P., Maciejasz M.: Rozwój opieki długoterminowej w Polsce – stan i rekomendacje.

History of care services

Traditionally in Poland it has always been the family who provided care for its elderly, disabled or sick members. In the 80s, Anna Kotlarska-Michalska confirmed this caring role of the family in her research. The most important forms of aid were care and nursing during an illness, which met the expectations of the elderly.[5] Although after 1989, during the transformation period, there have been significant changes in patterns of family life, an empirical analysis conducted in 2006 by Irena Kotowska and Irena Wóycicka among older people at a retirement age showed that in households that required care, services were mainly provided by the closest family and relatives, while the use of other care providers was rare.[6] At the same time, a study conducted by Sophia Kawczyński-Butrym among social workers in the eastern regions of Poland indicated a problem of neglect of care occurring in families of social assistance clients in which elderly people lived. Most of the surveyed social workers said that in the environments of their clients there is a lack of interest in the fate of their elderly parents.[7] Moreover, attitudes change, there appear new definitions of the roles of parents, children and relatives. The level of acceptance for extra-familial care is growing, which raises the demand for services. The availability of other forms of care provided by

[5] Kotlarska-Michalska A.: Funkcja opiekuńczo-zabezpieczająca wielkomiejskich rodzin pracowniczych. Poznań: WN UAM; 1990.

[6] Kotowska I., Wóycicka I., red.: Sprawowanie opieki oraz inne uwarunkowania podnoszenia aktywności zawodowej osób w starszym wieku produkcyjnym. Raport z badań. Warszawa: Departament Analiz Ekonomicznych i Prognoz, Ministerstwo Pracy i Polityki Społecznej; 2008.

[7] Kawczyńska-Butrym Z.: Problemy opieki nad człowiekiem starszym – obszary pomocy i wsparcia, „Praca Socjalna" nr 4, Warszawa; 1999. s. 16.

informal caregivers, alongside traditional ones, gives the customer a choice. In Poland, the main organizer of extra-familiar care services for the elderly is the public social assistance.

Definition, objectives, types of care services

According to Article 50 Item 1 of the Law of 12th of March 2004 on Social Assistance[8], "a person living alone, who due to age, illness or other reasons requires the help of other people and is devoid of it, is entitled to assistance in the form of care or specialist care services". Within the care services the most lonely elderly, the chronically ill and the disabled receive support to meet their basic living needs in their place of residence.

Another definition of care services can be found in the document *Long-Term Care in Poland*, where: "Long-term care is the professional or unprofessional, intense and long-term care and nursing services provided daily to dependants (incapable of independent existence) in terms of nutrition, movement, body care, communication and household supplies".[9]

According to the Law those entitled to care services include:

- a person living alone, who due to age, illness or other reasons requires the help of other people and is devoid of it,
- a person who requires the help of others, while his or her family and his or her spouse who lives apart, ascendants or descendants cannot provide such assistance.[10]

Based on the literature and the definitions above, it may be stated that the target group of the aforementioned services includes people who are:

- lonely, isolated, with no family support,
- ill,
- disabled,
- dependent,
- elderly.[11]

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[8] Ustawa z dnia 12 marca 2004 roku o pomocy społecznej (tj. Dz. U. z 2009 r. nr 175, poz. 1362 ze zm.)
[9] Augustyn, M.: Opieka długoterminowa w Polsce. Opis, diagnoza, rekomendacje. Warszawa: Klub Senatorów Platformy Obywatelskiej; 2010.
[10] Mejsner B.: Lokalne inicjatywy na rzecz ustalania kryteriów jakości i standaryzacji usług opiekuńczych świadczonych w miejscu zamieszkania-przykłady dobrych praktyk autorstwa. [online] Dostępny w: http://www.wrzos.org.pl/projekt1.18/download/Ekspertyza%20ZE%20OS.pdf.
[11] Mejsner B.: Lokalne inicjatywy na rzecz ustalania kryteriów jakości i standaryzacji usług opiekuńczych świadczonych w miejscu zamieszkania-przykłady dobrych praktyk autorstwa. [online] Dostępny w: http://www.wrzos.org.pl/projekt1.18/download/Ekspertyza%20ZE%20OS.pdf.

The aim of the care services provided for older people in their place of residence is to enable them to continue functioning in their current environment (for as long as possible), despite the constraints they experience in catering for their basic and essential needs on their own and in spite of the barriers to integration with the environment. Through appropriate support offered to an elderly person in the form of such care, the above-mentioned limitations and barriers should be mitigated, helping to maintain or raise the level of their life (in spite of the continuing process of ageing). Providing services in an organized manner, adequate to the identified needs, should always assume the participation of the elderly person in performing specific activities within the scope of the services (the services being of a supportive and activating nature, not doing things for the elderly) and close cooperation in performing the services with the immediate environment of the elderly person (in accordance with the principle of subsidiarity).

The results of care services of appropriate quality include:

- maintaining or improving the physical fitness of an elderly person, his or her good mental condition and the level of integration with the community according to individual abilities and needs,
- maintaining a stable health condition,
- avoiding complications associated with hospitalization, long-term or chronic disease,
- avoiding complications resulting from prolonged immobilization (blistering, pressure sores, contractures, respiratory, digestive, circulatory complications),
- compensating for the reduced ability to walk independently with the help of another person,
- improving the person’s well-being,
- maintaining or increasing self-reliance,
- maintaining or increasing activity,
- reducing social isolation.[12]

Care services can be classified into:

1. Assistance in meeting everyday needs:

a) Feeding:

[12] Staręga- Piasek J., Balon K., Rutkiewicz G., Stec K., Szmaglińska I., Zielon M.: Standard usług opiekuńczych dla osób starszych świadczonych w miejscu zamieszkania. Wspólnota RoboczaZwiązków Organizacji Socjalnych; 2011. s. 4.

- preparation and delivery of meals (including at least one hot meal) and food products for the remainder of the day, taking into account the recommended diet and respecting food hygiene,
- assistance in eating meals or feeding an elderly person, if required by their state of health.

b) Economic activities:

- bringing coal, lighting up the stove,
- cleaning: - maintaining the cleanliness of the immediate environment of an elderly person (excluding heavy cleaning work) - taking the rubbish out - maintaining household appliances continuously clean, including sanitary equipment - cleaning windows
- maintaining kitchen utensils and dishes clean,
- maintaining the cleanliness of auxiliary equipment to facilitate daily functioning (eg. wheelchair, walker, lift),
- shopping,
- washing clothes, bed linen, necessary ironing or taking and collecting things from the laundry.

c) Organizational activities:

- arrangement of medical visits and offering support during them, if necessary,
- buying prescription medicines,
- running official errands or accompanying during visits to offices or other institutions and organizations,
- help in regulating fees (on request),
- assistance in the organization of free time,
- reporting the need to repair appliances and house installations.

d) Other activities arising from the individual needs of an elderly person.

2. Hygiene:

a) Care:

- hygiene - washing the body, washing hair, bathing,
- combing,
- nail clipping,
- shaving,
- assistance in dealing with physiological needs,

- laying an ill person in bed and help in changing positions,
- preventing the formation of pressure sores or blistering,
- changing nappy pants,
- cleaning dentures.

b) Changing underwear and bed linen.

c) Turndown service.

d) Other activities arising from legitimate individual needs of an elderly person.

3. Care recommended by the doctor:

    a) Care:

- tapping,
- applying wraps and compresses,
- change of dressings,

    b) Administration of drugs orally, by inhalation or transdermally (rubbing),

    c) Measurement of temperature, blood pressure, sugar levels etc.,

    d) Other activities arising from the individual recommendations.

