European Network of Economic Policy Research Institutes

ANCIEN

Assessing Needs of Care in European Nations

QUALITY ASSURANCE POLICIES AND INDICATORS FOR LONG-TERM CARE IN THE EUROPEAN UNION

COUNTRY REPORT: POLAND

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Abstract

The aim of this report is to bring together all the information concerning quality assurance in long-term care (LTC) in Poland. In doing so, we analyse a number of legal regulations and administrative actions in the health care and social sectors, review reports on quality control by the supervising institutions and look at the available statistics reflecting quality in LTC. A general assessment of the LTC quality system reveals a number of drawbacks. There are no well-elaborated LTC standards that are monitored in a systematic and comparable way. The responsibility for assessment falls under several public institutions and the legal regulations are spread across different acts covering the health care and social sectors. The standards for home-based LTC are not defined well enough or monitored in terms of the quality of the care provided. The lack of monitoring of quality in informal LTC also poses a huge problem.

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Quality Assurance Policies and Indicators for Long-Term Care in the European Union

Country Report: Poland

ENEPRI Research Report No. 109/April 2012

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Introduction

The aim of this report is to bring together all information concerning quality assurance in long-term care (LTC) in Poland. As a consequence of the division of the LTC system between the health care and social sectors, obtaining information about overall standards in the LTC system, its provision, legal regulations, supervision and quality control is very difficult. Ensuring proper standards in LTC services is the responsibility of several national institutions that are located in different segments of the state administration. They have varying responsibilities and cover diverse areas of LTC services. Also, LTC standards are defined in several unrelated regulations established by a number of public institutions (such as the Ministry of Health, the Ministry of Labour and Social Affairs and the National Insurance Fund).

Consequently, in this report we have attempted to bring all of this information together. In doing so, we analyse several acts and regulations from the health care and social sectors, review reports on quality control by the supervising institutions (such as the Supreme Audit Office (NIK), Patients' Rights Ombudsman and Chief Sanitary Inspectorate) and look at the available statistics reflecting quality in LTC.

Based on the information gathered, a consistent and comprehensive overview is provided. In the first part, we describe the institutions in the health care and social sectors responsible for quality. We also present some of the post-assessment conclusions of supervisory bodies. In the second part, we list the acts and regulations in which LTC standards are defined. In the third part, we summarise the quality requirements for different aspects of LTC as presented in the relevant documents. Then a general assessment of LTC quality and brief conclusions follow.

1. Institutions responsible for quality

Ensuring proper standards in LTC services is the responsibility of several national institutions, which are located in different segments of the state administration. Their separate responsibilities include the following:

- the types of occupational qualifications required to perform LTC services and definition of the tasks and activities entailed in LTC occupations;
- the range and quality of LTC services financed from public sources; and
- the professional and sanitary standards required in institutional LTC.

Systematic and comprehensive supervision of the quality of LTC requires coordinated action, which should be based on elaborated standards. To develop LTC standards, Ewa Kopacz, the minister of health, established a special team of experts in 2010. She also drafted a regulation,

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which was subject to public consultation in 2011.[1] So far, LTC quality assurance has been an activity undertaken by various independent institutions, which makes the overall coordination much more difficult. These activities can be classified separately under the health and social sectors.

Institutional activities in the health care sector

1) Activities include drafting the legal regulations for medical professions involved in LTC, along with the requirements for competencies and education, for example
   - in 2003, a new, specialised nursing qualification was defined, namely a qualification in LTC nursing. According to the regulation, an LTC nurse should have the title of a specialist in this field and at least have completed the qualifying course in the field of nursing;[2] and
   - in 2007, a new profession of medical worker was introduced. To qualify for it, one needs to have completed vocational school or post-secondary school.
2) The tasks, range of services and specific nursing activities of LTC nurses are defined or reviewed by the Council and Professional Association of Nurses (Szwałkiewicz and Kausen, 2006) and published in medical journals (Derejczyk et al., 2005).
3) The contracting for LTC services by the National Insurance Fund and supervision of their provision are stipulated by a regulation of the National Insurance Fund president.[3] It defines the conditions for the conclusion and implementation of contracts for LTC provision. The "card of nursing activities for [an] LTC nurse" is presented in an appendix of 2007 to this regulation.
4) The professional and sanitary standards for institutional LTC are defined in the Regulation of the Minister of Health of 10 November 2006. It outlines the technical and sanitary requirements for health care facilities and equipment (Dz. U. Nr 213, poz. 1568 ze zm). Additionally, the Order of the National Insurance Fund president of 23 October 2008 defines conditions for the negotiation and implementation of contracts for the provision of nursing and care services, palliative care and hospice care. The Order clarifies the requirements related to personnel, residential conditions and equipment, medical and aid equipment, and other requirements, including ISO certificates and certificates of the Centre for Development of Quality and Safety in Health Systems (CMJ).
5) The supervision and quality control of health care facilities, including those providing LTC, is defined in the Act on Health Care Units of 30 August 1991 as well as in the Regulation of the Minister of Health of 18 November 1999 (Dz. U. Nr 94, poz. 1097). The Act sets out detailed rules for the supervision of independent, public health care institutions and medical transport. Quality control is undertaken by funding bodies (local authorities) and sanitary-epidemiological audit institutions under the supervision of the