4. Ensuring contact with the environment:

    a) Initiating and facilitating contact with the family and the local environment,

    b) Organization of leaving the apartment for outings,

    c) Help in meeting spiritual needs, including religious ones,

    d) Assistance in meeting cultural, sports and recreational needs,

    e) Other activities resulting from the individual needs of an elderly person.[13]

It should be emphasized that it is one thing to help an older person who is still self-sufficient in running the household (shopping, cleaning, cooking, or other activities included in the economic care services) and another to assist a person in terms of care (e.g. maintaining personal hygiene, washing, dispensing medication). Currently, both are included in a single category of care services, hence the difficulty in separating the two types. In practice, in turn, it is very important, because professional help in terms of household assistance and a range of care services does not have to be provided by the same person.

A division into medical and nursing services and care services is also used, but it must be emphasized that the patients eligible for the long-term nursing care are the chronically sick

[13]Staręga- Piasek J., Balon K., Rutkiewicz G., Stec K., Szmaglińska I., Zielon M.: Standard usług opiekuńczych dla osób starszych świadczonych w miejscu zamieszkania. Wspólnota RoboczaZwiązków Organizacji Socjalnych; 2011. s. 8-10.

and disabled patients, incapable of self-care, who obtained from 0 to 40 points according to modified Barthel index and undoubtedly require implementing at least one of the established nursing services for over two weeks.[14]

On the other hand, specialized care services mean is a specialized forms of nursing: rehabilitation or therapy, tailored to the type of illness and disability, provided by people with special professional skills. It should be noted that neither the interested parties, nor even social welfare centres fully utilize specialist care services. Barriers limiting the use of such forms of assistance arise, among others, due to the lack of knowledge on the legal regulations on specialist care services, as well as the ignorance of social workers and managers of Social Welfare Centres of the application procedures for funding tasks assigned to government administration. The results of the study show that social welfare centres that do not organize specialized care services, downplay the requests submitted by the parties interested in this form of help, and sometimes the staff of Social Welfare Centres are not aware of the existence of such forms of assistance. There are also not enough experts providing specialized services, whereas social welfare centres are not very flexible in dealing with such cases, they are not familiar with the this type of specialists on the local market and they do not present the right approach to solve the client's problem.[15]

Informal carers in Poland

In the case of elderly single-person households, apart from family members, services can be provided by people from the so-called informal networks. According to reference literature, an informal supervisor is a person who provides regular, permanent, physical and (or) emotional support and assists with everyday activities to someone who is physically or mentally disabled, mentally ill, or is an older person whose psychophysical condition can be defined as poor. The often interchangeably used terms include "a family caregiver" and "an informal caregiver". However, it should be noted that the group of informal caregivers often includes friends, neighbours or acquaintances.[16]

[14]Perek-Białas J.: Urynkowienie usług opiekuńczych dla osób starszych w Polsce – możliwości i ograniczenia. W: Racław M., red.: Publiczna troska, prywatna opieka. Społeczności lokalne wobec osób starszych. Warszawa: Instytut Spraw Publicznych; 2011. s. 65-67. ISBN 978-83-7689-022-7.
[15]Deja A.: Wykorzystanie specjalistycznych usług opiekuńczych jako jednej z form wsparcia dla osób z autyzmem. Fundacja Synapsis; 2006, 2, 23.
[16]Rosochacka-Gmitrzak M.: Wsparcie opiekunów nieformalnych – w stronę równowagi społecznych oczekiwań i opiekuńczych możliwości rodzin. W: Racław M., red.: Publiczna troska, prywatna opieka. Społeczności lokalne wobec osób starszych. Warszawa: Instytut Spraw Publicznych; 2011. s. 137-156. ISBN 978-83-7689-022-7.

The basic forms of care provided by informal family caregivers include: emotional support, instrumental activities performed in and outside the home (such as transportation, meal preparation, shopping), grooming and personal hygiene (for example, bathing, feeding, dressing, changing nappies) and making contact with agencies specializing in services for seniors, coordinating and supervising them. A relatively short but quite precise definition is offered by L. Thompson, who runs a support programme for informal family carers at Georgetown University, who recognizes them as "relatives of the people in need of care." Informal care is based on the idea of social support, referring to the resources of family, friends and neighbours. An informal caregiver may live with the person requiring care or be only responsible for meeting the person's needs, adjusting his or her individual daily routine.[17]

If possible, the first caregiver of an elderly person requiring care is usually the spouse. The majority of carer of this profile are older people who experience the same health problems themselves and, most importantly, often hide from the environment the fact that their health deteriorates for fear of losing the possibility of caring for their spouse and of doing it at home. The needs of care may evolve, putting an increasing burden on the partner who, as research shows, attempts to hide the fact from other family members, afraid to lose their and their spouse's independence. This leads to the deliberate exclusion of possible supply of support for the primary caregiver, and, in consequence, to an actual decrease in the period of care provided by the partner due to an overload of responsibilities.[18]

Here the activities of the third sector may be appreciated. When the scope of assistance for an elderly person is wider and includes assistance and help with personal hygiene, washing, bathing, dressing and dispensing medicines, such people, even if they are not professionals, (also from the immediate environment), should be properly trained and instructed on how to perform the tasks most effectively, not only for the elderly but also for themselves as carers.[19]

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[17]Rosochacka-Gmitrzak M.: Wsparcie opiekunów nieformalnych – w stronę równowagi społecznych oczekiwań i opiekuńczych możliwości rodzin. W: Racław M., red.: Publiczna troska, prywatna opieka. Społeczności lokalne wobec osób starszych. Warszawa: Instytut Spraw Publicznych; 2011. s. 137-156. ISBN 978-83-7689-022-7.
[18]Cox C., Who is responsible for the care of the elderly. A comparison of policies in the United States, the United Kingdom and Israel, [w:] Social Work, t. 4, red. A. Buchanan, Palgrave Macmillan, Basingstoke 2008, s. 298.
[19]Perek-Białas J.: Urynkowienie usług opiekuńczych dla osób starszych w Polsce – możliwości i ograniczenia. W: Racław M., red.: Publiczna troska, prywatna opieka. Społeczności lokalne wobec osób starszych. Warszawa: Instytut Spraw Publicznych; 2011. s. 65-67. ISBN 978-83-7689-022-7.

The great majority of dependent people in Poland receives care primarily from their family and relatives, although according to a study of European trends its share is decreasing.[20] However, in very many cases, providing such care is not a voluntary decision, but a necessity. 75% of carers feel that there is no choice when it comes to taking responsibility over patient care.[21] Caring for a sick person changes many aspects of life for the caregiver, especially his or her work and financial situation, their relations with the environment, their health and well-being. Empirical studies show that "a small number of municipalities has implemented support for families or individual family members caring for dependants. Only 18% of respondents indicated that their municipality offers care also for the carers of older people. At the same time, more than 64% of the respondents indicated the need for such measures".[22]

Leaving caregivers without support or assistance could lead to a situation where, because of their financial problems (or even poverty, in extreme cases) or a deterioration of their mental and physical health, the carers will stop providing care and will need support from social assistance themselves. As a result, the cost of the help that will have to be covered by the family and the entities of local social policy, as a consequence of the lack of action at the early stages of care, will be much higher than if adequate measures had been taken earlier.[23] Unfortunately, informal carers feel unappreciated and claim that their needs are overlooked or ignored. They do not receive the necessary information or training on how they should take care of a sick person. They need to "fight" for help, and if they receive it, it is insufficient or of poor quality.[24] The development of respite care would significantly relieve the caregiver and make it possible to avoid the negative consequences of excessive care burden and thus improve the quality of life of the patient and the caregiver. The units making decisions to grant social assistance due to a long-term illness should recognize and appreciate the economic/financial value of care provided by informal carers, and thus be aware of the losses they will incur, if the carers stop providing care.[25]

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[20]Golinowska S.: Społeczno-ekonomiczne konsekwencje starzenia się populacji. W: Kleer J., red.: Konse-kwencje ekonomiczne i społeczne starzenia się społe- czeństwa. Warszawa: PAN; 2008, 35.
[21]Perek-Białas J., Stypińska J.: Carers@Work-National Report Poland; 2010, 42.
[22]Instytucje wobec potrzeb osób starszych. Raport, IRSS, Warszawa 2010, 81.
[23] Błędowski P., Maciejasz M.: Rozwój opieki długoterminowej w Polsce – stan i rekomendacje. Nowiny Lekarskie 2013, 82 (1).s. 61–69.
[24]Buckner L., Yeandle S.: Valuing Carers 2011: Calculating the value of carers' support. Carers UK, Report; 2011, 2.
[25] Błędowski P., Maciejasz M.: Rozwój opieki długoterminowej w Polsce – stan i rekomendacje. Nowiny Lekarskie 2013, 82 (1).s. 61–69.