[1] See the website of the Ministry of Health (Ministerstwo Zdrowia, http://www.mz.gov.pl).

[2] Law on Nurse and Midwife Occupations of 7 November 2007 (Ustawa z dnia 7 listopada 2007 r. o zawodach pielegniarki i położnej, Dz. U. 2011 r. Nr 174 poz. 1039).

[3] Regulation of the National Insurance Fund President of 11 December 2009 on the type and conditions of realisation of contracts related to LTC services (Zarządzenie Nr 84/2009/DSOZ Prezesa Narodowego Funduszu Zdrowia z dnia 11 grudnia 2009 r. w sprawie określenia warunków zawierania I realizacji umów w rodzaju świadczenia pielęgnacyjne I opiekuńcze w ramach opieki długoterminowej) (http://www.nfz.gov.pl/new/index.php?katnr=3&dzialnr=12&artnr=3953).

national administration. The Chief Sanitary Inspectorate carries out regular inspections, which also involve assessments of stationary health care facilities. The Inspectorate presents the results of these assessments, indicating the scale of any negative opinions about the facilities inspected. In 2010, 6% of stationary LTC facilities received negative opinions.[4]

6) The Patients' Rights Ombudsman investigates the opinions and complaints of patients and their families, and attempts to resolve them in matters related to LTC provision. The Act on Patients' Rights and the Patients' Rights Ombudsman of 6 November 2008 has created a significant platform for societal oversight of health care services. According to the annual reports of the Ombudsman, persons with mental disorders and addictions report more objections with respect to their rights than the elderly do.[5]

7) The Supreme Audit Office, as the highest body of national power, under the coordination of parliament, supervises the operations of all public units. During 2007–09, an audit of stationary health care in nursing care facilities was conducted (NIK, 2010). The audit focused on compliance with all the regulations that stationary LTC services are obliged to follow. The results indicated numerous irregularities, especially related to difficulties in accessing LTC services, the acceptance of more patients than allowable, the prolonging of stays in LTC institutions, the derogation from regulations on density and the extension of the number of benefits provided compared with what was assumed in the contract.[6]

Institutional activities in the social sector

The LTC services provided in the social sector are based on regulations related to social assistance. The range, standards and rules on quality are included in the new Act on Social Assistance (of 2004, which in 2006 was supplemented by definitions of the standards to be achieved by the agreed deadline and in 2011 was amended with the introduction of more precise tasks and indictors for social work, Dz. U. 2004 Nr 64 poz. 593).

1) The necessary qualifications of caregivers in the social sector depend on the types of services they intend to provide (general or specialised) and the level of standard applied (optimal or minimal):

    - The optimal standard entails having an occupational diploma for a caregiver for the elderly, an environmental (home-based) caregiver, a medical worker, an assistant to a disabled person, a medical assistant, a nurse or a caregiver in a residential social-assistance home. It should be noted that the occupations of caregiver in a residential social-assistance home and caregiver for the elderly were established a couple of years ago. The educational requirements for these occupations include four semesters of education in post-secondary school or a supplementary course for social assistant workers without formal qualifications.

    - The minimal standard requires completion of a course in first aid.

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[4] See the website of the Chief Sanitary Inspectorate (Główny Inspektorat Sanitarny –"Solidarność w zdrowiu" [Solidarity in health], http://www.gis.gov.pl).

[5] See the website of the Ombudsman in Poland (Rzecznik Praw Pacjenta, www.bpp.gov.pl) and K.B. Kozłowska, *Sprawozdanie z realizacji zadań wynikających z ustawy z dnia 6 listopada 2008 r. o prawach pacjenta i Rzeczniku Praw Pacjenta (Dz. U. 2009 Nr. 52, poz 417) oraz przestrzegania praw pacjenta na terytorium Rzeczpospolitej Polskiej* [Annual Report of the Ombudsman's investigations based on the Act on Patients' Rights and the Patients' Rights Ombudsman of 6 November 2008], Rzecznik Praw Pacjenta, Warszawa, 2010 (http://www.bpp.gov.pl/dok/sprawozdania/sprawozdanie2009.pdf).