II HOME CARE POLICIES BY COUNTRY

The prospect of demographic change in the direction of increasing the percentage of people at the retirement age and the decline in the number of working-age population is an important challenge in the field of family and social support for the elderly and, as a result, a financial burden outside the health care system. In 20 years there will be a decline in the working-age population by approx. 2 million people. At the same time, a part of the employed population will shift from the economy to the sector of care for the growing population of seniors. In view of the changes on the labour market, one should expect a decline in GDP growth from the currently estimated one of approx. 6% to 2%.[26]

Research results clearly show that the need for care in older age groups of Poles is quite large, as e.g. more than 50% of people aged 75+ experience some or severe problems in performing daily activities. Nearly 78% of those aged 75 to 84 have a permanent disease or health problems.[27]

The obligation to care for the older person in Poland and provide a variety of care services is primarily the responsibility of the family.[28]

Informal carers of the elderly will require systemic solutions enabling them to provide care when they are not employed and are able to commit themselves to care, but also when they have to combine work with care. It is such informal family caregivers who play a key role in providing care for their loved ones – the older people in the family, and supporting them is a challenge for the senior policy.[29]

The concepts of “a family caregiver” or “an informal caregiver” have now become part of the firmly established vocabulary of literature on the theme of care for the chronically ill. Although there is no full agreement as to the differentiation of these concepts among researchers, social politicians, service providers or the carers themselves, it should be

[26] Założenia Długofalowej Polityki Senioralnej w Polsce na lata 2014-2020

[27] Kotowska I., Wóycicka I. Sprawowanie opieki oraz inne uwarunkowania podnoszenia aktywności zawodowej osób w starszym wieku produkcyjnym, Ministerstwo Pracy i Polityki Społecznej, Warszawa 2008

[28] Bledowski P. i wsp. Supporting Family Carers of Older People in Europe - National Background Report for Poland, LIT VERLAG, Hamburg 2006, J. Twardowska-Rajewska (red.), Senior w domu. Opieka długoterminowa nad niesprawnym seniorem, Wydawnictwo Naukowe UAM, Poznań 2007

[29] Założenia Długofalowej Polityki Senioralnej w Polsce na lata 2014-2020

assumed that the term “informal care” is a broader concept than that of “family care”. It applies to all care providers who do not meet the definition of “formal carers” that is those employed in the public service sector.[30]

In Poland, there are laws that to some extent regulate the situation of the elderly, including caring for them. The legislation is presented in Figure 1 below.

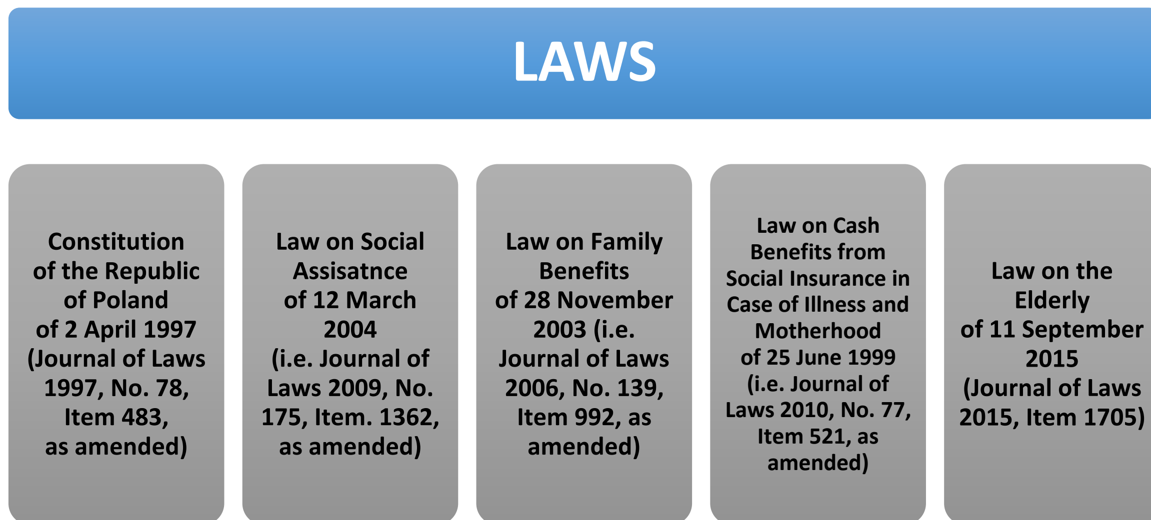

Figure 1. Laws.

The Constitution of the Republic of Poland of 2nd April 1997 (Journal of Laws 1997 No. 78 Item 483, as amended)[31]

In Article 68 Section 3, the Constitution of the Republic of Poland of 2nd April 1997 imposes the provision of special care for selected groups of the society on the public authorities. The groups mentioned there include children, pregnant women, people with disabilities and elderly patients. Unfortunately, this norm is purely indicative, as it imposes an objective without requiring its addressee to take concrete action.

The Law of 12th March of 2004 on Social Assistance (i.e. Journal of Laws 2009, No. 175, Item 1362, as amended[32]

[30] Zysnarska M. i wsp. Kobieta – opiekun osoby przewlekle chorej – wyznaczniki przeciążenia [w:] Nowiny Lekarskie 2010, 79, 5, 386–391
[31] Konstytucja Rzeczypospolitej Polskiej z dnia 2 kwietnia 1997 r. (Dz.U. 1997 nr 78 poz. 483 ze zm.)
[32] Ustawa z dnia 12 marca 2004 roku o pomocy społecznej (tj. Dz. U. z 2009 r. nr 175, poz. 1362 ze zm.)

The Law on Social Assistance regulates the functioning of extremely important forms of assistance to the elderly. A person living alone who due to age, illness or other reasons requires the help of other people and is devoid of it is entitled to assistance in the form of care or specialist care services. Care services include assistance in meeting everyday needs, hygienic care, nursing prescribed by a doctor and, if possible, ensuring contact with the environment. Specialized care services are the services tailored to the specific needs arising from the type of illness or disability, provided by people with special professional skills (Article 50, paragraph 1, 3, 4).

The system of social assistance provides benefits for people who do not start employment or stop working due to the need to provide care. These include the provision of an in-kind benefit in the form of paying social security contributions for the carer. A person eligible for such a benefit is a person who undertakes to exercise direct, personal care over a seriously long-term ill member of the family, his or her mother, father or sibling who lives elsewhere, and the mother- or father-in-law. The payment of social insurance contributions is not granted to someone who looks after the sick person, if the per capita income in his or her family exceeds 150% of the income criterion per capita in the family. This criterion amounts to PLN 351. A person applying for the benefit must obtain a medical certificate attesting to the necessity of exercising direct, personal care over the sick person. The medical certificate, submitted together with the application for a carer's benefit in the form of social security contributions, should be up-to-date. The Law on Social Assistance states that it needs to have been issued no earlier than 14 days before submitting the application for the benefit. The benefit is granted for a period of care. It cannot be granted to a person who is 50 years old on the date of the application and whose period of insurance (contributory and non-contributory) is shorter than 10 years. It also is not granted to a person whose period of insurance (contributory and non-contributory) amounts to 20 years for women and 25 years for men, noting that the non-contributory periods cannot exceed 1/3 of the proved contributory periods.

The Law on Family Benefits of 28th November 2003 (i.e. Journal of Laws 2006, No. 139, Item 992, as amended)[33]

33Ustawa z dnia 28 listopada 2003 roku o świadczeniach rodzinnych (tj. Dz. U. z 2006 r. nr 139, poz. 992 ze zm.)

A carer's allowance is a kind of care allowance which belongs to family benefits which are governed by the provisions of the Law on Family Benefits. According to Article 17 of the Law, these benefits are for people who do not start or who give up employment or other paid work to be able to care for a person holding a disability certificate. Obtaining the patient's certificate of moderate or slight disability is not a sufficient reason to grant an attendance allowance for his or her guardian, as additional circumstances should occur: the need for permanent or long-term care or assistance of another person in connection with a much reduced possibility of independent existence and the need for constant interaction of the child's guardian on a daily basis in the process of the child's treatment, rehabilitation and education. The presence of the above-mentioned circumstances, however, is not required, if the person in question holds a certificate of severe disability.

People eligible for the carer's allowance are set out in Article 17 of the Law on Family Benefits. These include: the mother or father of a disabled person, other people who have a maintenance obligation, excluding people with severe disabilities, as well as the actual guardian of a child.

The Law on Cash Benefits from Social Insurance in Case of Illness and Motherhood of 25 June 1999 (i.e. Journal of Laws 2010 No. 77 Item 512, as amended)[34]

Another kind of benefit that a person taking care of a sick member of the family could receive is the care allowance. It belongs to cash benefits from social insurance in case of sickness and maternity, known also as the provision of sickness insurance benefit. The care allowance is regulated by Article 32 and the subsequent articles. According to Article 32 the allowance may be granted to people who have a sickness insurance, both compulsory and voluntary, exempted from work because of the need to personally care for:

- a child under the age of 8, in the case of:
  - unexpected closure of schools which the child attends,
  - labour or illness of the insured spouse constantly taking care of the child, if the labour or illness prevented him or her from performing care,
  - stay of the insured spouse constantly taking care of the child in an inpatient health care facility;

[34] Ustawa z dnia 25 czerwca 1999 roku o świadczeniach pieniężnych z ubezpieczenia społecznego w razie choroby i macierzyństwa (tj. Dz. U. z 2010 r. nr 77, poz. 512 ze zm.)

- a sick child under the age of 14;
- another sick family member.

The monthly care allowance is paid in the amount of 80% of the salary of the insured. The acquisition of the right to the care allowance requires a medical certificate stating the necessity of the insured person to care for a sick family member. In order to obtain the care allowance, within 7 days from the issuance of a medical certificate the insured needs to submit it to the benefit payer, i.e. his employer or another payer of contributions of health insurance, or the Social Insurance Institution in the cases listed in Article 61 Section 1 Item 2 of the Law on Cash Benefits from Social Insurance in Case of Illness and Motherhood.

The Law on the Elderly of 11th September 2015 (Journal of Laws 2015, Item. 1705)[35]

On 1st January 2016 the legislation on the elderly of 11th September 2015 came into force. The purpose of the Law is to implement a system of monitoring the situation of the elderly. This task is to be carried out by public administration bodies, state agencies and other organizations involved in shaping the situation of the elderly. The scope of monitoring includes: the demographic situation, income situation, housing conditions, economic activity, family situation and the structure of households, the situation of people with disabilities, social activity and active citizenship, educational and cultural activity, sports and recreational activity, health, the availability and performance of social services, equal treatment and preventing discrimination based on age and the senior policy implementation.

Strategic documents at the national level for the informal carers of the elderly are presented in Figure 2.

35Ustawa z dnia 11 września 2015 r. o osobach starszych(Dz.U. 2015 poz. 1705)

Figure 2. The national strategic documents concerning the informal carers of the elderly.

The Assumptions of Long-Term Senior Citizen Policy in Poland for 2014-2020[36]

"The Assumptions of Long-Term Senior Citizen Policy in Poland for 2014-2020 (ZDPS) fulfil the obligations laid down in the Government Programme for Social Active Ageing for 2012-2013 (ASOS). The ASOS programme is the first nationwide programme developed on such a scale, designed for the elderly and intergenerational cooperation. The implementation of the ASOS Programme helped to lay the foundations for the senior citizen policy in Poland (a policy pertaining to elderly people and for the elderly). The Assumptions of Long-Term Senior Citizen Policy in Poland for 2014-2020 constitute a framework but offer a concrete set of necessary measures for the area of the senior citizen policy in Poland, which is directed at a wider audience. Firstly, at the society which, thanks to their skills and potential is a key element in the process of building and developing the policy of active and healthy ageing. Secondly, at the public authorities of all levels, the private sector, non-governmental and social partners, whose activities will allow for the proper management of assets resulting from the lengthening of life. The addressees of activities in the area of senior citizen policy defined in such a way and their close mutual cooperation will play the main part in ensuring the effectiveness of the main objective of the policy – improving the situation of older people for them to be able to age in dignity and in good health." ZDPS should be treated "as the beginning of an important process carried out in Poland, whose objective is to develop and implement the senior citizen policy not only at the national but also regional and local level."

[36] Założenia Długofalowej Polityki Senioralnej w Polsce na lata 2014-2020

The document indicates the necessary actions in various areas of public policy aimed at creating a synergy effect, such as:

- Health and independence (including the conditions of Medical Solutions – Protection, Security, Space and Residence);
- Activity of people 50+;
- Educational, Social and Cultural Activity of the Elderly;
- Silver Economy;
- Intergenerational Relationships.

A comprehensive approach taking into account the problems of the senior caregivers can be found in Priority 3 in the area of Health and Independence of ZDPS – "The development of social and care services tailored to the needs of older people" and its Aim 4 "The creation of systems supporting informal carers, particularly at the local level."

The recommended directions of intervention include:

- supporting the family and informal carers,
- developing systemic solutions to support those caring for the elderly (enabling to combine work and care),
- creating access to information on support options for carers and on how to improve the quality of care by informal carers,
- enabling long- and short-term care over the older person, for example in the case of the caregiver's hospitalization or respite care,
- the development of voluntary care (including in the neighbourhood, in the local environment).

  Other recommendations important for family caregivers and the quality of home care are also present in other sections of the document. It is worth turning one's attention to the postulate of creating a comprehensive system of geriatric care, including in particular the geriatric home care.

A novelty in Poland is recommended, i.e. the development of a system of benefits in cash or in-kind or in the form of cheques to cover expenses for services and care-related products (in combination with the eradication of the shadow economy in the care sector). It is also important to create conditions for increasing the diversity of care for the elderly: daily nursing homes, daycare caregivers, organized neighbourhood support, support for the development of

self-help, volunteering and other forms, elimination of legislative and administrative barriers to the regulation of employment of informal carers.

The possibility of improving the quality of care services for older people is to be seen also in:

- establishing a system of informing and educating caregivers about the problems associated with the care over an older person and the ways of dealing with them, together with the transfer of knowledge and experience from others,
- enabling education, training, practices and exchange of practices and experiences for informal caregivers who need to care for older people (the family, neighbourhood support, volunteers),
- introducing a register, qualification, confirmation of skills and competence and issuing certificates for formal and informal caregivers.