[6] See the website of the Supreme Audit Office (Najwyższa Izba Kontroli, http://www.nik.gov.pl).

2) The accommodation and care standards in residential social-assistance homes are defined by the Regulation of the Minister of Labour and Social Affairs of 19 October 2005 on social assistance homes (Dz. U. Nr 217, poz. 1827). Their implementation has mainly been enforced by EU regulations.

   There is a possibility to adjust care standards to specific regional needs. The regional standards of care services within the social sector were developed through the EU operational programme "Human Capital" (under the project "Creating and developing social service standards and social integration").

3) The public payment for residential social-assistance homes by the territorial self-government is dependent upon the achievement of proper standards. New regulations in this regard were stipulated in the Act on Revenues of the Territorial Self-Government Units of 13 November 2003 (Dz. U. z 2008 r. Nr 88, poz. 539, ze zm).

4) Municipalities (local territorial self-governments) are responsible for assessing the provision of care at residential social-assistance homes as well as access to them.

5) The audit conducted in 2009 by the Supreme Audit Office revealed some problems in the financing of social care as well as in the development of the infrastructure in residential social-assistance homes, which fall under the responsibility of district territorial self-governments. As a consequence of the difficulties in social care provision, the number of places in residential social-assistance homes has been constrained for the elderly in favour of persons with mental disorders. *Nota bene*, there is no place for these persons in the LTC services provided by the health care sector.

2. Legislation on the quality of LTC

Health sector

- Act on Health Sector Units (Facilities) of 30 August 1991 (Ustawa z dnia 30 sierpnia 1991 r. o zakładach opieki zdrowotnej, Dz.U. 1991 nr 91 poz. 408)
- Regulation of the Minister of Health on Access to Institutional Long-Term Care of 30 December 1998 (Rozporządzenie Ministra Zdrowia z dnia 30 grudnia 1998 r. w sprawie sposobu i trybu kierowania osób do zakładów opiekuńczo-leczniczych i pielęgnacyjno-opiekuńczych, Dz.U.1998 nr 166 poz.1265)
- Law on Health Care Services Financed from Public Sources of 27 August 2004 (Ustawa z dnia 27 sierpnia 2004 r.o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych, Dz. U. 2004 nr 210 poz. 2135)
- Law on Nurse and Midwife Occupations of 7 November 2007 (Ustawa z dnia 7 listopada 2007 r. o zawodach pielegniarki i położnej, Dz. U. 2001 r. Nr 57 poz. 602)
- Regulation of the Health Minister on Guaranteed Nursing and Care Services in Long-Term Care of 30 August 2009 (Rozporządzenie Ministra Zdrowia z dnia 30 sierpnia 2009 r. w sprawie świadczeń gwarantowanych z zakresu świadczeń pielęgnacyjnych i opiekuńczych w ramach opieki długoterminowej, Dz. U. 2009. Nr 140, poz. 1147)
- Project concerning the regulation of the Minister of Health on Standards and Medical Procedures in Nursing in Institutional Long-Term Care of 16 December 2010 (Projekt rozporządzenia Ministra Zdrowia z dnia 16 grudnia 2010 r. w sprawie standardów postępowania i procedur medycznych wykonanych w zakładach opieki zdrowotnej z zakresu pielęgnowania w opiece długoterminowej)

- Regulation of the Minister of Health on the Type and Scope of Preventive, Diagnostic and Rehabilitative Treatment Provided by a Nurse or Midwife without the Consultation of a Doctor of 7 November 2007 (Rozporządzenie Ministra Zdrowia z dnia 7 listopada 2007 r. w sprawie rodzaju i zakresu świadczeń zapobiegawczych, diagnostycznych, leczniczych i rehabilitacyjnych udzielanych przez pielęgniarkę albo położną samodzielnie bez zlecenia lekarskiego, Dz. U. 2007 Nr 210 poz.1540)

Social sector

- Act on Social Assistance of 12 March 2004 (Ustawa z dnia 12 marca 2004 r. o pomocy społecznej, amended in 2006 and 2011, Dz. U. 2004 Nr 64 poz. 593)
- Regulation of the Minister of Labour and Social Affairs on Residential Social-Assistance Homes of 19 October 2005 (Rozporządzenie Ministra Polityki Społecznej z dnia 19 października 2005 r. w sprawie domów pomocy społecznej, Dz. U. 2005 Nr 153, poz. 1276)
- Act on the Revenues of the Territorial Self-Government Units of 13 November 2003 (Ustawa z dnia 13 listopada 2003 r. o dochodach jednostek samorządu terytorialnego, Dz. U. 2008 r. Nr 88, poz. 539)

3. Standards

The basic quality indicators for residential LTC services are mainly related to the number of caregivers/personnel devoted to the patient:

- for LTC nurses, 0.4 personnel per patient, and
- for medical workers, 0.5 personnel per patient.