The Government Programme for Social Active Ageing (ASOS) for 2014-2020[37]

The design of this programme has been based on the experience of a programme under the same name conducted in 2012-2013, which consisted of two components: the long-term (system) and the short-term (tender) component. The tender component continues in the next ASOS programme designed up to 2020, whereas the effect of the implementation of the long-term component constitutes a separate document entitled *The Assumptions of Long-Term Senior Citizen Policy in Poland for 2014-2020* referred to earlier. The basis for the ASOS Programme for the years 2014-2020 are the conclusions of the two editions of the tenders from previous years showing that a form of social activity promoted within the project activity is focused on the immediate needs of seniors (passive activity in which seniors are the direct recipients of services designed to meet their needs). There is a very small group of projects aimed at stimulating the active activity of seniors, directed towards the outside world and serving broader social goals, such as those within local communities. In addition, when creating the programme the progressive changes in the structure of the society (low birth rate, migration, mainly for profit and involving people at the productive age) have been taken into account, indicating a growing need for high-quality care services for older people with reduced independence. The component of the current tender programme was based around these assumptions, calling for action in four priority fields:

I. Education for the elderly

[37]Rządowy Program na rzecz Aktywności Społecznej Osób Starszych na lata 2014–2020

II. Social activity
III. Social participation of the elderly
IV. Social services for the elderly (external services).

The priority concerning education points to the importance of the knowledge of law and economics, knowledge relating to healthy ageing, language learning and the use of new technologies, but also to the importance of shaping interpersonal skills and preparing seniors to perform voluntary work.

Lines of action assigned to the priority of the social activity of older people also mention volunteering by seniors, including building social networks within and between generations, but also physical activity and prevention of e-exclusion of seniors.

Increasing social participation of older people is to be based on the efforts of local communities, civic assistance and active participation in the creation of civic groups and public benefit organizations.

It is important that in determining the priorities of the ASOS Programme's tender component their authors have not forgotten about the role and importance of caregivers, including informal carers of the elderly, which is incorporated in the description of the priority on services. It includes training for carers and volunteers on caring of the elderly (it is worth noting that training caregivers is also part of the priority on education), promoting various forms of self-help and supporting families in the care over an older person, primarily through the development of services based on voluntary activity, and also increasing the availability of care services. The authors of the programme attribute particular importance to the priority on the development of social services for the elderly (along with the priority concerning social participation). The programme's budget amounts to PLN 280 million for 2014-2020 coming from the state budget, where 95% of the annual budget (PLN 40 million) will be allocated for grants (open tenders). The programme provides the practical inclusion of the third sector in the operation of activating seniors, because the entities authorized to use the funds allocated in the programme are non-governmental organizations and entities mentioned in Article 3 Section 3 of the Act on public benefit activity and volunteerism. At the same time, the programme allows cross-sectoral cooperation. Entities which cannot be a beneficiary of the programme may benefit from a grant indirectly by entering into a partnership with the bidder. The formula of partnership in the programme relates in particular to local government

units (including its organizational units, including e.g. those without legal personality, social welfare centres or regional centres of social policy) and universities.[38]

The Programme "Solidarity across generations. Measures aiming at increasing the economic activity of people over 50"[39]

The third document, which refers to caregivers is the Programme "Solidarity across generations. Measures aiming at increasing the economic activity of people over 50" adopted on 24th December 2013 with ASOS and ZDPS (as a continuation of a package of government measures to increase the employment of people over the age of 50 in Poland, conducted since 2008 within the framework of a programme under the same name). The Programme indicated that although in the period from 2008 to 2013 a number of planned activities was carried out, maintaining the present favourable momentum of change and the objective may require a fresh look at the programme. Therefore, the objective of the current programme "Solidarity across generations" is to achieve an employment rate of 50% for people aged 55-64 by 2020, which in 2013, according to data from the Central Statistical Office, amounted to 40.6% (annual average data). This objective and the accompanying specific objectives and lines of action set in the programme are all the more important because of the beginning of the implementation of the next EU financial perspective for 2014-2020. It is crucial now when a large part of the funds, and therefore activities in the area of the labour market policy, remains the responsibility of regional authorities and local beneficiaries which will implement projects in the future. The programme "Solidarity across generations 50+" emphasizes the provision of care, including care of the elderly, by working people.

One of the challenges formulated in the programme is to support those who, on the one hand, will be excessively involved in the care of their older family members because of the almost non-existent solutions that would support them in this care, but on the other hand – especially in light of the changes in regulations to increase the retirement age – will have to combine care with work (the growing importance of the problem of "double burden").

[38] Biuletyn Regionalnego Ośrodka Polityki Społecznej w Krakowie, 3/2014
[39] UCHWAŁA Nr 239 RADY MINISTRÓW z dnia 24 grudnia 2013 r. w sprawie ustanowienia Programu Solidarność pokoleń. Działania dla zwiększenia aktywności zawodowej osób w wieku 50+

Under Priority 3.3 “The implementation of system solutions to encourage people aged over 50 to remain in employment and start work”, among others, the following directions of intervention are defined:

- the development and, first and foremost, popularization of the existing solutions supporting the reconciliation of professional and family life, such as flexible working arrangements (job-sharing – i.e. dividing a full-time job position between two or more employees, part-time work, telework). It is important for these solutions to take into account the prospect of individual needs (e.g. own and family members’ health problems, duties of care for the elderly),
- it will also be essential to introduce solutions reducing the burden of caring for dependants (elderly family members), including the development of a system of daily support for those in need of care and assistance to the elderly – day care centres,
- the development of qualifications of a guardian of the elderly, accepted by all stakeholders, their inclusion in the integrated register of qualifications and creating a network of institutions validating the competencies of guardians of older people within the framework of non-formal and informal learning,
- increasing the employment rate of people aged 50+ (above all, including facilitating the return to work after a period of inactivity caused by caring for an elderly person or by an illness) through an analysis of potential solutions in the tax and benefit system, introducing greater progressiveness in the assessment of the income situation and allowing the gradual phasing out of benefits (particularly the social assistance benefits for people who obtain income from work).

III HOME CARE SERVICES APPLICATIONS WITH DATA

In Poland, no one collects accurate data on informal carers or prepares detailed reports on the subject. There is no register of informal carers. There is very little data on the subject. The available data is presented below in Part III.

A. Home Care in figures

The ageing of the population is a process that has begun in the mid-twentieth century and continues to this day. Its intensity in Poland results in a significant increase in the number of people aged over 65 in relation to the total population. In the years 1988-2011 the percentage of people at the retirement age increased by 43.7%.[40] In addition, there is a constant increase in the number of people at very old age (80+), that is the people who require care most frequently. At the same time, the total dependency ratio in Poland will increase from 42 people at the non-working age (0-14, 65+) per 100 people of working age (15-64) in 2010 to 58 people in 2035.[41] An important issue is also a more healthy life of older people, as over the years there is a growing likelihood of physical and (or) mental disability. Studies by the Central Statistical Office show that old people have most difficulty with bathing the whole body, sitting down on a chair, lying down on the bed and getting up, dressing and undressing.[42] The number of people who have a problem with these activities increases with age. According to the survey of the Institute of Labour and Social Affairs, in 2009 in Poland such problems were reported by 25% of people aged 70-79 years old and 30% of those aged 80 and more. Women experience such difficulties more often. Among people aged 70 and more, 129 thousand people experienced slight limitations to self-service, 923 thousand experienced medium limitations, and 301,000 – serious ones. Therefore, the potential need for care in this group can be assessed at more than 1.3 million people.[43] On the other hand, according to the study carried out by the Ministry of Labour and Social Policy in 2008, as much as 27% of men and 41% of women over the age of 75 required care. At the same time,

[40]Główny Urząd Statystyczny, SytuacjademograficznaPolski.Raport2011-2012, Warszawa 2012
[41]Główny Urząd Statystyczny, Prognozaludnościnalata2014-2050, Warszawa, 2014.
[42]Główny Urząd Statystyczny, StanzdrowialudnościPolskiw2009r., Warszawa, 2011.
[43] Błędowski P., Szatur-Jaworska B., Szweda–Lewandowska Z., Kubicki P., RaportnatematsytuacjiosóbstarszychwPolsce,InstytutPracyiSprawSocjalnych,Warszawa 2012, s. 58-62

23% of men and 25% of women needed help.[44] In addition, over 50% of people aged 75+ assessed their health as very poor and poor.[45]

The Polish society is already very old in terms of demographics and this situation is reflected in the expenditure of the National Health Fund for health care. An analysis of the National Health Fund expenditures for hospitalization, taking into account the age of patients, showed that in 2009 people over 65 years of age constituted 26.3% of patients in total, which amounts to more than 1 million 350 thousand people. In 2009 this group of beneficiaries needed over 2 million 300 thousand hospital stays, which accounted for 28.3% of all hospital admissions. To finance hospitalization in 2009 the Fund allocated PLN 24 billion, which includes PLN 8 billion spent on hospitalizations of people over the age of 65, which accounted for 33.6% of the total expenditure. Analysing the proportions in the total number of treated patients, on average, out of 100 people using health care, 60 are hospitalized more than once a year. In the group of patients over 65 years of age the average already amounts to 72 people. Out of every 100 insured, a total of 14 people was hospitalized. The corresponding rate for those aged over 65 is almost twice as high and amounts to 27 people.[46]

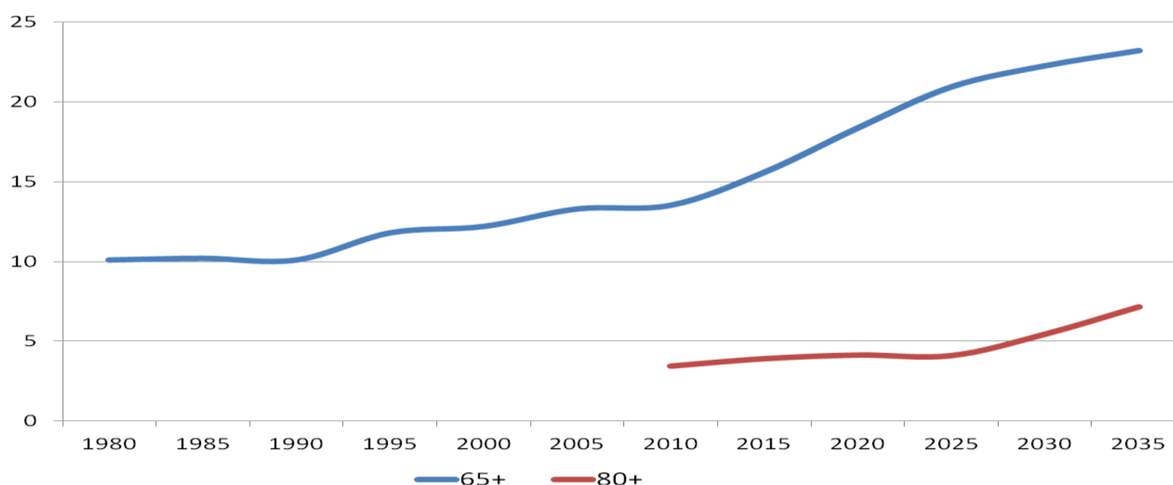

Figure 3. The percentage of people aged 65+ and 80+ in Poland in the years 1980-2035.
Source: Stan faktyczny i perspektywy rozwoju opieki długoterminowej w Polsce

[44] Kotowska I.E., Wóycicka I., Sprawowanie opieki oraz inne uwarunkowania podnoszenia aktywności zawodowej osób w starszym wieku produkcyjnym. Raport z badań, Ministerstwo Pracy i Polityki Społecznej, Warszawa 2008, s. 73 – 86.
[45] Perek-Białas J., Urynkowienie usług opiekuńczych dla osób starszych w Polsce – możliwości i ograniczenia. [w:] Racław M., red., Publiczna troska, prywatna opieka. Społeczności lokalne wobec osób starszych, Instytut Spraw Publicznych, Warszawa 2011, s. 61.
[46] Stan faktyczny i perspektywy rozwoju opieki długoterminowej w Polsce. Warszawa: Ministerstwo Zdrowia; 2012.

Demographic projections show that the number of users of long-term care will double in the next 20 years (data includes mainly the age of users). The future users will have different needs and problems, as well as other resources to deal with them, because this group will be made up of both new generations of older people and younger service users and together will require a more diversified service offer of long-term care.[47]

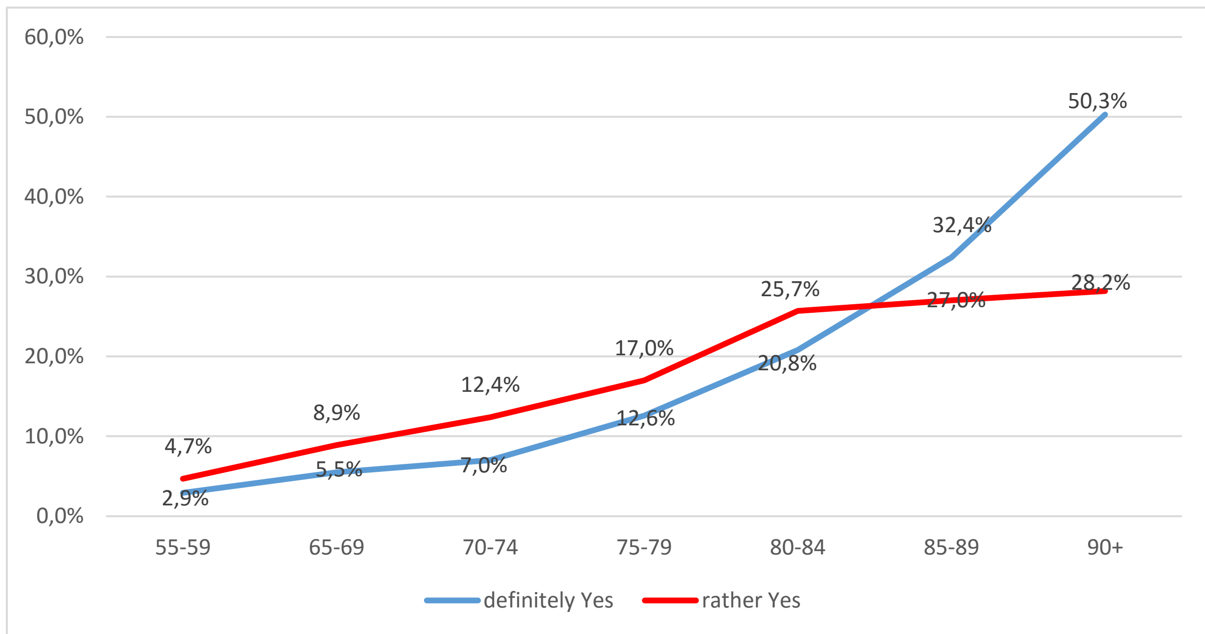

Figure 4. The elderly notifying the need for assistance of other persons by age groups.
Source: Stan faktyczny i perspektywy rozwoju opieki długoterminowej w Polsce