To satisfy the growing demand for LTC services, new medical occupations have been defined: an LTC nurse (2003), a medical worker (2007) and caregivers in social services (2001). Several additional courses aimed at enhancing the qualifications of caregivers have also been introduced (thanks to the programme "Human Capital" financed by the European Social Fund).

In stationary LTC services, several standards concerning accommodation and equipment requirements have been defined, as follows:

- *Place of living*. In the social services sector, bedrooms should accommodate at most three persons, at a minimum size of 9 m^2 for a single bedroom and 6 m^2 per person for double and triple bedrooms. There should be a bed, table, chairs and a nightstand for each person, at least one living room in the flat, one bathroom for at most five persons and one toilet for at most four persons, with an additional room for washing and drying clothes.
- *Meals*. In social services, there should be at least three meals, with a break between meals no shorter than four hours and the availability of some snacks. In the health care system, the minimum standards depend on the disability of the individual. In general, LTC institutions in the health care sector should ensure that the abilities of an individual in self-care are maintained, that these abilities (when lost during the lifecycle) are taught, that assistance is provided in all the necessary activities in self-care if an individual has lost them and that hygiene is ensured. Food should be prepared a minimum of three times a day, a patient should be fed if unable to do so him or herself, and drinks should be provided at least five times a day.
- *Cleaning*. Rooms should be cleaned at least once per day, with detergents being available for this purpose.

Rules attempting to standardise living conditions in social LTC institutions were only introduced to the Act on Social Assistance in 2006. LTC institutions had a ten-year period of adaptation to incorporate changes. Owing to financial limitations, however, they were unable to do so. Consequently, the period for adaptation was extended for another five years (Jurek, 2011).

Home-based LTC is mainly provided by environmental nurses. According to the standards, these nurses should provide care and nursing services to patients no less than 1.5 hours per day, on average four times a week.

Concerning informal LTC, which constitutes a major part of LTC services in Poland, even still no strategy or regulation has been established to ensure appropriate quality and to support informal carers.

There is no obligation for LTC institutions to obtain quality certificates; however, there is a possibility to obtain voluntary ones. Only some private LTC homes might wish to gain a voluntary certificate of quality in the social as well as the health care sector. The high demand for LTC, combined with the restricted and insufficient supply of these services, discourages institutions from making the effort to obtain any quality certificate (Jurek, 2011).

4. General assessment of the LTC quality system

A general assessment of the LTC quality system, taking into consideration four basic criteria, reveals a number of drawbacks, as outlined below. No specific indicators for assessing LTC quality are used by supervisory institutions. As a result, only general estimations by experts are possible, based on research in the field, the time spent on analyses by a particular supervisory institute and the experience it has.

- *Effectiveness*. The LTC system in Poland is relatively inexpensive, owing to the way LTC is provided. First, it is mainly provided by household members and relatives from outside the household as informal LTC provision. Second, the distribution of formal LTC is strictly controlled. The quality of LTC is supervised and the results of assessments undertaken by the Supreme Audit Office indicate a slow rise in LTC standards in the health care and social sectors.
- *Safety*. Safety in publicly provided LTC is assured by applying the appropriate professional and sanitary standards. Also, employment requirements apply with respect to nurses and caregivers. Annual reports presented by the Chief Sanitary Inspectorate confirm the effectiveness of safety supervision.
- *Responsiveness*. The strict control of the distribution of formal LTC services results in the system being perceived as closed and hardly accessible. This situation is caused by the high level of demand for services in the health care sector and constraints in the social sector.
- *Coordination*. We observe a lack of coordination at the macro as well as the micro level between the LTC services provided by the social sector and health care sector. This factor constitutes a significant weakness in the overall system (Golinowska and Sowa, 2010).

Conclusions

The analysis of the existing state of LTC quality assurance in Poland has shown that it is still an open issue for public authorities. There are no well-elaborated LTC standards that are monitored in a systematic and comparable way. The responsibility for assessment falls under several public

institutions and the legal regulations are spread across different acts covering the health care and social sectors.

At the same time, some efforts are underway to improve the quality of LTC provision. To develop LTC standards, the minister of health established a special team of experts in 2010. Additional courses aimed at enhancing the qualifications of LTC workers have been introduced. There have also been some legislative attempts to increase the insufficient number of LTC workers.