On the other hand, the PolSenior study offers data to estimate the number of dependent persons who will generate demand for environmental care services. As one of the indicators of the state of functioning of a person the study applied the ADL and IADL scales used to assess the degree of independence. The ADL Scale – Activities of Daily Living – is used to measure independence in carrying out basic activities associated with self-service (e.g.: performance of activities of personal hygiene, dressing, eating, control of physiological needs, the use of toilets, motor skill). The subjects were divided into three groups, depending

[47] Stan faktyczny i perspektywy rozwoju opieki długoterminowej w Polsce. Warszawa: Ministerstwo Zdrowia; 2012.

on the number of points scored, on a 0-6 scale: fit –people that received from 6 to 5 points, partially fit – the result of 4 to 3 points and impaired – from 2 to 0 points.[48]

Age	**Score**		
	6-5 points	4-3 points	≤ 2 points
65-69	99.9	-	0.1
70-74	98.9	0.5	0.5
75-79	97.2	1.7	1.1
80-84	94.1	2.9	2.9
85-89	88.3	4.3	7.4
90+	79.1	8.1	12.8

The table above shows the results of the assessment of the ability to perform basic life functions, according to the ADL scale in the PolSenior study.[49]

An attempt has been made to estimate the recipients of informal care in Western Pomerania on the basis of the benefits provided. The results are shown in the following table.

Type of benefit	**The number of people with a benefit granting decision**	**Total number of benefits**
Specialist care services in the place of residence for people with mental disorders	448	84 007
Granted because of a prolonged illness	1 897	5 516
Granted due to disability	2 865	10 046
Care services - total	3 684	605 327

[48]Wizner B., Skalska A., Klich-Rączka A., Piotrowicz K., Grodzicki T.: Ocena stanu funkcjonalnego u osób w starszym wieku, [w:] PolSenior. Aspekty medyczne, psychologiczne i ekonomiczne starzenia się ludzi w Polsce, (red.) M. Mossakowska, A. Więcek, P. Błędowski, terMedia, Poznań; 2012.
[49]Wizner B., Skalska A., Klich-Rączka A., Piotrowicz K., Grodzicki T.: Ocena stanu funkcjonalnego u osób w starszym wieku, [w:] PolSenior. Aspekty medyczne, psychologiczne i ekonomiczne starzenia się ludzi w Polsce, (red.) M. Mossakowska, A. Więcek, P. Błędowski, terMedia, Poznań; 2012.

Specialist care services	186	17 141
The fee for the municipality for a stay in a nursing home	1 577	8 793

Source: Own study based on "Sprawozdanie półroczne z udzielonych świadczeń pomocy społecznej -pieniężnych, w naturze i usługach za styczeń - czerwiec 2010", Ministerstwo Pracy i Polityki Społecznej.

In 2010, in Western Pomerania nearly 4,000 people were covered by the care services. While almost 2,000 people received benefits due to an extended illness. Unfortunately, this is only a small portion of people who are under the care of informal carers, and one also needs to be aware that these numbers are growing year to year.

As far as the supply of support for families is concerned, the caring potential of the family will decrease, which means fewer opportunities to meet the needs within the family. The caring capabilities of a family may be measured with three coefficients:

A. The potential support ratio, which is the ratio of people aged 15-64 to the number of people aged 65 and over;
B. The ratio of support to parents (parent support ratio), which is the number of people aged 85 and more per 100 people aged 50-64;
C. The ratio of the care potential, which is the proportion of women aged 45-64 to the number of people aged 80 and more.

Year	Potential support ratio	Parent support ratio	The ratio of the potential of care
2012	498.6	7.1	386.3
2015	443.7	8.5	354.4
2016	425.0	9.0	344.5
2020	359.2	10.4	323.4
2025	305.8	11.4	330.2
2030	287.5	10.3	271.2
2035	276.6	13.1	219.2

Source: Szweda-Lewandowska Z.: Rynek usług opiekuńczych – perspektywy rozwoju w kontekście starzenia się populacji.

Whereas there were almost 500 people aged 15-64 per 100 people aged 65 and over in 2012, in 2020 it will be fewer than 360 people, and in the last year of the forecast – 276 people. At the same time, the number of people in the oldest age group, i.e. 85 years old or more, per 100 people aged 50-64 will increase in 2020 from 7 to 10 people. In 2020, per 100 people potentially requiring support there will be 219 women aged 45- 64.[50]

An attempt to estimate the number of informal carers of older people in Poland (informal carers are in fact not registered anywhere, with the exception of those few who collect e.g. a special care allowance or make use of available 14 days per annum care allowance paid by the Social Insurance Institution), was conducted as part of an international EUROFAMCARE project implemented in 2003-2004. Based on the number of older people with disabilities or requiring assistance the result amounted to almost 2 million. 97% of caregivers are females, which makes the field of care the domain of women. Men do not get involved in the care of dependants, leaving issues of organizing and coordinating support on the shoulders of women.[51]

The results of the European health survey conducted in 2014, in turn, show that informal care or help was performed regularly at least once a week by almost 16% of the respondents, that is by almost every sixth respondent. More often these were women than men (18% and 13% respectively) aged 50-59 years (every fourth person). In addition, more than 3/4 of the people who provided care assisted only family members, especially if it was helping a man or a person residing in the country. Whereas women and city dwellers were also helping people from outside the family – every fifth respondent. Only a small group was taking care of both family members and people who did not belong to their family. In addition to the question about the core support group, just over 1% of respondents said that there are no people whom they can rely on in case of serious personal problems. Just over 5% of the respondents felt that other people take little or no interest in their affairs. Every tenth respondent replied that getting help from neighbours was difficult, and one in 14 that it was very difficult. [52]

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[50]Szweda-Lewandowska Z.: Rynek usług opiekuńczych – perspektywy rozwoju w kontekście starzenia się populacji. Optimum. Studia Ekonomiczne nr 2 (68) 2014.

[51]Szweda-Lewandowska Z.: Rynek usług opiekuńczych – perspektywy rozwoju w kontekście starzenia się populacji. Optimum. Studia Ekonomiczne nr 2 (68) 2014.

[52]Zdrowie i zachowanie zdrowotne mieszkańców Polski w świetle Europejskiego Ankietowego Badania Zdrowia (EHIS) 2014 r. Główny Urząd Statystyczny; 2015.

B. Good practices implemented locally

❖ Foundation TZMO SA „Razem Zmieniamy Świat" [53]

The DAMY RADĘ project is a project whose main goal is to help people who were faced with the need to provide care to their loved ones because of their advanced age, chronic illness or other serious diseases. People who have to reorganize their lives every day to take care of their loved ones, usually feel helpless, do not know how they should proceed, what rights they enjoy and to whom they can turn for help. That is why they the "Damy Radę" Guide was created. It collects the most important information and tips useful in the care of chronically ill at home. It contains answers to questions about:

- how to prepare to care,
- how to adapt the house to the needs of the dependent person and how to care for him or her to avoid one of the biggest problems of long-term immobilization, i.e. bedsores,
- how to proceed in this difficult situation in order to be able to take care of one's own health, as well,
- which documents one needs to remember about to take advantage of the benefits one may be paid and to avoid unnecessary problems with formalities.

The information from the Guide is supplemented by the damy-rade.info website, which contains even more useful information on the daily care of the dependent person. For those who wish to broaden their knowledge in a practical way, free workshops are organized with the participation of experts on the care of dependents. During the workshop, caregivers learn, among others:

- the proper care, grooming, washing and toileting of the patient,
- selecting the right absorbent articles,
- anti-bedsore prevention techniques.

The participation in the workshop also provides a possibility for an individual consultation with a specialist about a specific problem which the carer cannot cope with.