Yet, other conditions for the development of institutional LTC quality are still not sufficiently consistent. Moreover, the standards for home-based LTC are not defined well enough or monitored in terms of the quality of the care provided. Finally, this lack of monitoring of quality in informal LTC poses a huge problem in terms of LTC quality assurance.

Bibliography

Derejczyk J., T. Grodzicki, A. Jakrzewska-Sawińska, A. Jóźwiak, A. Klich and K. Wieczorowska-Tobis (2005), Standardy świadczenia usług medycznych w specjalności geriatria [Standards of geriatric care, consensus], Stanowisko Polskiego Towarzystwa Gerontologicznego Kolegium Lekarzy Specjalistów Geriatrii w Polsce i Konsultanta Krajowego w dziedzinie Geriatrii, *Gerontologia Polska* [*Polish Gerontology*], Vol. 13, No. 2, pp. 67–83.

Głównego Inspektora Sanitarnego (2011), *Stan Sanitarny Kraju w roku 2010* [Sanitary Situation in Poland in 2010], Raport Głównego Inspektora Sanitarnego, Warsaw (http://www.gis.gov.pl/userfiles/file/stan_sanitarny_kraju_za_rok_2010.pdf).

Golinowska, S. and A. Kozierkiewicz (2008), *Quality in and Equality of Access to Healthcare Services: Country Report*, HealthQUEST, European Commission, Brussels.

Golinowska, S. and A. Sowa (2010), Działania samorządów lokalnych w opiece i integracji niesamodzielnych osób starszych [Activities of local authorities towards integration and care of older citizens], MPiPS oraz IPiSS, Warsaw.

Jurek, Ł. (2011), O Jakości usług świadczonych w domach pomocy społecznej [About the quality in social homes], *Polityka Społeczna* [Social Policy], No. 3/2011.

Kozłowska, K.B. (2010), *Sprawozdanie z realizacji zadań wynikających z ustawy z dnia 6 listopada 2008 r. o prawach pacjenta i Rzeczniku Praw Pacjenta (Dz. U. 2009 Nr. 52, poz 417) oraz przestrzegania praw pacjenta na terytorium Rzeczpospolitej Polskiej* [Annual Report of the Ombudsman's investigations based on the Act on Patients' Rights and the Patients' Rights Ombudsman of 6 November 2008], Rzecznik Praw Pacjenta, Warszawa, 2010 (http://www.bpp.gov.pl/dok/sprawozdania/sprawozdanie2009.pdf)

NIK (2010), *Informacja o wynikach kontroli funkcjonowania zakładów opiekuńczo-leczniczych* [Information on the results of the control of nursing care facilities operations], NIK, Warsaw (http://www.nik.gov.pl/plik/id,1874,vp,2244.pdf).

Szwałkiewicz, K. (2006), Opieka długoterminowa w świadczeniach pielęgniarek i opiekunek [Long-term care services in the work of nurses and carers], Stowarzyszenie na rzecz chorych długotrwale unieruchomionych 'Niebieski Parasol', Toruń.

EUROPEAN COMMISSION
European Research Area

SEVENTH FRAMEWORK PROGRAMME

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ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long-term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiological and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

Work Packages. The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the back of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance.

Principal and Partner Institutes

CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination. Other partners include: German Institute for Economic Research (DIW); Netherlands Interdisciplinary Demographic Institute (NIDI); Fundación de Estudios de Economía Aplicada (FEDEA); Consiglio Nazionale delle Ricerche (CNR); Universitá Luiss Guido Carli-Luiss Business School (LUISS-LBS); Institute for Advanced Studies (IHS); London School of Economics and Political Science- Personal Social Services Research Unit (PSSRU); Istituto di Studi e Analisi Economica (ISAE); Center for Social and Economic Research (CASE); Institute for Economic Research (IER); Social Research Institute (TARKI); The Research Institute of the Finnish Economy (ETLA); Université de Paris-Dauphine-Laboratoire d`Economie et de Gestion des organisations de Santé (DAUPHINE- LEGOS); University of Stockholm, Department of Economics; Karolinska Institute-Department of Medecine, Clinical Epidemiology Unit ; Institute of Economic Research, Slovak Academy of Sciences (SAS-BIER); Center for Policy studies (PRAXIS). Most of the ANCIEN partners are members of the European Network of Economic Policy Research Institutes (ENEPRI).

For more information, please visit the ANCIEN website (www.ancien-longtermcare.eu) or the CEPS website (www.ceps.eu).