The workshops are organized throughout the country, once a month in every province. In 2016, 6 workshops took place in Szczecin, in the West Pomeranian province, each attended by an average of 15 people.

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[53]http://damy-rade.info/o-projekcie/

- ***Parafia Ewangelicko-Augsburska w Szczecinie***[54]

Within the framework of the Government Programme for the Social Activity Ageing (ASOS) for 2014-2020, in 2015 founded an Assistance Group, which is a thriving organization of active 60+ volunteers. The organization was established as part of the Project „GRUPA PoMocowa SENIORÓW", in relation to the task: social services for the elderly. The Project is open to older people who want to become volunteers and want to help other seniors, and to people wishing to participate in the integration activities.

- ***Polski Czerwony Krzyż***

Western Pomerania Polish Red Cross (PRC) began its activities on 22nd June 1945 by taking on the care of the incoming repatriates from the east and west. Through the PRC tens of thousands of families were able to find their loved ones, receive documents, use the handed out clothing, meals and food parcels. PRC ran hospitals and medical points, trained in health care, treated the sick, performed disinfection. It organized ambulances for districts that needed one and launched a number of blood donations.

The biggest event of that period in the Recovered Territories was the launch of the Regional Hospital of the Union of Lublin in 1946 with 630 beds and equipment which came from the American and Canadian Red Cross. In 1948, the hospital opened the first institution in Pomerania under the name "Blood Transfusion and Storage Centre."

After 1948 the situation and life in the post-war country changed. The state began to take over medical and nursing institutions, and blood donor centres together with their equipment (including ambulances) from PRC for the benefit of the "Social health service".

The beginnings of the '60s in the PRC activities in Western Pomerania included primarily the creation of care centres for the sick at home and training nurses of the PRC emergency service and the organization of the first Honorary Blood Donations clubs. The first Centre Of Patient Care at Home was established in 1965 in Szczecin, and by the end of the '60s they were created in all the then district towns in the province.[55]

One of the basic objectives of the Red Cross is to prevent human suffering and mitigate its consequences and improve the living conditions of people in need, in all circumstances and at all times, thanks to the mobilization of all forces and means. To fulfil this objective the Red Cross has set its statutory tasks in the field of health and social

[54] https://www.facebook.com/GrupaPomocowa/
[55] http://www.pck.szczecin.pl/index.php/rys-historyczny-pck

assistance, organization and running of care and social, and rehabilitation centres, as well as recruitment, training and organizing staff and volunteers needed to perform these tasks.

The care and social assistance is the responsibility of the state. The task of the Polish Red Cross, as an NGO, is to complement the welfare role of the state within its statutory tasks and own organizational and financial capabilities. The tasks of the state in this area are regulated in detail by the Law on Social Assistance and the implementing provisions of this Law and a number of other laws covering other areas of support to citizens not included in the above-mentioned Law on Social Assistance. Under the existing legal order and recognition of the activity of the non-governmental sector, almost every piece of legislation in the social area indicates the cooperation with NGOs.

In terms of performing PRC's tasks in the broadly understood social area and the care services Article 50 of the Law on Social Assistance is of particular importance. The Article speaks directly of the obligation on the part of the local authority to secure a care service or specialized care service for the people listed in the Law. According to the cited provision, a single person, who due to age, illness or other reasons requires the help of others, is eligible for care services which include assistance in meeting everyday needs, hygienic care, nursing and, where possible, contacts with the environment. The second form of benefits that can be obtained by a person in need of care services are specialized care services tailored to the specific needs resulting from the type of illness or disability.

Therefore the main aim of PRC, assuming that it carries out its statutory task, is to skilfully reach the entities obliged by virtue of laws to perform tasks described as care services, demonstrate its experience, trained staff, reliability in carrying out the task, work towards becoming a leader among other entities conducting similar tasks and a professional partner for the state services, and, above all, for its direct customers, i.e. its end beneficiaries, meaning the cared for people.[56]

IV SWOT ANALYSIS

The interdisciplinary Advisory Board meeting was attended by the following people:

1. prof. dr hab. n. zdr. Beata Karakiewicz – a representative of the health sector
2. dr n. zdr. Marta Giezek – a representative of the social welfare sector
3. mgr Tomasz Osman – a representative of the NGO sector
4. mgr Andrzej Klim – a representative of the business sector

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During the meeting of experts the subjects raised were those of the long-term care in Poland, care services and informal carers. Based on the findings during the meeting notices, information, and recommendations a SWOT analysis was prepared, which is presented below.

Strengths	Weaknesses
1. An emotional bond between the elderly person and his or her carer.	1. The lack of support to the caregiver from other family members.
2. The elderly person stays in a familiar environment – a sense of security.	2. Financial problems of family caregivers due to lack of work or part-time work.
3. Attachment between the caregiver and the person he or she cares for.	3. The high cost of home care services based on the market services.
4. The involvement of carers.	4. Health problems of caregivers resulting from stress and neglecting their own health.
5. Self-help by older people in senior clubs and from volunteering seniors.	5. The lack of information on solutions that can facilitate care.
6. The existence of institutions and organizations providing services to the elderly.	6. The lack of trust in institutions on the part of caregivers.
	7. The age of caregivers, who are often elderly themselves.
	8. The lack of preparation of informal carers to provide care.
	9. The lack of time and willingness on the part of caregivers to receive training on care and nursing.

Chances	Threats
1. The change of state policy in relation to the service system – from institutional to home services.	1. Ageing population.
2. Training for informal carers.	2. Increasing average life expectancy.
3. Financial support for carers who give up paid employment completely or partially.	3. Decreasing fertility rate.
4. Establishing a greater number of daycare homes for the elderly with transportation, rehabilitation and warm meals for the elderly.	4. Changes in the family model (economic migration, the weakening of family ties).
5. Temporary forms of support for the carer who doesn't work (a few hours a week).	5. Difficult access to information which is located in many sectors – health, social insurance, social assistance.
6. Adapting daycare homes to the needs of seniors with varying degrees of efficiency, including people with dementia.	6. No reports on the number of informal carers in Poland or the region.
7. Temporary residence for the elderly person (at least once a year) – a break for the caregiver.	7. Exclusion and discrimination of older people.
8. Free transport services.	8. Low income of elderly people in relation to the basic needs and the reality of the market.
	9. Too low income criterion in the Law on Social Assistance to provide free assistance.
	10. Reduced level of care for the elderly by family members.

9. Co-ordinator / assistant of home care as a form of support for carers.
10. New forms of obtaining information, e.g. E-consultancy.
11. Psychological support for carers.
12. The creation of support groups associating caregivers.
13. Non-governmental organizations supporting informal carers, e.g. through free training.
14. Good cooperation between NGOs, local governments, schools, hospitals and social assistance in terms of services for the elderly.
15. Educating volunteers on supporting older people.
16. Social workers visiting people over 70 years old.
17. Issuing a guide for seniors and caregivers.
18. The possibility of obtaining financial support from assistance funds for activities for the elderly.
19. The increase in wealth of the society, including the elderly.
20. Implementation of programmes and social projects for the elderly.

Conclusions

1. The number of older people will not decrease but is going to grow day to day.
2. It is not possible to reduce the number of informal carers, therefore they need to receive support on all possible levels:
   a. Financial – increasing care benefits, financial compensation for giving up work
   b. Health – prevention programmes, free tests, psychological counselling
   c. Training – free workshops on care and nursing the elderly
3. Local policies should focus on measures for seniors and informal caregivers.
4. Cooperation should be established among the health sector, social services, NGOs and the business sector in activities for the benefit of senior citizens and informal caregivers.
5. Emphasis should be placed on improving the system of information flow.